

Improving Health Outcomes in HUSKY Health Members

Community Health Network of CT, Inc.
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- Access to Providers
- Member Engagement
- Data Analytics
- Population Health Outcomes
- Utilization Improvements
- Clinical Support Programs
- Opportunities in 2018



Our Provider Network Continues to Grow

CMAP Changes, CY 2015 – CY 2017

	CY 2015	CY 2016	CY 2017	Percent Change CY 2015-CY 2016	Percent Change CY 2016-CY 2017
Total Primary Care Providers (PCPs)	3,454	3,511	3,602	+1.65%	+2.59%
Total Specialty Providers	16,940	17,154	17,764	+1.26%	+3.56%
Total HUSKY Membership	739,238	768,149	795,454	+3.91%	+3.55%



■ Member Attribution

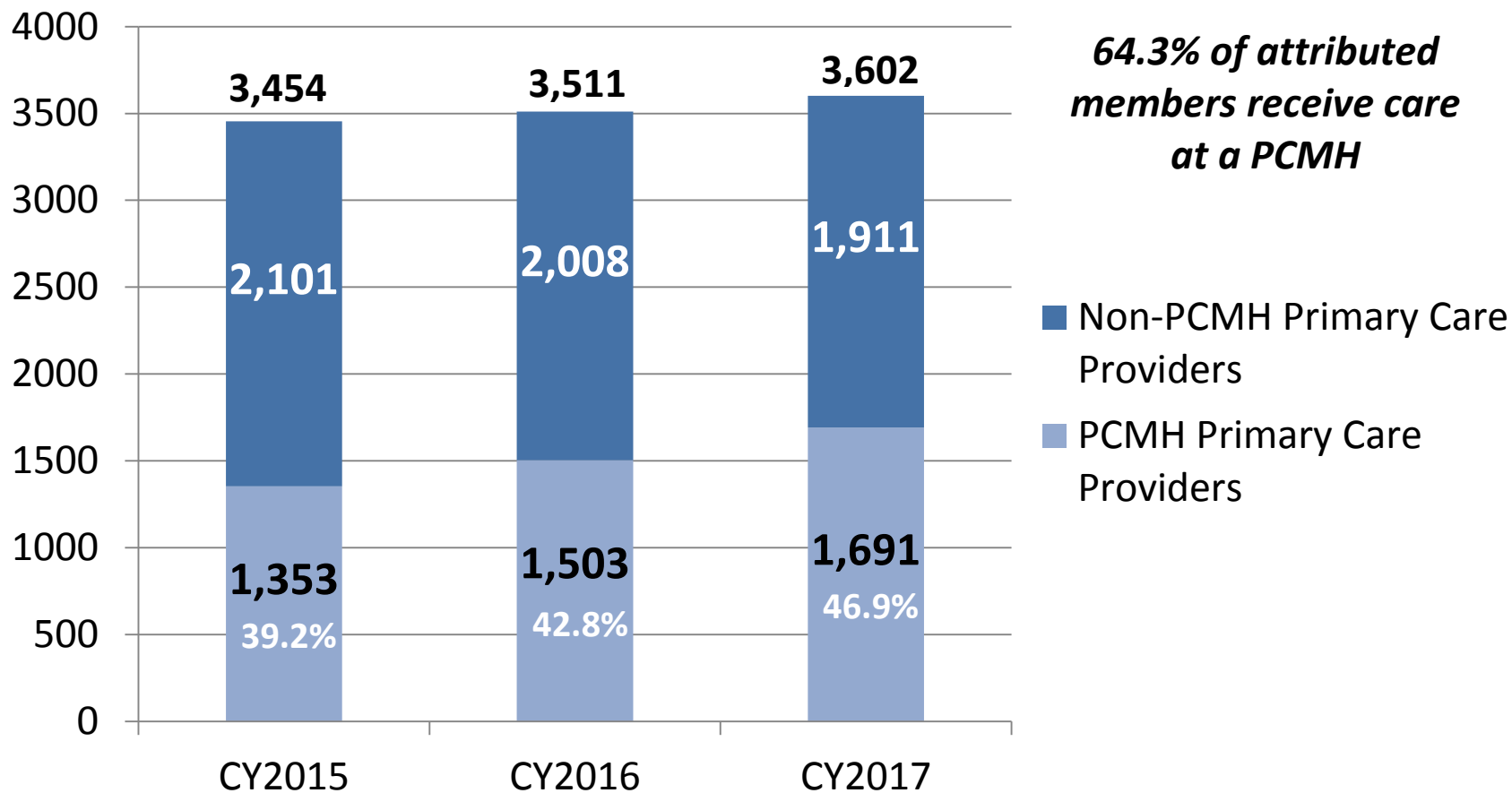
- The attribution process is based on member claims data for a select set of preventive and evaluation and management (E & M) procedure codes billed by a provider who is designated as a PCP
- Members may also select a PCP

■ A member may not be attributed to a PCP if:

- Codes billed do not fall into the preventive and E & M codes that are used for attribution
- A member has other insurance (such as commercial or Medicare) and HUSKY did not receive claims for these services
- A member hasn't had a claim billed for the select preventive and E & M services in the prior 15 months



CMAP Primary Care Providers & Person-Centered Medical Home (PCMH) Primary Care Providers



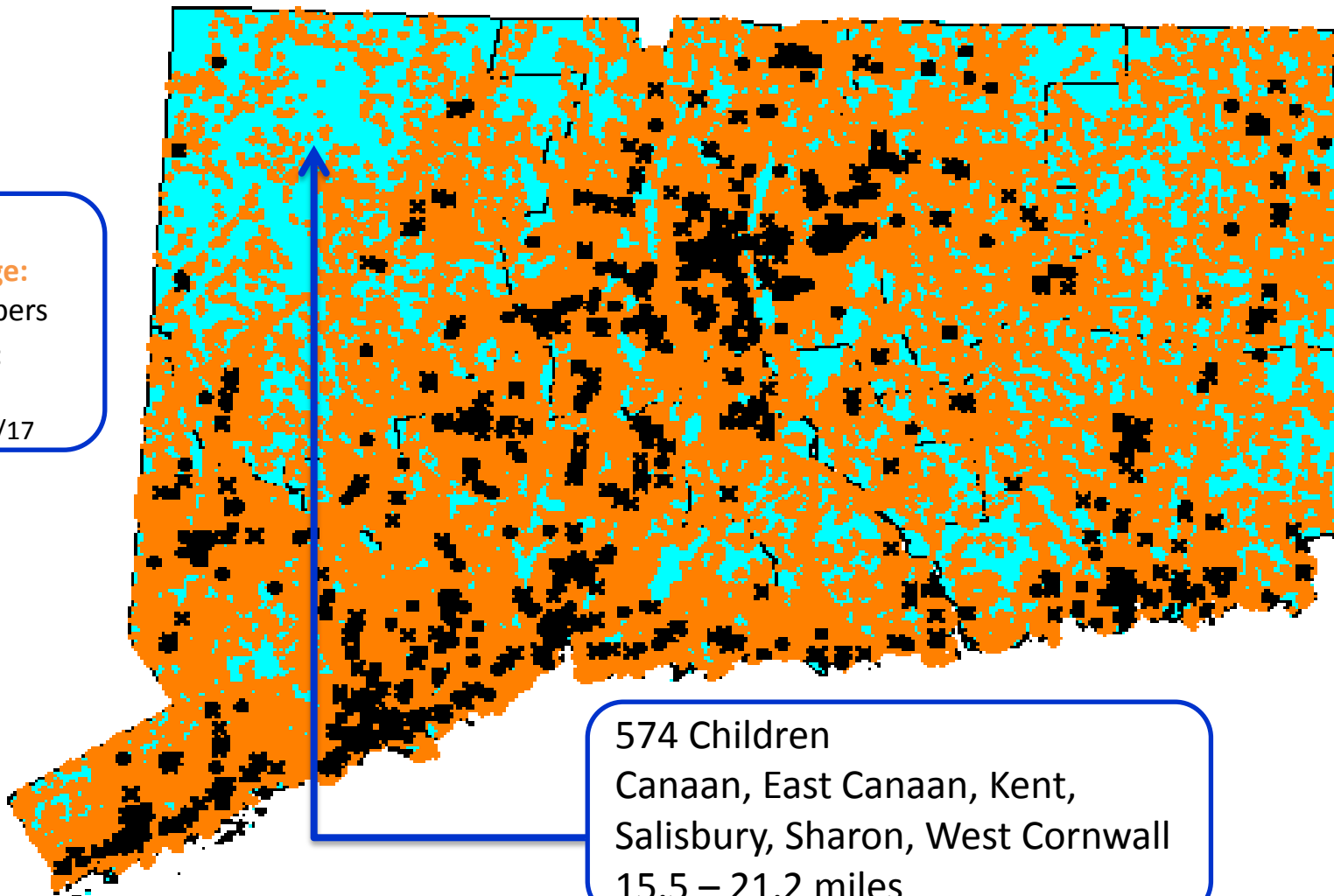
Membership Map*: Access to PCPs with Open Panels

Adults: 100% within 15 miles; Children: 99.8%

Key:

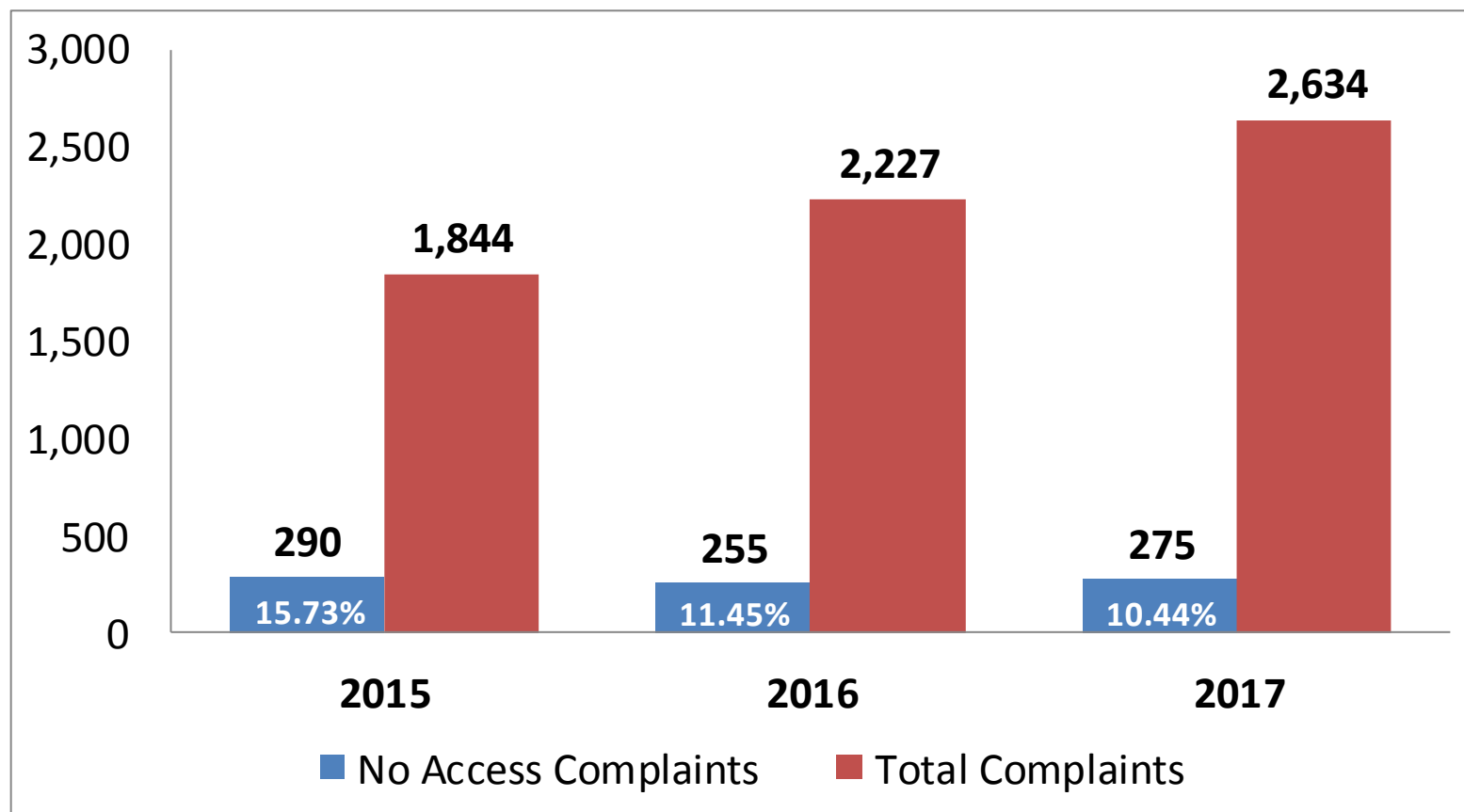
- **Orange:**
Members
- **Black:**
PCPs

*As of 12/17





Complaints Received: No Access*



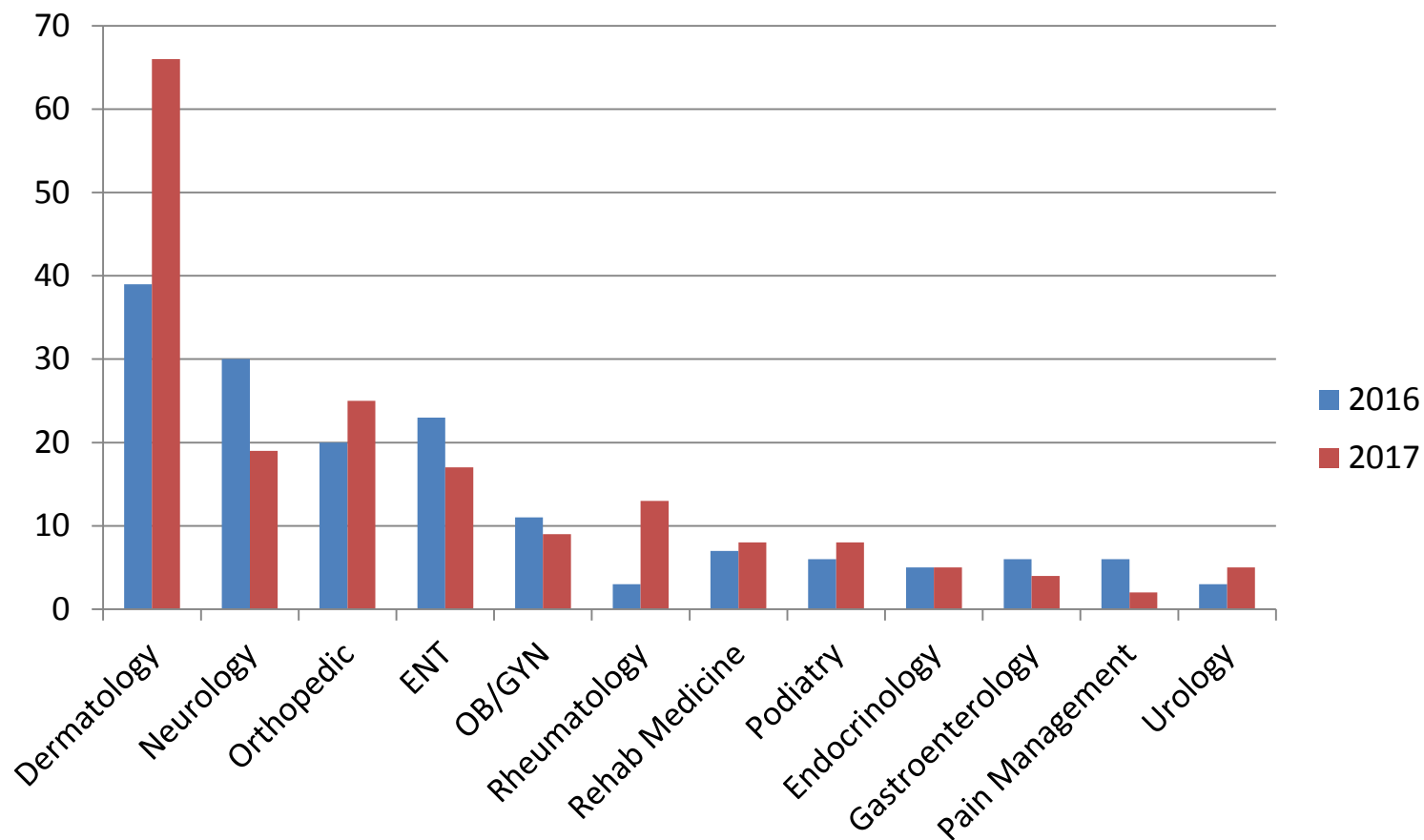
Membership: 2015: 739,238
2016: 768,149
2017: 795,454

**The category of "no access" refers to complaints made by members having difficulty finding a provider.*



Access Complaints by Specialty

100% of complaints were resolved





- Member Advisory Workgroup (MAW) is a diverse group of 15-17 members
- Accomplishments:
 - Reviewed and edited the Member Handbooks and Member Brochure
 - Edited the Provider Directory landing page and search pages
 - Designed a user-friendly benefit grid for members to use when looking for covered services
 - Created a teen brochure and a companion parent brochure to inform members what questions they may want to ask their provider
 - Discussed various topics and provided feedback including: PCMH+, use of social media, medication adherence, website satisfaction, email campaigns, keeping wellness visits and follow-up visits after an appointment, and missed appointments



217K+ HEAD OF HOUSEHOLD Email addresses	910K+ EMAILS SENT	870K+ EMAILS DELIVERED
325K+ EMAILS OPENED*	90.7% RETENTION RATE Members who remained subscribed to email	2.4M+ AUTOMATED CALLS MADE
1M+ SUCCESSFUL AUTOMATED CALL MESSAGES	14 AUTOMATED CALL CAMPAIGNS	30 SECONDS Length of automated call

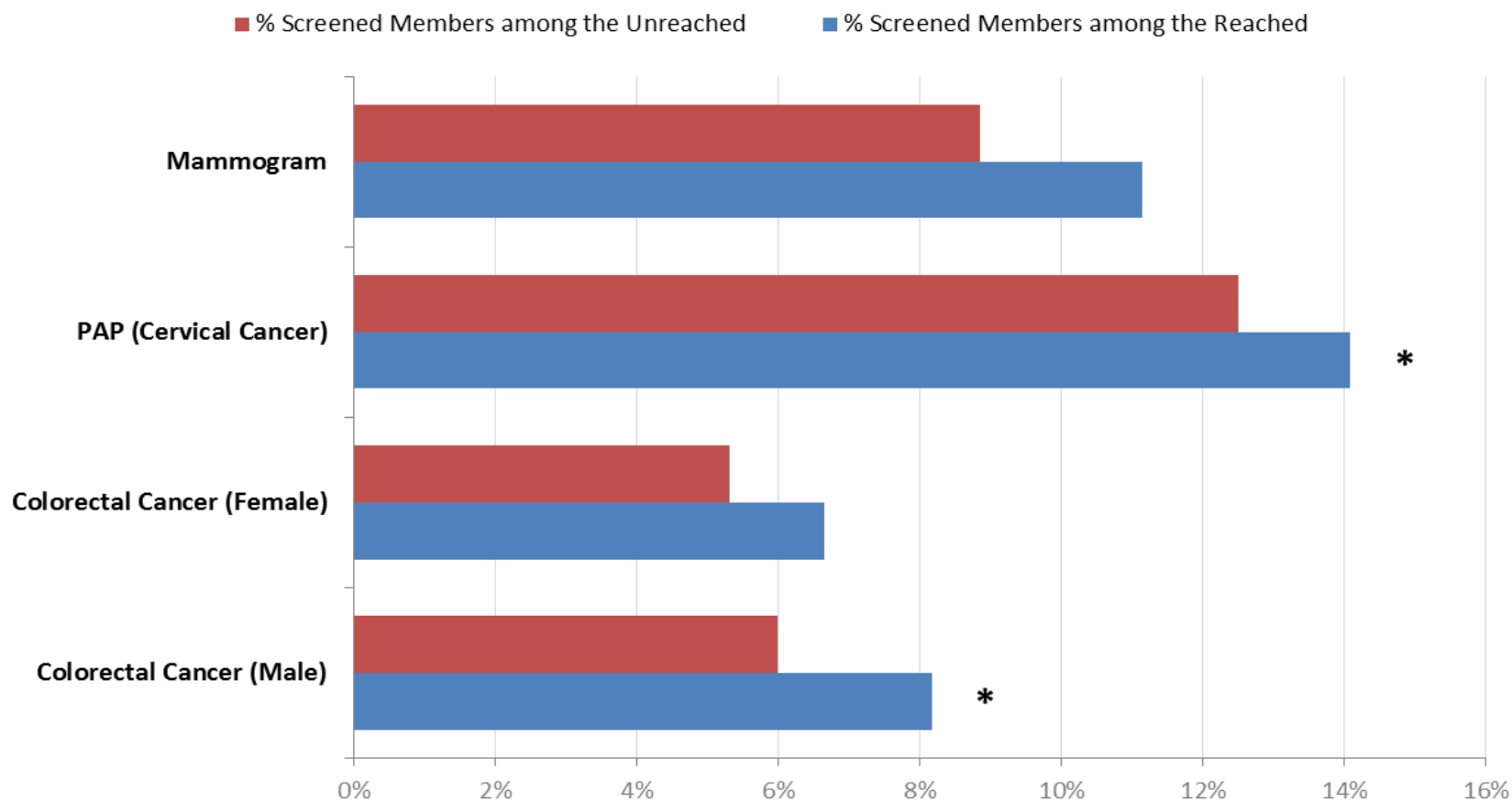
**Email Tracking:* An image is inserted into every email bulletin sent to members. When an email is opened, the image is displayed and the system tracks the email as opened.



Example: Preventive Care- Cancer Screenings

CY 2016 Automated Call Results for Previously Unscreened Members

% of Members who Subsequently Received Screenings after Successful vs. Unsuccessful Calls



* = P value < 0.001



- CHNCT's Community Affairs department partners with community organizations and local non-profits who serve HUSKY Health members to establish community engagement HUBs currently in five cities throughout the state
- These HUBs provide HUSKY Health members the opportunity to meet face-to-face with program representatives to assist with navigating their benefits and connecting to local community resources

Mr. L is a HUSKY member in his 40's who lives with his wife who is the sole wage earner and their 4 children. He stays home as the primary caretaker. The family has HUSKY benefits as well as SNAP. He contacted Member Engagement Services requesting help in locating a pain management provider, and was referred to the Escalation Unit. They spoke with the member and learned that he was seeing a non-CMAP pain specialist since 2014. Payment for office visits was difficult, but he felt the medication he was receiving was essential and was not aware of any in-network providers. The member did have a PCP, but was uncomfortable with that PCP managing his pain.

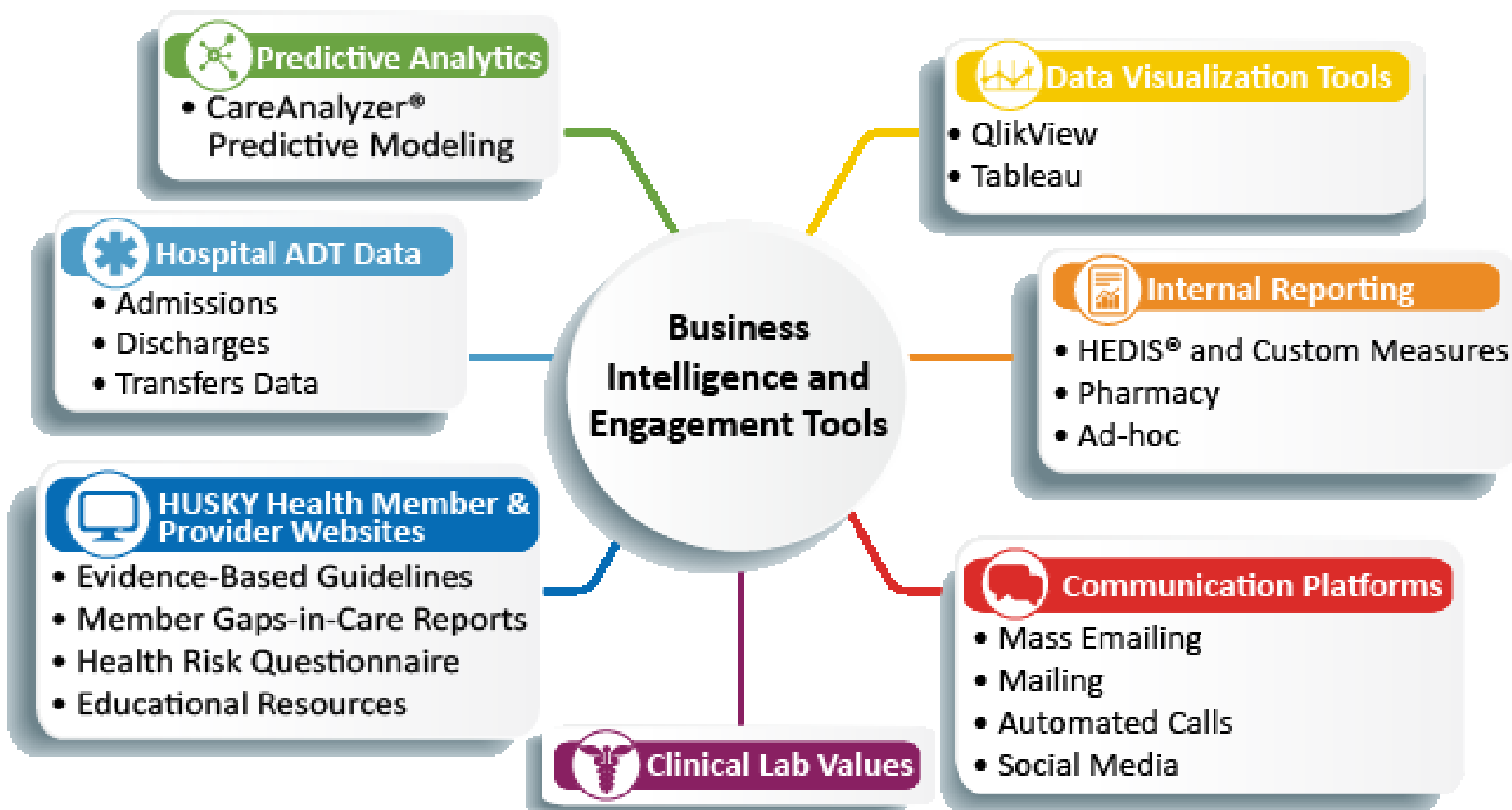
He indicated that his chronic pain prevented him from work that required physical labor. It also limited his activities with his children. Their income level resulted in inadequate food for the family, inability to pay energy bills, and a clothing need for the children. Mr. L was maintained on long-acting opioids. He desired to be able to be more active. These issues caused him to experience anxiety.

The Escalation Unit representative provided assistance in applying for energy assistance, information on local food pantries to supplement SNAP benefits and resources for children's clothing. Mr. L was also referred to the CTBHP for assistance in locating a BH provider that might help him address the anxiety he was experiencing.

The EU representative worked with the member to identify a provider that offers both pain management and primary care services, who he saw shortly thereafter and continues to see on a monthly basis. His medications have been changed over time. He is no longer on any opioids. His pain is managed through a reduced dose of methadone as well as alternative therapies. Mr. L is compliant with his monthly appointments and has a contract with the provider regarding his pain management plan.



- As the medical ASO, CHNCT uses data from claims, Hospital Admit, Discharge, and Transfer logs, chart reviews, and member touches to:
 - Inform tools that stratify:
 - Practices based on performance on health outcomes measures
 - Members based on risk due to medical conditions, adverse social determinants of health, access to care, and preventative care
 - Craft Member and Provider interventions to address barriers





■ Provider Tools

- Individual Practice Profiles
 - Practices with greater than 50 members receive an individual practice profile
 - Each individual practice profile includes the following:
 - 43 selected HEDIS® and DSS custom measures
 - Comparisons to practice setting, statewide and national benchmarks (where available)
- Annual Provider Profiling Report- tool used to stratify providers (by practice setting)
 - Statistical Analysis done for every measure on profile, includes a Box-Whisker plot for each measure
 - Identifies practice's performance at mean, median, and the 5th, 25th, 75th, and 95th percentile
 - Used to target practices for interventions



DSTHS CareAnalyzer®

PCP Profile

ACG® Risk Adjusted
Report Period 01/01/2017 to 12/31/2017
Provider Attribution Method PCP
Cost Basis Allowed Dollars
Costs Excluded None
Cost Truncation \$ 100,000
Provider [REDACTED]
Peer Group APRN/NP

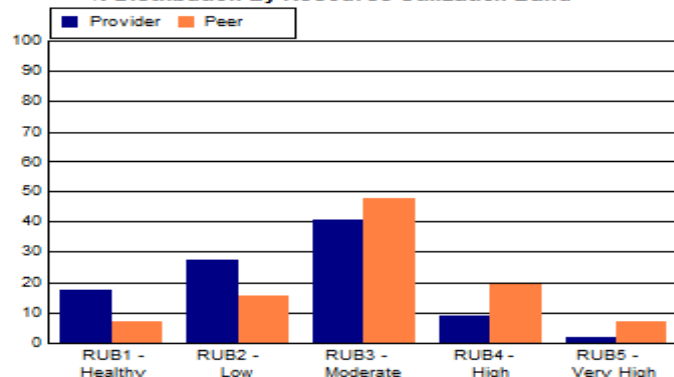
SUMMARY PROVIDER

Member Count	553	Office Visits (%)	45
Avg Age	8	Professional Costs (%)	15
Avg Months Enrolled	12	# Members Truncated	4
Avg PMPM Cost (\$)	349.35	Total \$s Excluded	669,098.40
Avg RRS	0.71		
Cost Index	1.22		

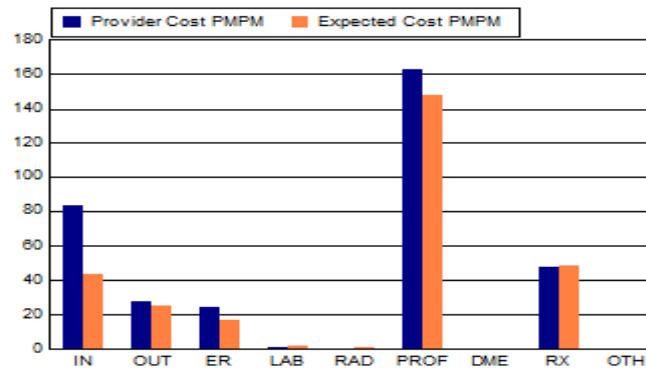
PEER COMPARISON

# Providers	585
Avg RRS	1.50
Avg Panel Size	208
# Member Truncated	803
Total \$s Excluded	53,825,212.53

% Distribution By Resource Utilization Band



Cost Distribution By Major Service Category



% Office Visits by Complexity

	Provider (%)	Peer (%)
Preventive	56	12
Low Complexity	6	3
Low to Moderate Complexity	0	8
Moderate Complexity	37	49
Moderate to High Complexity	0	27
High Complexity	0	2

Cost Distribution by Major Service Category - Detail

	Provider Cost PMPM (\$)	Expected Cost PMPM (\$)	Cost Index
Inpatient	83.84	44.41	1.89
Outpatient	27.73	25.06	1.11
ER	24.09	17.04	1.41
Lab	1.34	2.09	0.64
Radiology	0.61	0.82	0.74
Professional	163.10	147.47	1.11
DME/Home Health	0.45	0.60	0.75
Pharmacy	48.19	48.84	0.99
Other	0.00	0.00	0.00
Total	349.35	286.33	1.22



■ Provider Website

- Evidence-based guidelines
- Patient Management Tools
- Secure portal
 - Gaps in Care reports

■ Value-Based Initiatives

- PCMH/PCMH+
- OB P4P

Provider Home | Member Home

Home > Condition Management Resources > Asthma Control



Find a Doctor | Condition Management Resources | Prior Authorization | Medical Management | Person-Centered Medical Home | Reports & Resources

Asthma Control

Of patients in Connecticut who have a diagnosis of asthma, almost half have uncontrolled asthma.¹

HUSKY Health supports **guidelines from the National Asthma Education Prevention Program** to improve asthma control for HUSKY members. The **Guidelines Implementation Panel (GIP) Report for: Partners Putting Guidelines Into Action** identified six clinical practice recommendations to assist providers with the implementation of the guidelines.

To help you quickly reference the GIP recommendations and access corresponding resources assembled by HUSKY Health, please use the below information when caring for your HUSKY patients with asthma.

	GIP Clinical Practice Recommendations	Asthma Control Resources
Symptom Control	Assess asthma severity at the first visit to determine initial treatment.	For information on assessing asthma severity, access the Asthma Care Quick Reference guide here .
Inhaler Use	Use inhaled corticosteroids as recommended to control asthma.	The Asthma Medication Ratio (AMR) can help you to assess your patient's ability to take asthma medications as prescribed. To use our AMR calculator, click here . If a patient has an AMR under 0.5, consider referring them to Intensive Case Management (ICM) for additional support with resolving barriers to medication use. To learn more about ICM, click here .
Action Plans	Use written asthma action plans to guide patient self-management.	Asthma Action Plans from the Connecticut Department of Public Health are available below. <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;">  <p>0-11 Years</p> </div> <div style="text-align: center;">  <p>12 Years and Up</p> </div> </div> <p>You can complete these forms electronically and print them for your use. For instructions on how to complete an Asthma Action Plan, click here.</p>



Report Type:

- Adult Diabetes Screening Tests - Gaps in Care
- Adult Preventive Visits Age 21 - 49 - Gaps in Care
- Adult Preventive Visits Age 50 - 64 - Gaps in Care
- Asthma Controller Medications
- BEH and Developmental Screenings - Gaps in Care
- Breast Cancer Screenings - Gaps in Care
- Cervical Cancer Screenings - Gaps in Care
- Child Diabetes Screening Tests - Gaps in Care
- Child Well-Care Visits - Gaps in Care
- Colorectal Cancer Screenings - Gaps in Care
- Daily Admission and Discharge Report
- Daily Pharmacy Report
- ED Utilization Report
- Inpatient Claims Report
- Member Satisfaction Survey with Provider Services
- Monthly Pharmacy Report
- Patient Panel Report
- PCMH Plus Patient Panel Report

On behalf of the HUSKY Health Attribution Flyer

By accessing

- The information and state
- CHNCT's
- Access to the information contained in these reports is on a strictly need to know basis and you may not use any patient PHI for any purpose other than for treatment of the patient.

Report Help Guides:

Select

ACCESSING UTILIZATION REPORTS AT THE BOTTOM OF THIS PAGE.

Connecticut, Inc. (CHNCT) is providing Primary Care Providers (PCPs) with access to claims reports for their attributed inform you of your HUSKY Health patients' utilization. To help you understand the attribution process, click here for our

Accept the following requirements:

on (PHI) and you are required to protect the confidentiality of this information in accordance with all applicable federal warranties regarding the accuracy or completeness of the information accessed herein and the information available

Please Note: All patient utilization data with a behavioral health, substance abuse or HIV related diagnosis has been removed from the utilization reports. If you are a PCP and would like access to this data for the HUSKY Health patients who are attributed to you, you must ask each patient to sign a Consent to Disclose Sensitive Health Information form, specifically permitting CHNCT, on behalf of the HUSKY Health program, to provide you (the PCP) with access to this sensitive claims data. A general authorization form for the release of medical or other information is not sufficient for this purpose. HUSKY Health members are not required to sign this consent form. However, if a HUSKY Health member provides consent, CHNCT will include this data in the PCP's utilization reports. You may obtain a copy of the blank consent form by [clicking here](#). Please forward all signed consent forms to CHNCT's Compliance Officer by either fax (203.265.2780) or mail: CHNCT, Attn: Compliance Officer, 11 Fairfield Boulevard, Wallingford, CT, 06492.

PCP Portal Report Survey:

The HUSKY Health secure provider portal provides all Primary Care Providers (PCP) with access to reports which contain information and data about your HUSKY Health members. To help us make sure these reports are useful for you as they can be, we have a brief survey we would like you to take.

Click [here](#) to complete the survey.

Adult Diabetes Screening Tests - Gaps in Care

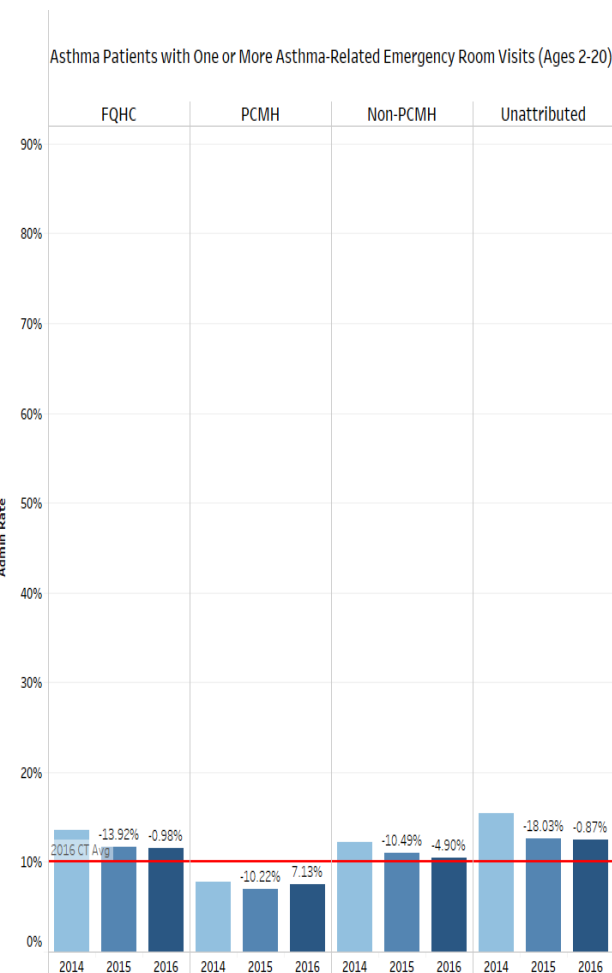
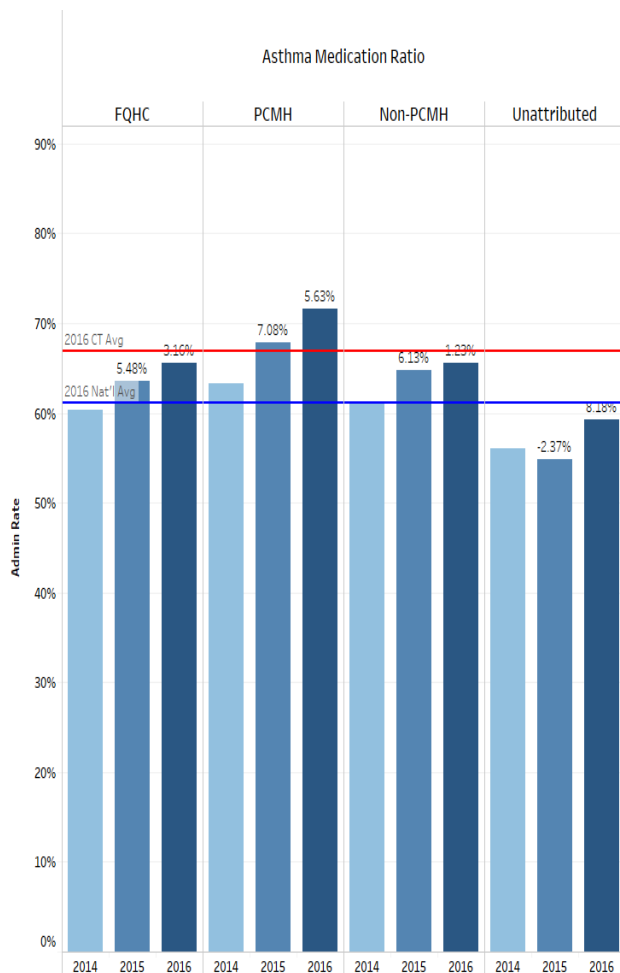
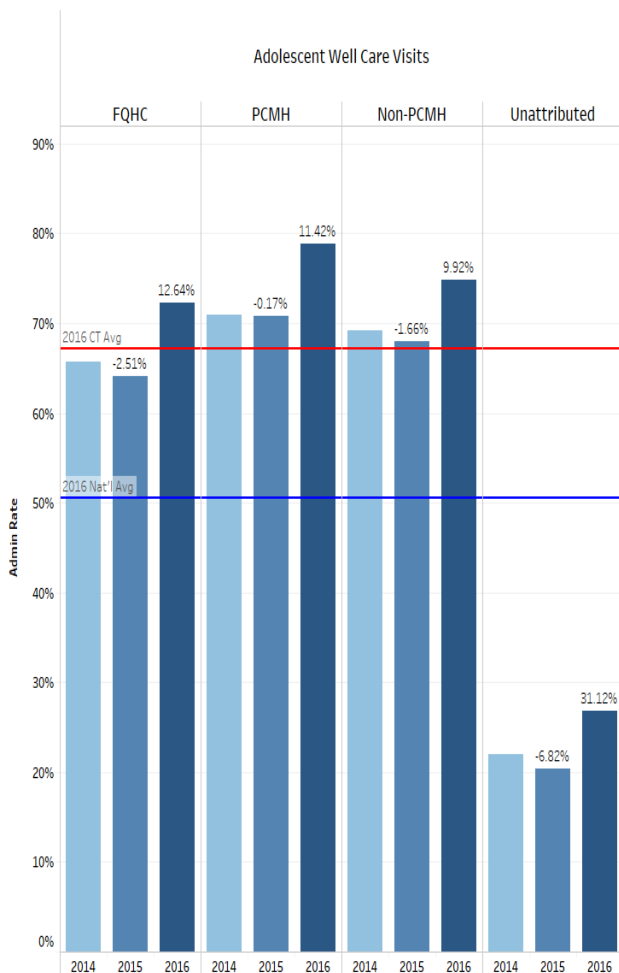
Date	Name
12/20/2017	999999999 AdultDiabetes 2017-12-17.xls
12/20/2017	999999999 AdultDiabetes 2017-12-17.pdf
12/20/2017	999999999 AdultDiabetes 2017-12-17.csv
11/20/2017	999999999 AdultDiabetes 2017-11-17.xls
11/20/2017	999999999 AdultDiabetes 2017-11-17.pdf
11/20/2017	999999999 AdultDiabetes 2017-11-17.csv



- **Health Outcomes Measures Improvements**
 - Select Health Outcomes Measures by Practice Setting
- **Utilization Improvements**
 - Inpatient Metrics
 - Frequent ED Utilizers
 - Physician Services
 - High Cost Members

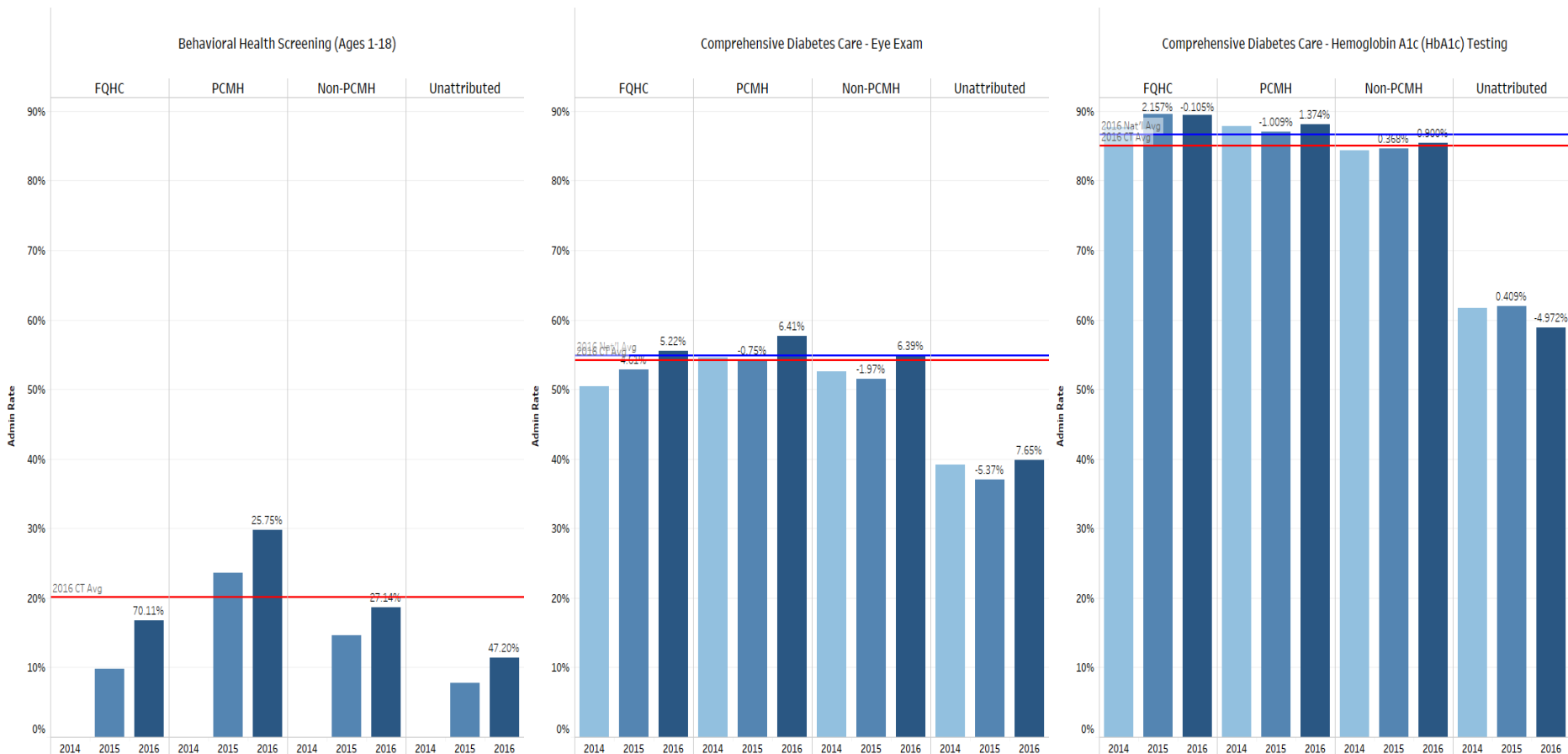


Select Outcomes Measures by Practice Setting



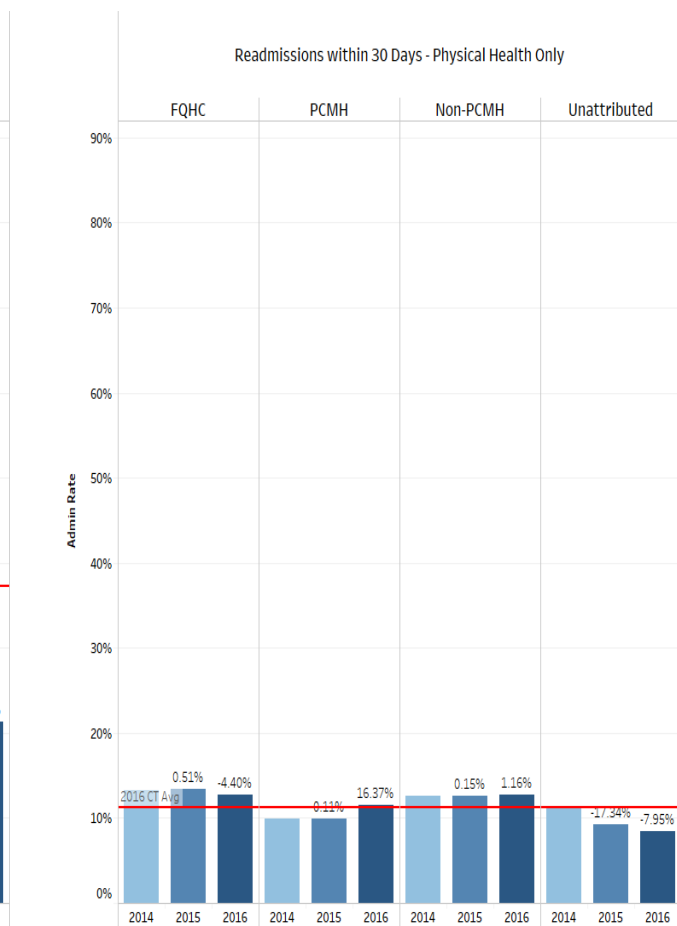
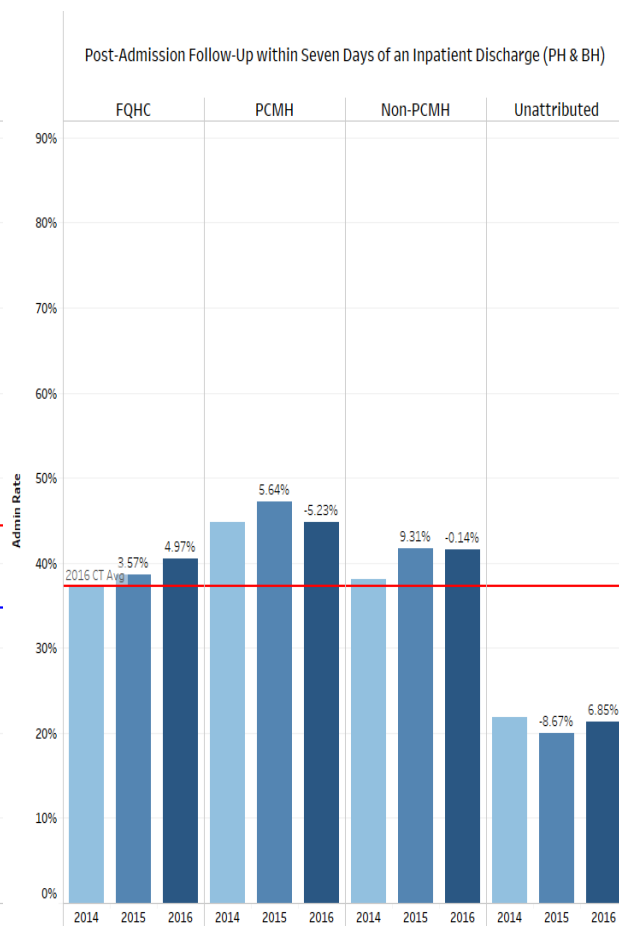
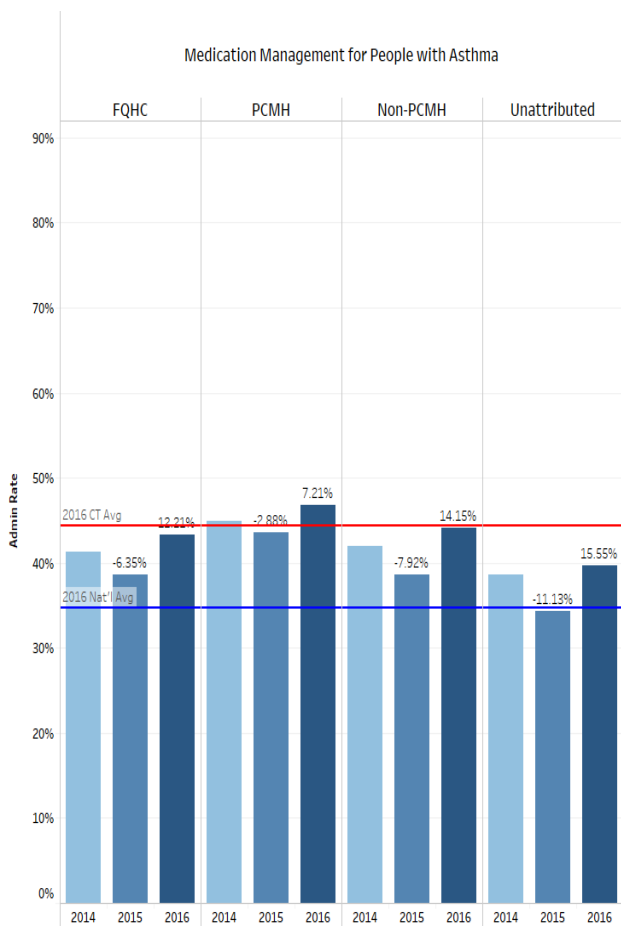


Select Health Outcomes Measures by Practice Setting



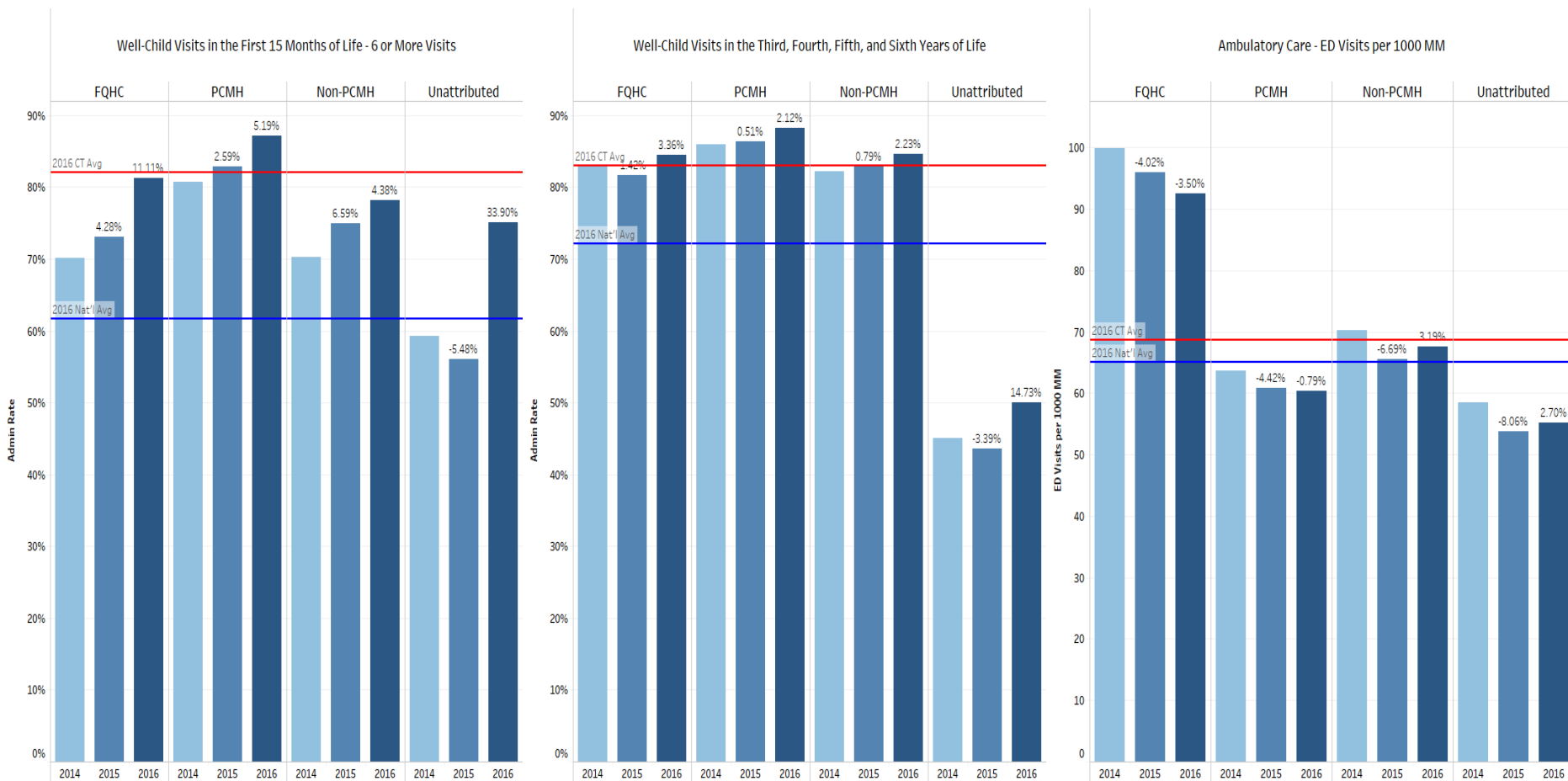


Select Health Outcomes Measures by Practice Setting





Select Health Outcomes Measures by Practice Setting





Routine care is increasing

Utilization Changes: Physician Services

	CY 2015		CY 2016		CY 2017		CY 2015 vs CY 2017	
COE Description	Util	Util/1000	Util	Util/1000	Util	Util/1000	Util/1000	%
Clinic Services	189,975	232	187,696	230.3	187,728	226.1	-5.9	-2.5
FQHC – Medical	702,989	858.6	756,645	928.5	788,787	949.9	91.3	10.6
Other Practitioner	459,228	560.9	526,855	646.5	580,637	699.2	138.3	24.7
Physician Services – All	3,948,428	4,822.50	4,403,791	5,404.00	4,655,918	5,606.90	784.4	16.3



Hospital utilization is decreasing

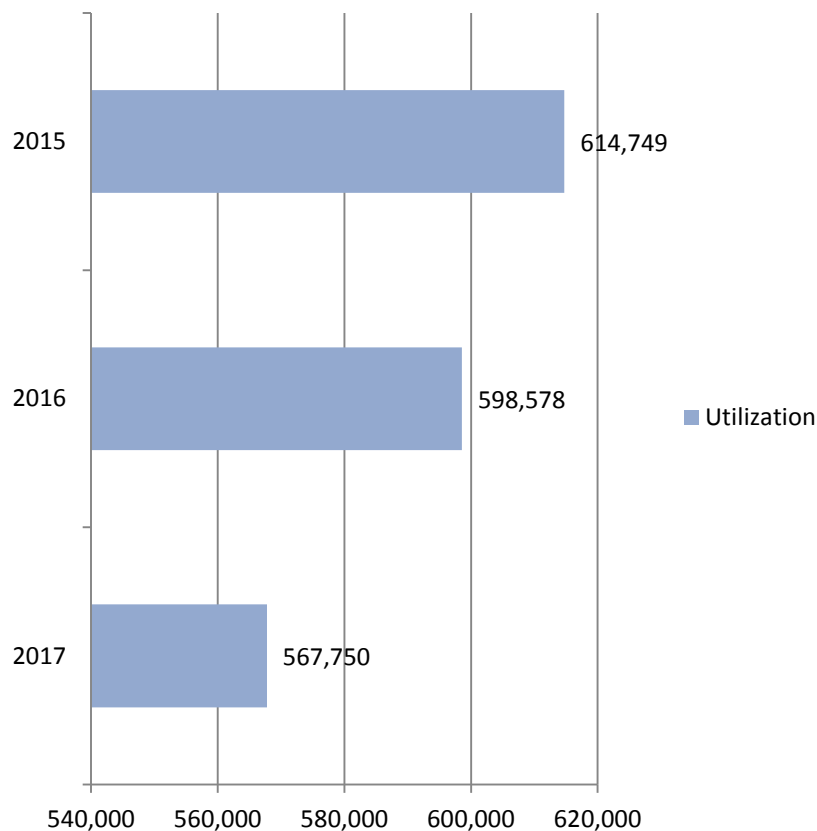
Inpatient Metrics

	2015	2016	2017	CY 2015 vs CY 2017	
Admissions	84,777	85,618	80,573	-4,204	-4.96%
Admissions per 1,000	103.54	105.06	97.03	-6.51	-6.29%
Re-admission Rate	11.35%	11.26%	10.95%	-0.40%	-3.52%
Days/1,000	479.7	472.4	428.1	-51.6	-10.76%
Average Length of Stay (ALOS)	4.63	4.50	4.41	-0.22	-4.75%

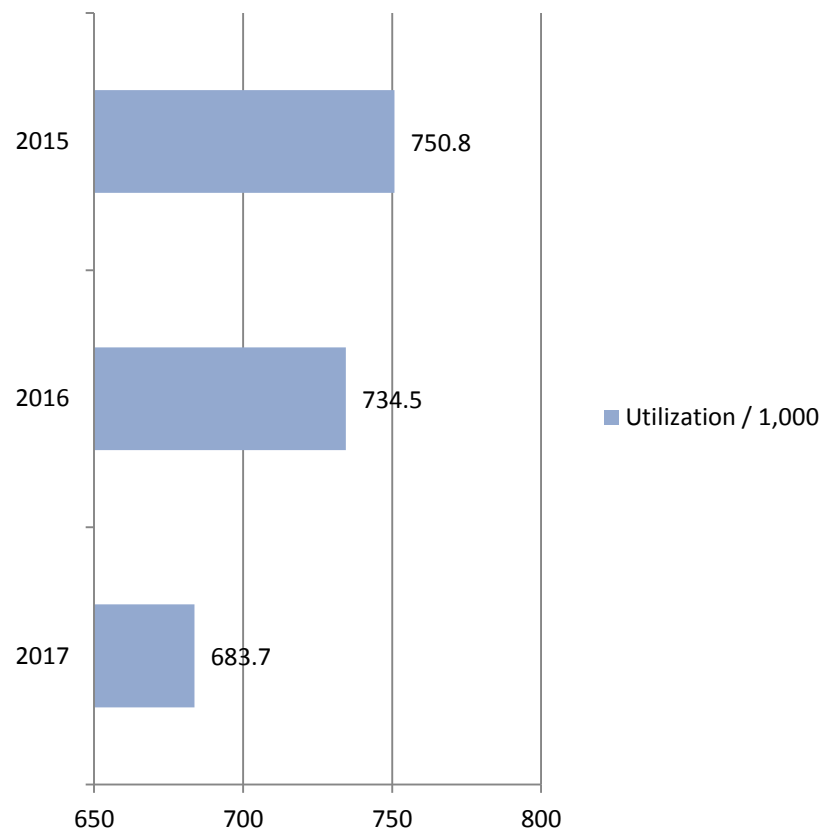


ED utilization is decreasing

Utilization



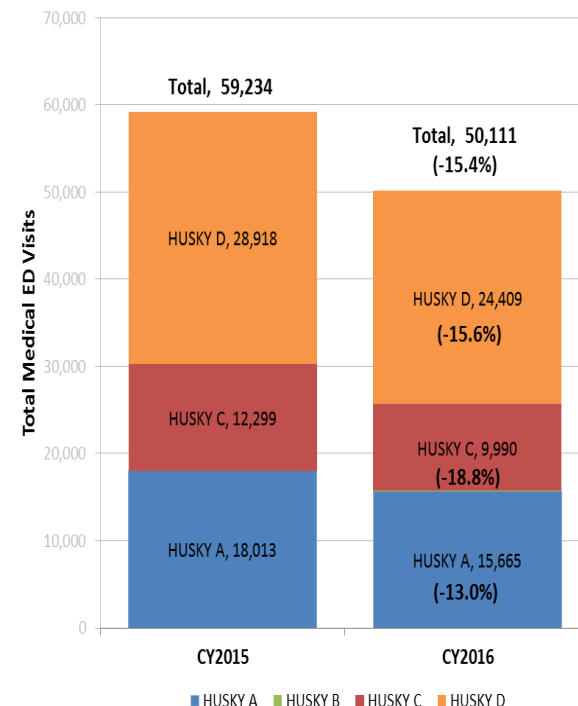
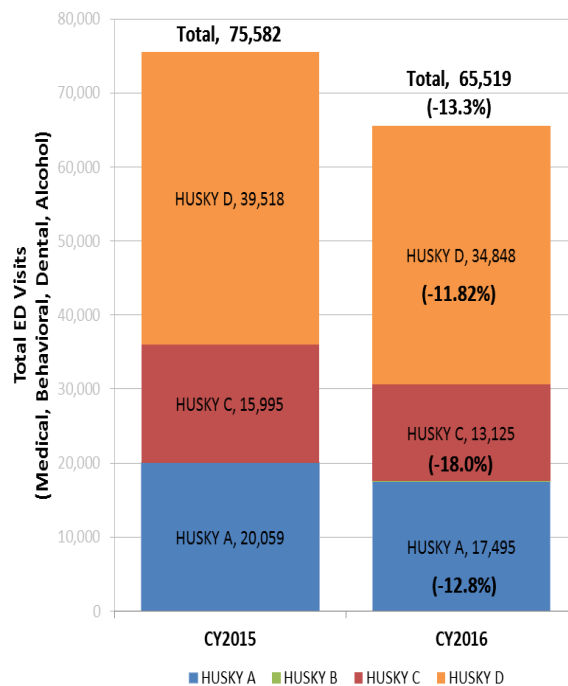
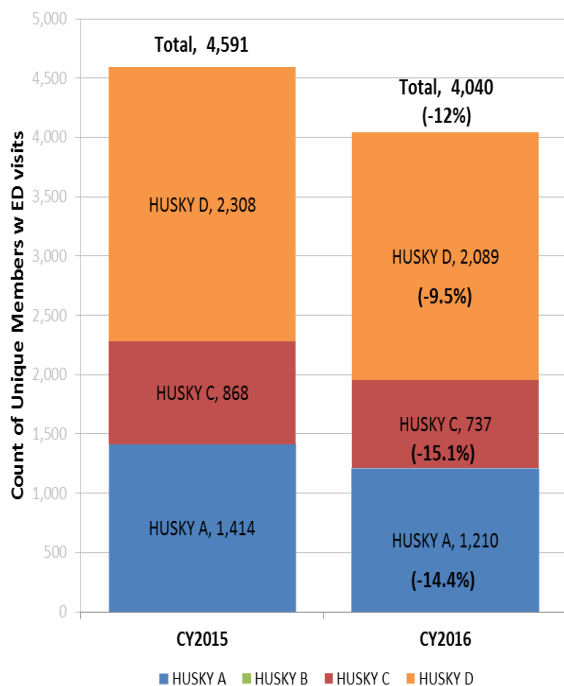
Utilization / 1,000





ED Frequent Utilizers*

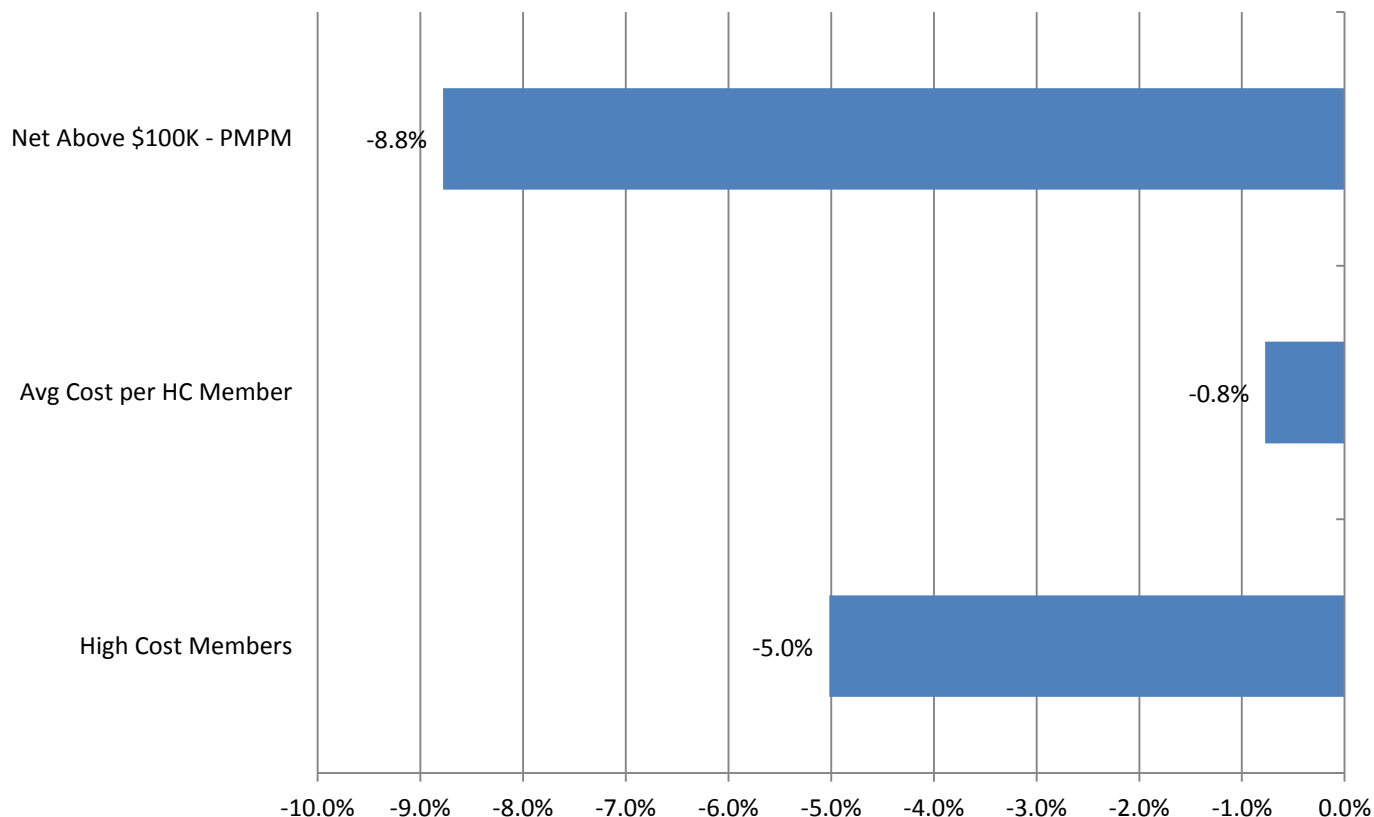
ED Visits in CY 2016 vs. CY 2017



* Defined as 10 or more visits in CY



% Change in High Cost Members* CY 2016 vs. CY 2017



*A high cost member had more than \$100K in paid claims in a CY.



- **Condition Management**
 - Diabetes
 - Sickle Cell Disease
 - Pain Management Program
 - High-Risk Pregnancy



Overview ☒ ADD ☒ Asthma ☒ Autism & Dev Delay ☒ **Diabetes** ☒ Prediabetes ☒ Hypertension ☒ Maternity-Delivery ☒ Obesity ☒ Substance Use ☒ Pain Management ☒ Tobacco Use ☒ GeoAnalytics

Clinical Condition Analysis - Diabetes ☒ **Current Selections** Clear Selections **Member Details**

Community Health Network of Connecticut, Inc.

Condition Year
2016 2017 2018

Age

0	8	16	24
1	9	17	25
2	10	18	26
3	11	19	27
4	12	20	28
5	13	21	29
6	14	22	30
7	15	23	31

Continuous En ☒ Y ☐ N

Total Members: 76,171

Avg Age: 56

Avg HbA1c: 7.4

% Mbs with HbA1c Result: 37.0%

Adult vs Child

Adult: 74,372
Child: 1,799

Members by Type

Type I: 8,975
Type II: 67,196

HbA1c Levels at End of Reporting Period (Members with lab result: 28,181)

Additional Conditions: 66,243

Hypertension	71%	54,246
Obesity	30%	22,974
Tobacco Use	29%	22,356
Asthma	20%	15,076
Substance Use	15%	11,045
ADD	2%	1,247
Maternity-Delivery	1%	1,025

Diabetic Members With Additional Conditions

1	27,895
2	21,153
3	11,864
4	4,406
5	886
6	39

Diabetes by Age

2017 vs 2016 Population Variance

Type I: -1,463
Type II: 2,231

HbA1c Testing: 83.3% Denominator: 42,896
Race

Asian Non-Hispanic	CY Rate	PY Rate
All Other/Multiple Races/Unknown	CY Rate	PY Rate
Hispanic	CY Rate	PY Rate
Black/African American Non-Hispanic	CY Rate	PY Rate
White/Caucasian Non-Hispanic	CY Rate	PY Rate



■ Member:

- Website:

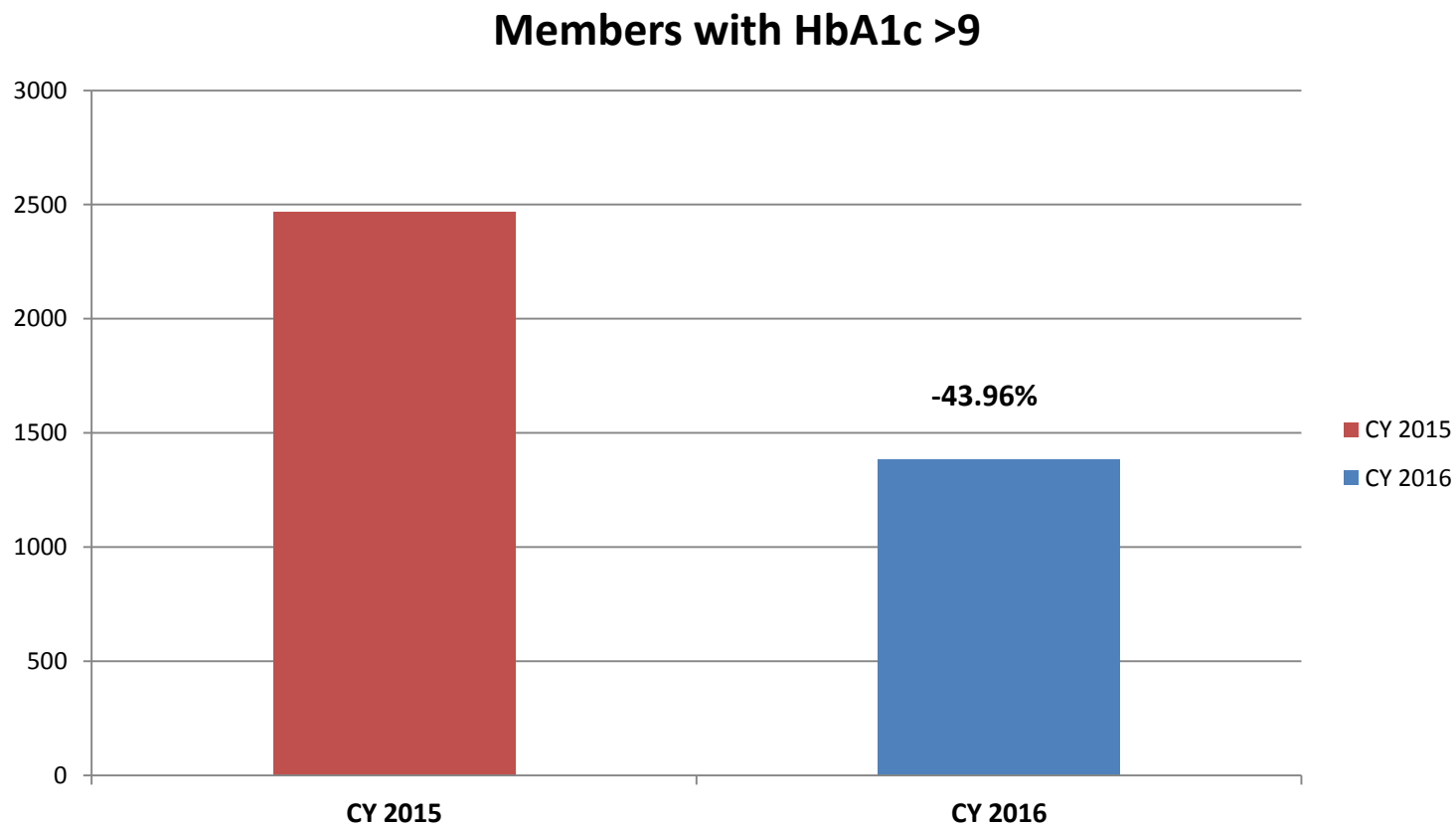
- Educational Materials
- Self – Management tools

- Care Management programs – Team assignment

- ICM works with higher risk members who have:
 - Care coordination needs
 - Adverse social determinants of health
 - Multiple health conditions or complications
- Transitional Care (TC) works with lower risk members who need proactive coaching for:
 - Taking Medications
 - Healthy Eating
 - Self-Monitoring and access to needed supplies
 - Assistance with making and keeping provider appointments



Members in Poor Control (HbA1c>9) Managed by Care Management



Member Story

Mrs. G is a HUSKY member in her late 50's with high blood glucose levels and an HbA1c as high as 13, identified by lab values. Because she had no other comorbid conditions, CHNCT's Transitional Care (TC) nurse contacted Mrs. G.

Mrs. G told our nurse she was not engaging in physical activity or watching what she was eating. She was using her insulin as ordered, but altering the dosage on her own.

With the help of her TC nurse, Mrs. G worked on making the lifestyle changes she needed to bring her diabetes into better control. Our TC nurse coached her on diet/nutrition, exercising regularly and taking her medications as prescribed. Mrs. G and the nurse worked on her goals, which she eventually met.

She embraced exercise through dance and created a series of videos on social media.

On a recent call, Mrs. G said: "The doctor visit went super well. My blood sugars are much better. I am exercising every day, even if it is just for awhile and my clothes fit better." She said she feels well enough now to actively look for a job.



■ **Tools:**

- **Internal Reports**

- Team created report looking at utilization patterns, use of PCP, hospitalizations and ED visits, and pharmacy data
- Identified opportunities:
 - Highest utilizing members (HUM's)
 - Lack of PCP
 - Failure to prescribe hydroxyurea
- Blinded data shared with sickle cell consultants to education treating providers

- **ADT Data**

- Inpatient Admission Notifications
- ED Visit Notifications
- Used to create notifications to consultants to contact treating providers (details following)

■ Member:

- CHNCT's ICM sickle cell disease (SCD) specialty program is a multi-disciplinary team-based practice model working collaboratively to enhance the health and quality of life for HUSKY Health members living with sickle cell disease.

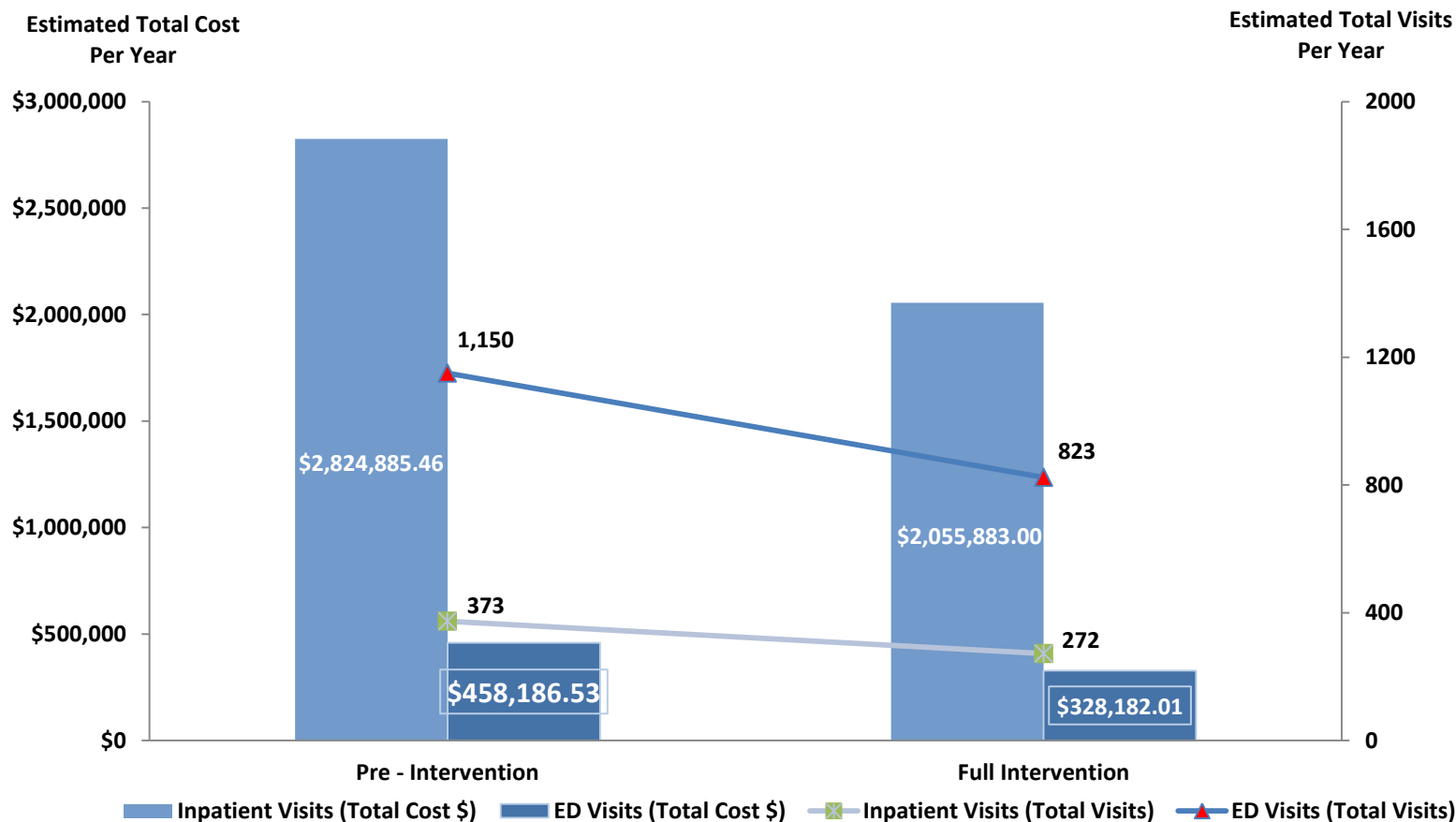
■ ICM nurses work with members who have SCD to:

- Help member's understand their condition, the significance of diagnostic testing, preventative screenings, complications and treatments
- Manage their medication regime and participate in their PCP or specialist's plan of care
- Follow their sickle cell action plan correctly
- Decrease ED utilization and hospital admissions related to SCD crisis
- Connect them with a hematologist for those who don't have one
- Facilitate a smooth transition for adolescents and their care givers to adult providers
- Address any barriers to care and adverse social determinants impacting the member/family



■ Provider:

- Use of sickle cell consultants
- Medical Directors of Adult Sickle Cell Programs at YNHH and UCONN engaged by CHNCT
 - Inpatient: IPCM notifies consultant of 2nd or higher admission in rolling 12 months for high utilizing member (HUM)
 - ED: Transitional Care uses ADT data to identify a HUM real-time in ED and notifies consultant
 - Discuss utilization patterns and post-visit care continuity options with treating provider at hospital (ED or hospitalist MD)
 - Provided information on OP and day-hospitalization programs offered for sickle cell patients



There was \$899,007 (annualized) LESS spent for ED/Inpatient visits than would have been spent pre-intervention.

Note:

Per CHNCT, the Cost Per Inpatient Visits (\$7,571) and Cost Per ED Visits (\$399) represent *all* types of patients, including surgical.

The average costs per case for patients with Sickle Cell Disease may be lower, and would result in less "savings".

Member Story

Ms. D is a HUSKY member in her mid-40's who had over 100 ED visits and 6 admissions in 2016 when she first enrolled in ICM. In addition to her sickle cell disease (SCD), she had a cardiac history and several behavioral health conditions.

Ms. D was diagnosed with SCD at age 2 and her mother who also had the condition died in her 40's. While she felt she was well versed in her condition, she still required multiple ED visits for management of her pain in 2016.

Using the ADT data, CHNCT made real-time referrals to the SCD consultant to engage with the hospital ED staff each time the member was in the ED. The consultant was able to discuss a discharge plan of care with ED staff. Ms. D was started on infusion therapy by her hematologist with appointments twice a month.

Ms. D agreed to work with ICM in 2017 to work on her goal of reducing her pain. She and her nurse worked together for approximately 10 months. In 2017, she had **88 fewer ED visits and 5 fewer admissions.**



Connecticut Department of Social Services

Making a Difference

Member Identification/Risk Stratification: Pain Management Program

Overview ADD Asthma Autism & Dev Delay Diabetes Prediabetes Hypertension Maternity-Delivery Obesity Substance Use Pain Management Tobacco Use GeoAnalytics



Clinical Condition Analysis - Substance Use

Current Selections Clear Selections Member Details

Total Members: 97,972

Inpatient Rate Per 1,000: 45.52

ED Rate Per 1,000: 236.78

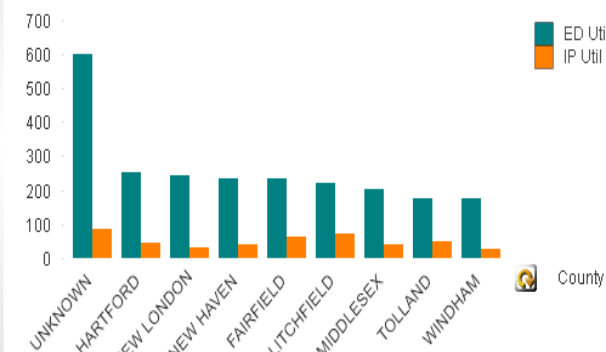
% of Members with MAT: 28.9%

IP and ED Utiliz... PMPM Variance ED PMPM Varia... IP PMPM Varian...

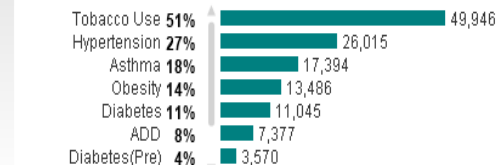
IP and ED Utilization For Any Diagnosis

Additional Conditions: 69,466

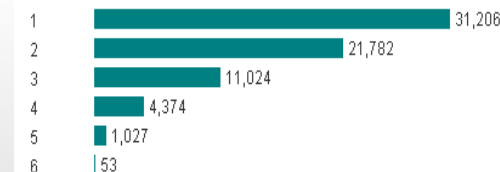
IP and ED Utilization Per 1000 Members



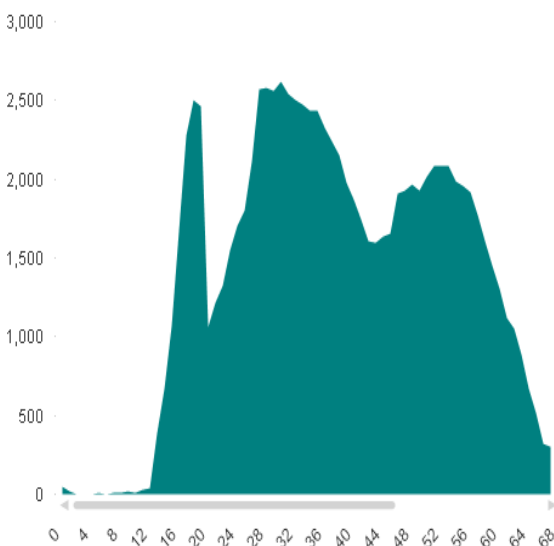
County	ED Util	% of Total ED	ED Trend	IP Util	% of Total IP	IP Trend
HARTFORD	879,541	25%		145,273	29%	
NEW HAVEN	259,839	25%		40,664	29%	
FAIRFIELD	256,293	26%		45,645	30%	
NEW LONDON	145,472	21%		26,522	24%	
LITCHFIELD	78,131	27%		10,978	32%	
WINDHAM	40,651	32%		6,444	35%	
MIDDLESEX	38,288	25%		5,043	29%	
TOLLAND	32,048	32%		5,368	35%	
UNKNOWN	18,773	26%		3,077	30%	
OUT OF STATE	8,524	49%		1,223	54%	
	1,522	15%		309	20%	



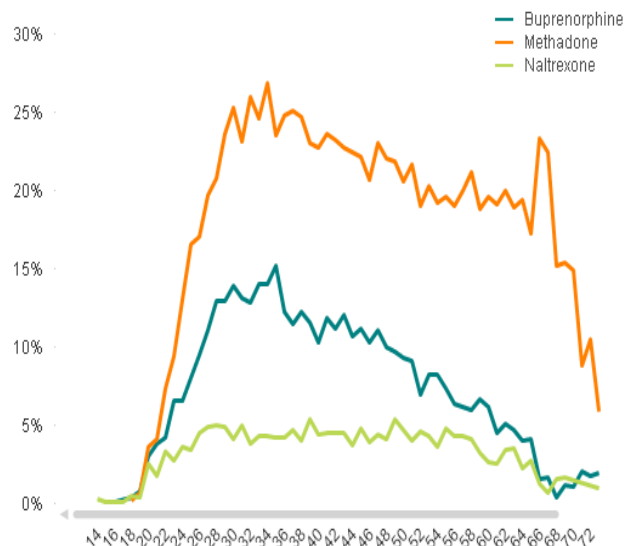
Substance Use Members With Additional Conditions



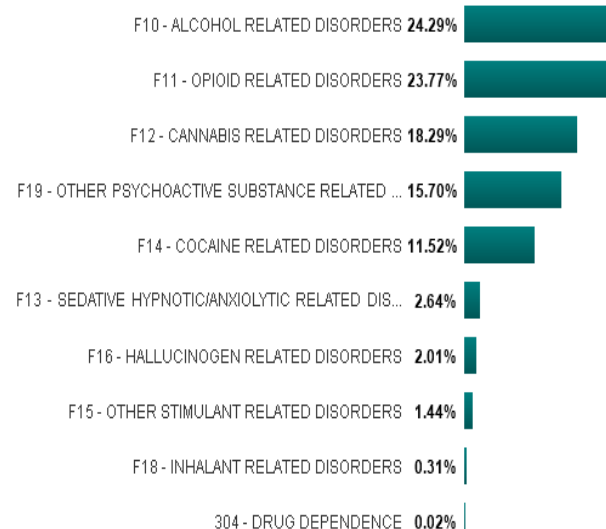
Substance Use by Age



% of Members Receiving MAT

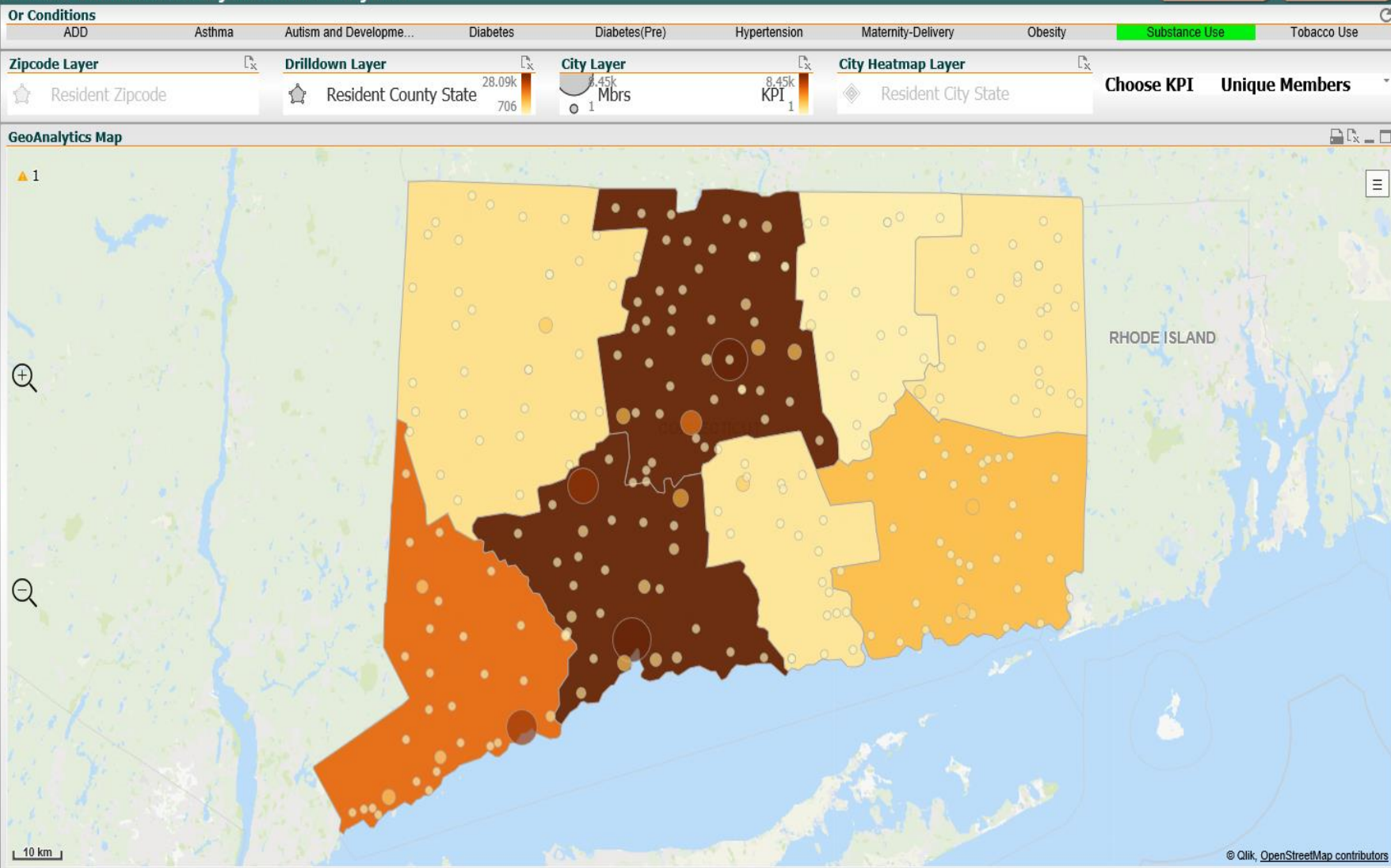


Substance Use by Diagnosis





Clinical Condition Analysis - GeoAnalytics

[Clear Selections](#)[Member Details](#)



■ Member:

- Access

- Escalation Unit

- Assisting members in finding pain management providers

- Medication Assisted Treatment (MAT) Prescriber Recruitment

- Actively recruiting existing MAT prescribers to CMAP network

- Encouraging CMAP PCPs to seek MAT certification

- Collaboration with CTBHP

- » Listing medical MAT providers on Beacon MAT map

- » Offering Beacon's Project ECHO as support program for medical MAT Providers



■ ICM

- ICM utilizes a monthly high opioid utilization report, which uses pharmacy data to identify and reach out to members who are receiving opioid medications equaling 300 morphine milligram equivalent (**MME**) doses or greater to:
 - Complete a comprehensive assessment of needs including social determinants of health impacting member
 - Assist the member with establishing a primary care relationship and other providers/services as needed
 - Encourage and reinforce members to maintain care with established provider and pharmacist
 - Work with the member on setting goals and sharing care plan with their provider
 - Accompany members to provider visits as needed to work on and reinforce plan of care for ongoing coaching and education



■ **Provider Education:**

- Webinar: The Practical Aspects of Prescribing Opioids for Chronic Pain, Dr. Lloyd Saberski
 - Offered 1.25 hours of Cat 1 CME credits
- Live Continuing Medical Education (CME)
 - Essentials of Primary Care Psychiatry
 - 12/ 16- 17/2016, 10/13 – 14/2017
 - Managing Behavioral Health Conditions in a Primary Care Setting 9/15/2018
 - Collaboration with CTBHP – 8 hours of CME
- Pain Management Microsite/HUSKY Health Provider Portal
 - http://www.huskyhealthct.org/providers/providers_pain_management.html



■ Provider Notification

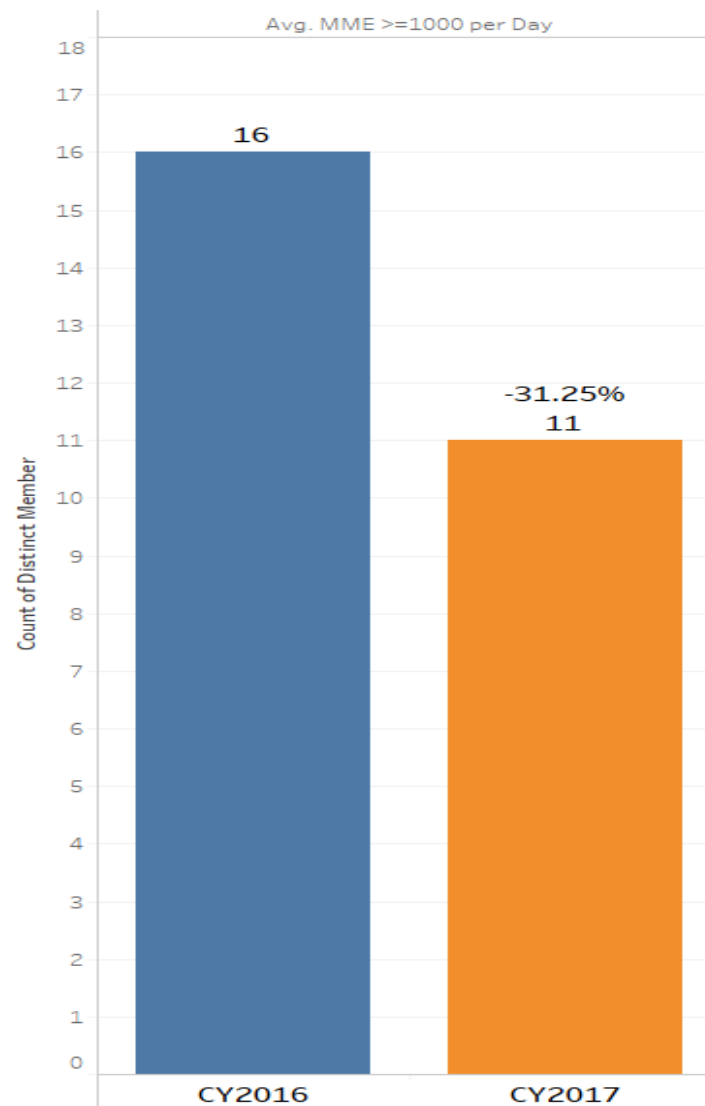
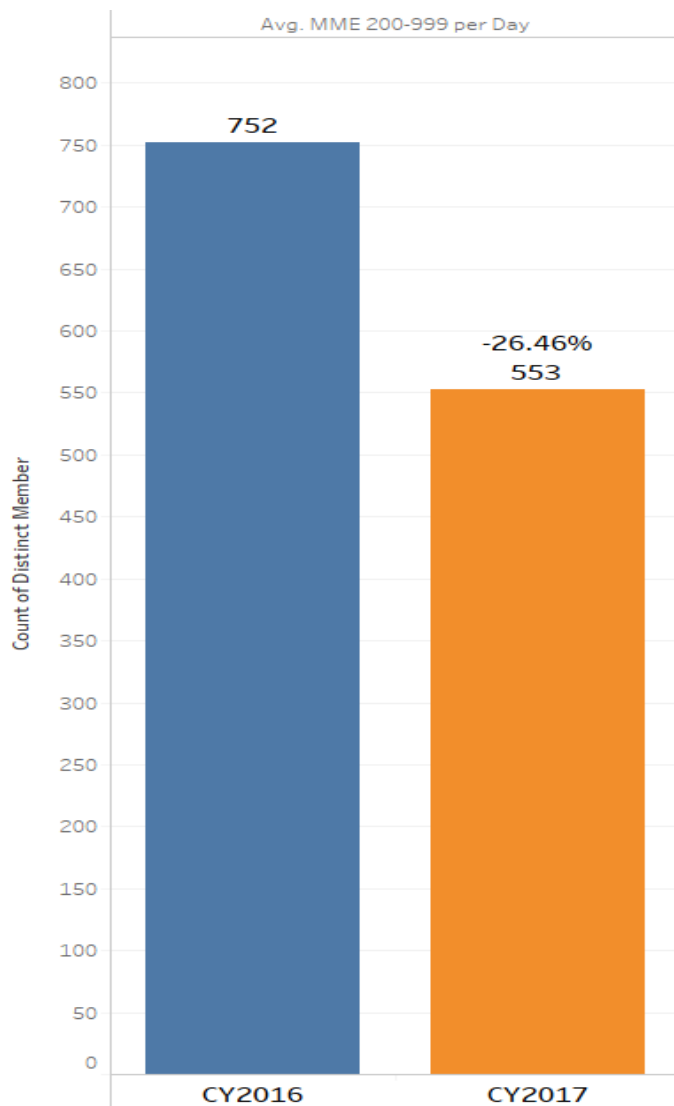
- High Opioid notification:
 - Quarterly Mailing to PCPs with members receiving >100 MME/day in prior 90 day measurement period
 - Impact:
 - 2016: 3,815 PCP letters mailed covering 4,955 members
 - 2017: 3,469 PCP letters mailed covering 4,194 members

■ Hospital Collaboration (CHA ED Medical Directors group)

- Presented data by Hospital on opioid scripts/1000 ED visits
 - Reviewed resources available at CHNCT and CTBHP
- Participated in UConn Opioid Task Force



Opioid Use in CY2016 vs. CY2017 with Morphine Milligram Equivalent (MME)



Member Story

Mr. W is a HUSKY member in his 30's and was visiting the ED frequently for pain issues when he was first identified for ICM contact. He had a traumatic arm injury and almost lost his arm. Mr. W had very little function in his arm and needed pain management; he had gone to various EDs 25 times in 2016, as he had problems staying engaged with a provider.

ICM worked with Mr. W to develop a trusting relationship and to work on his goals. The ICM nurse secured a pain provider for Mr. W and encouraged him to keep his appointments. He needed help with arranging transportation between his home and the new pain provider's office. The nurse also worked with Mr. W's PCP to arrange for physical therapy to increase his arm functionality.

Mr. W's narcotic dosage has since decreased. He has more use of his arm with the therapies, and in 2017 he had 16 less ED visits. He continues to set realistic goals and hopes to be able to return to the work he did prior to his arm injury.



■ **Tools:**

- Provider Referrals (Notification Forms)
- Pharmacy data
- Health Risk Questionnaire results
- Member Engagement referrals

■ **Interventions:**

- Member:
 - ICM:
 - » Healthy Beginnings: A multidisciplinary team trained to deliver support and care management services for:
 - Members with high and low risk pregnancies as well as
 - NICU infants up to a year post discharge
- Provider:
 - OB P4P

■ Member:

- Initiatives on this team are geared towards supporting the provider's plan of treatment to positively improve birth outcomes and promote well child care.
- Some interventions include:
 - Person-centered coaching provided regarding:
 - The provider treatment plan, including the importance of keeping all prenatal and dental appointments
 - Following up with members who are missing perinatal appointment
 - Inter-conception care regarding well-care, family planning
 - Food safety; i.e. My Plate, foods to avoid to reduce exposure to mercury; self-care for nausea, staying hydrated
 - The benefits of breastfeeding and lactation support to breastfeeding parents and breast pumps as a member benefit
 - Signs and symptoms of post-partum depression
 - Routine well- baby care such as car seat safety, sleep safety, well-care and immunizations
 - Referrals to support agencies such as WIC, SNAP, Nurturing Families, Birth to 3

Primary Goal of The OB P4P

To improve the care for pregnant women and the outcomes of their newborns covered under the HUSKY Health programs.

- **Two pilot timeframes:**
 - July 1, 2013 - June 30, 2014
 - June 1, 2015 - November 30, 2015
- **New timeframe:**
 - July 1, 2018 – June 30, 2019



■ Performance Measures: OB P4P

- Timely Completion of the online prenatal & postpartum OB notification forms
- First Prenatal Visit within 14 days of pregnancy confirmation
- Full Term Spontaneous Vaginal Delivery
- Postpartum Visit within 21-56 Days Postpartum

■ Other Outcomes: OB P4P

- Percent of babies admitted after birth to a newborn intensive care unit (NICU)
- Percent of babies delivered by Cesarean section (C-section)
- Percent of babies delivered by Cesarean section when the mother had no prior Cesarean section
- Appropriate use of a 17-hydroxyprogesterone (17P), which has been shown to reduce preterm birth in women who have a prior history of preterm birth



Top 10 Maternal Risk Factors

Prior C-
Section
Obesity
Asthma
Advanced Maternal Age
Lack of Transportation to
Appointments Smoking
Chronic Health Condition(s)
Sexually Transmitted Disease
(STD) History of PTL

Gestational Weeks at 1st Prenatal Visit

1 to 6 13%
7 to 12 63%
13 to 19 13%
20 to 26 5%
27 or more 5%
Not Reported 1%

Completion of the prenatal
online notification forms within
14 days of the first prenatal
visit. **46.67%**

45.99% Completion of the postpartum
online notification forms within
14 days of the first postpartum
visit.

First prenatal visit within 14 days of a
confirmed pregnancy. **84.68%**

78.71% At least 1 postpartum visit within 21-56
days postpartum.

Full term, vaginal delivery after
spontaneous labor whenever
medically possible. **35.24%**

70% of the enrolled
members had a
vaginal birth

N=1,18

75 (6.31%) Labors
were induced

Full Term* Birth Rate

64.20%

*39 weeks gestation

Early Term* Birth
Rate

28.98%

*37 to 38 weeks
gestation

Data Source: Online OB notification forms completed for services dates of June 1, 2015 to November 2015.

CY 2016 Healthy Beginning Members HEDIS® Rate Comparison to CY 2016 HEDIS® Hybrid Rate
Source: MedMeasures®

Measure	CY 2015 Healthy Beginnings Member Rate	CY 2015 HEDIS® Hybrid Rate HUSKY A and B	CY 2016 Healthy Beginnings Member Rate	CY 2016 HEDIS® Hybrid Rate HUSKY A and B
Frequency of Prenatal Care >81%	55.56%	59.02%	73.77%	66.33%
Timeliness of Prenatal Care	86.67%	85.57%	93.44%	87.44%
Postpartum Care	62.22%	64.18%	73.77%	70.85%

Member Story

Ms. S was referred to the Healthy Beginnings ICM program due to high ED utilization reports and pregnancy. Ms. S was 6 months into her second pregnancy and had gone to the ED for her asthma four times within eight days. The ICM nurse set up a face-to-face meeting and upon her arrival, Ms. S was vacuuming. The ICM nurse's assessment revealed many asthma triggers in the home including dust and clutter. The nurse coached Ms. S on recognizing triggers and gave her recommendations on how and why to clear the house of these triggers. She asked Ms. S to have someone else in the home do the vacuuming because the dust from it can cause an asthma attack. The family kept a cat in the basement which is where Ms. S would do the laundry. They talked about having someone else in the house go in the basement to do the laundry and most importantly to change the cat litter.

They also talked about the proper use of her medications during pregnancy and the importance of keeping OB appointments. Ms. S was coached on prenatal and postpartum care. Before the first visit was over, the ICM nurse made an appointment for Ms. S to see her pulmonary doctor for follow-up after the ED visits.

Ms. S was missing appointments with her OB and pulmonary doctors due to relying on friends for rides. However many times the friends did not show up or on time. The ICM CHW worked with Ms. S on arranging HUSKY Health transportation as well as addressing food source needs.

In the end, Ms. S gave birth to a healthy baby girl and both are doing well. Her asthma remains under control and she has not had any further ED visits related to her asthma.



- Focus on Prevention
 - Obesity
 - Prediabetes
 - Hypertension

Childhood obesity has tripled over the past 30 years

- 18% of children 2-19 years are obese
- 14% of children 2-5 years are obese, an increase of 9% from 2014 to 2016
- 8% of children younger than 2 years are obese

Childhood obesity tracks into adulthood

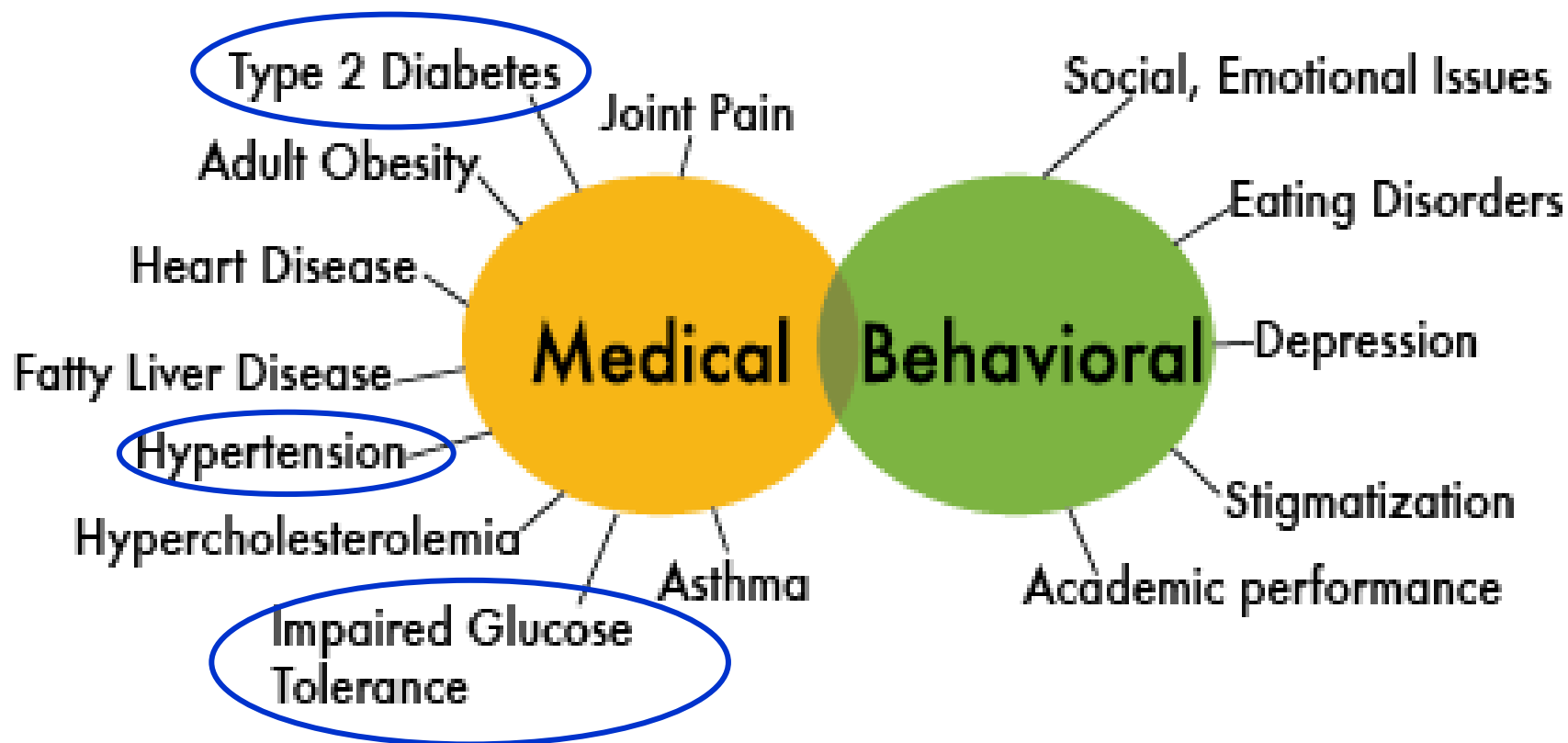
- Early and rapid excessive weight gain tracks into later childhood and adolescence with worse health outcomes than children with normal weight

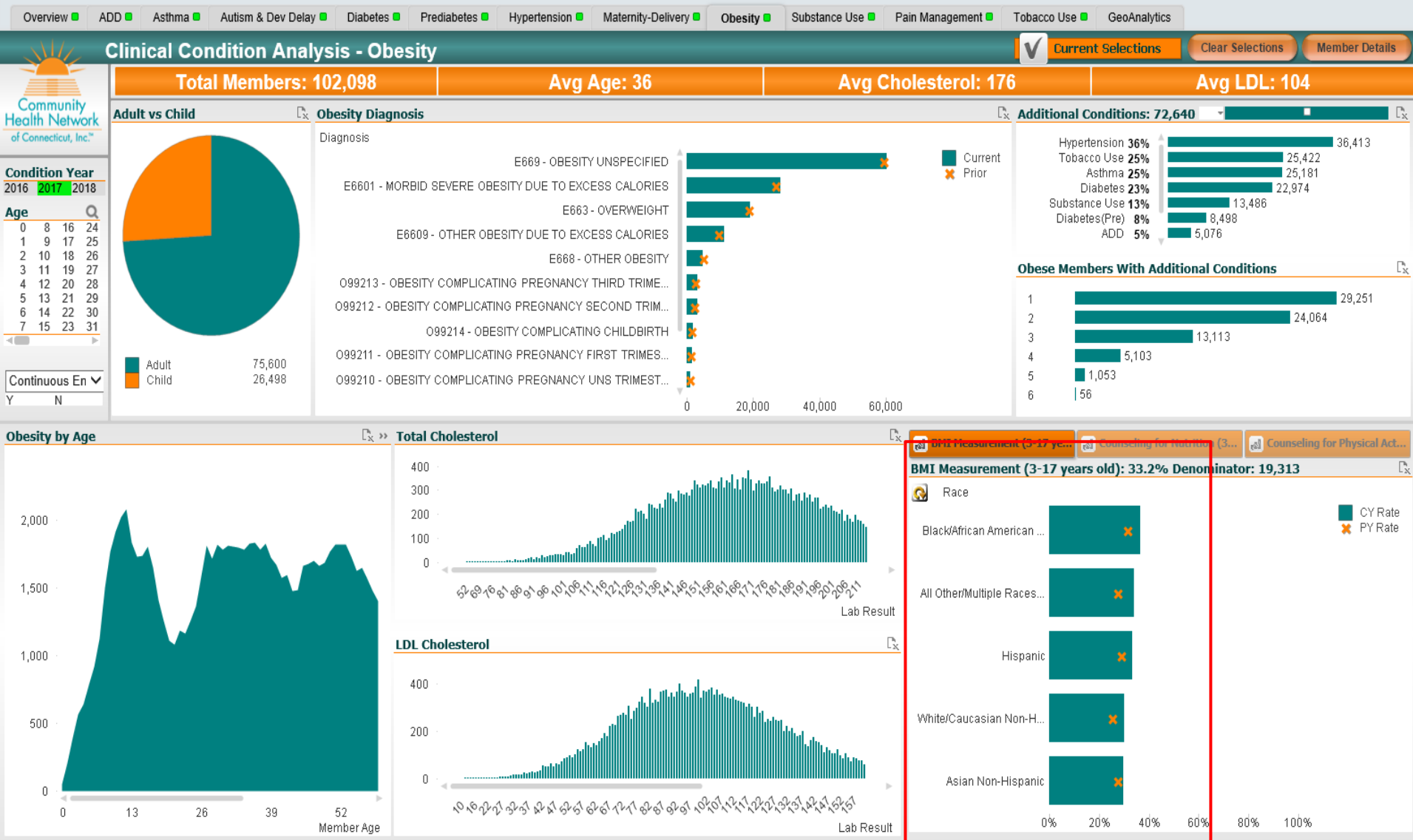
Rates are higher for low income and minority children

- 19% in black children
- 22% in Hispanic children

Significant impact of obesity-related illness on health care costs

- 21% of annual medical spending, roughly \$160 billion
- Childhood obesity leads to \$14 billion in direct medical costs





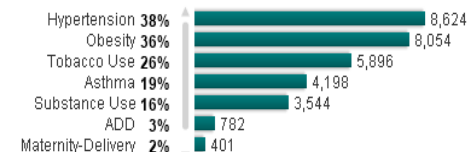
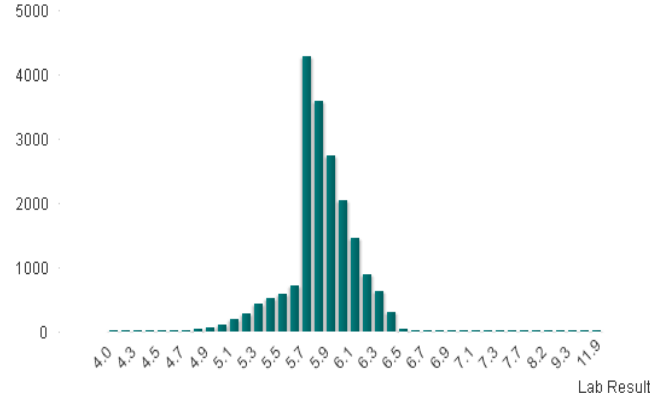
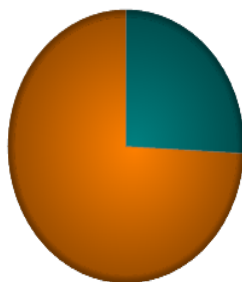
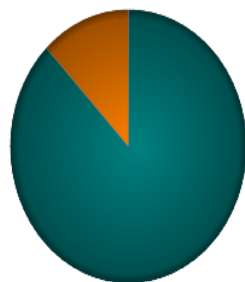


■ Planned Interventions:

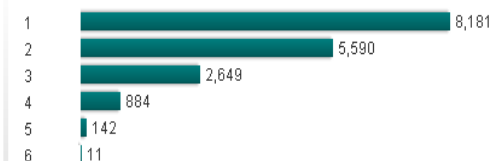
- PCP/PCMH Webinar targeting obesity prevention in youth in collaboration with CHDI
- Addition of WCC measure to Individual Practice Profiles and Provider Profiling Report
- Development of a Provider Portal Gaps-in-Care Report
- Member portal weight management tools
- Member email campaign



Clinical Condition Analysis - Prediabetes

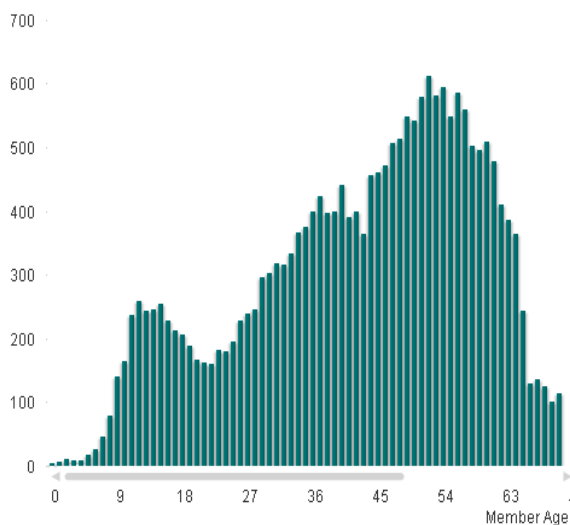
[Current Selections](#)[Clear Selections](#)[Member Details](#)**Total Members: 22,519****Avg Age: 44****Avg HbA1c: 5.8****Adult vs Child****Members With a BH Visit****HbA1c Levels (Members with lab result: 18,925)****Additional Conditions: 17,457**

Prediabetic Members With Additional Conditions

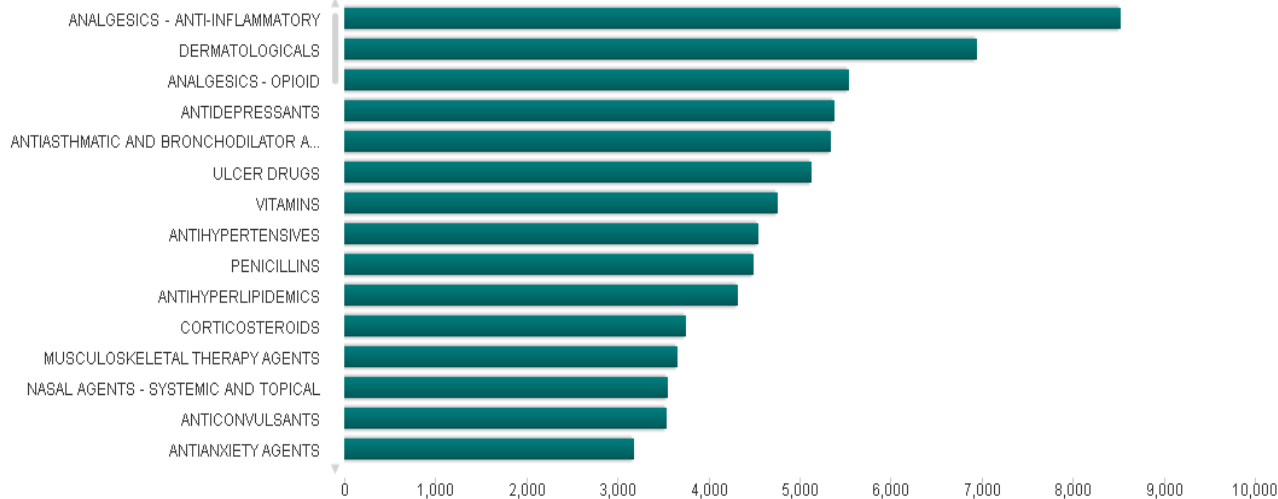


Prediabetes by Age

Members with Prescriptions

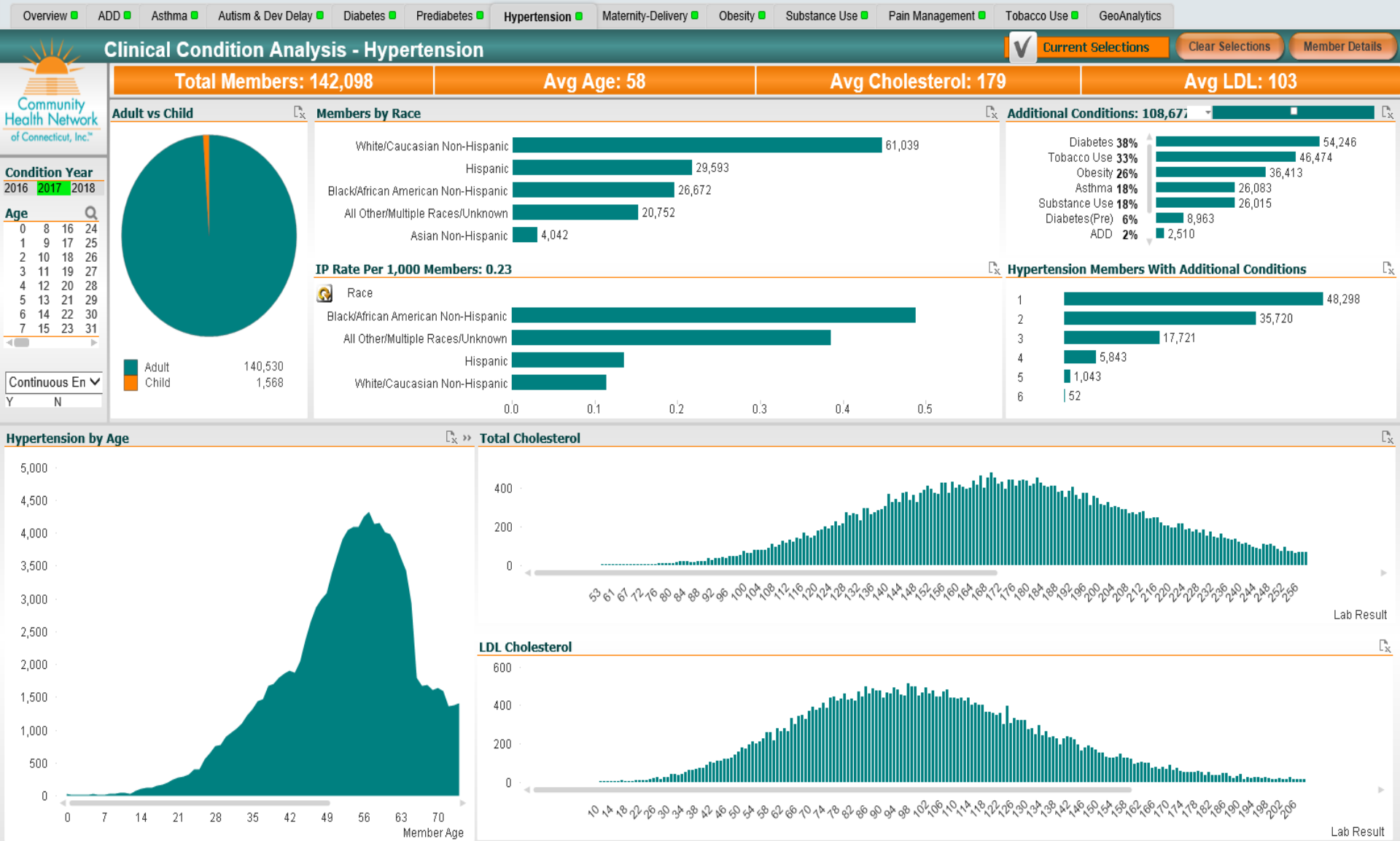


Drug Category





- Exploring enrollment in CDC recognized Diabetes Prevention Program (DPP)
 - Possible pilot with existing vendor
 - Collaboration with FQHC programs
- Member Interventions
 - Direct member calls from CM to pediatric members' HOH
 - Website tools and Educational materials
- Provider Interventions
 - Webinar: Stressing importance of correct coding and coding for adverse Social Determinants of Health (SDOH)
 - Collaboration with statewide initiatives (CHDI)





EmPOWERED to Serve™



Program Description

Community Health Network of Connecticut, Inc. (CHNCT), on behalf of the HUSKY Health program, and in partnership with the American Heart Association (AHA) EmPOWERED to Serve™ program, is working toward creating a culture of health within multicultural communities.

CHNCT will implement a new pilot program to improve the health of HUSKY Health members living with hypertension. To accomplish this, CHNCT will collaborate with the AHA's EmPOWERED to Serve™ program; the umbrella for all of the multicultural initiatives at AHA. The program's Health Lessons offer a way to engage communities and motivate community members to take steps towards creating a culture of health. In addition to focusing on the topics covered in the EmPOWERED to Serve™ program, CHNCT will incorporate physical activity and nutrition education into the pilot.

The EmPOWERED to Serve™ program is built on key evidence-based scientific principles:

1. The practice of self-monitoring and tracking of BP readings at home or outside of the healthcare provider office setting.
2. Use of a digital self-monitoring tool to track BP readings.
3. The practice of self-management skills related to BP management.
4. Use of health mentors to motivate and encourage participants.
5. Attention to multi-cultural issues that result in hypertension being a health disparity for African-Americans and Latino/Hispanics.

The CHNCT pilot of the EmPOWERED to Serve™ program will target 15-20 participants per session and will take place at a Federally Qualified Health Center (FQHC). The AHA will provide a blood pressure cuff for each participant, training and technical assistance for CHNCT staff, as well as educational webinars for participating providers at the FQHC. Providers will refer eligible members to the program based on the member's measurements and risk factors. The session will last four months. The first month will consist of four weekly sessions. A pre-survey will be used before the first session to establish a baseline. After the first month, follow-up testing and a post-survey will be conducted to measure participant progress.



Meet Mr. Finnegan...

(video)



■ Questions?