# CHNCT Presentation to MAPOC

*December 13, 2019*

Community Health Network of Connecticut, Inc.™

**Proudly serving over 800,000 HUSKY members**

# About CHNCT, Inc.

- Community Health Network of Connecticut, Inc. (CHNCT) is a not-for-profit 501(c)(4) organization founded in 1995 by a group of Federally Qualified Health Centers (FQHCs) whose vision was to create a health plan that would bring managed care to underserved populations in the same way that FQHCs bring them medical services.
- Our founders include: *Charter Oak Health Center, Cornell Scott-Hill Health Center, Fair Haven Community Health Center, Generations Family Health Center, Optimus Health Care, Inc., Southwest Community Health Center, and StayWell Health Care, Inc.*
- CHNCT has partnered with the Connecticut Department of Social Services (DSS) first as a Managed Care Organization (1995), an ASO for the SAGA Program (2004), and MCO for the Charter Oak Health Plan (2008).
- Since 2012, CHNCT has served as the medical Administrative Services Organization (ASO) for the HUSKY Health program.
- CHNCT is a CMS-certified Quality Improvement Organization (QIO)-like entity enabling DSS to obtain an additional 25% federal match in the amount of $13.5 million for certain medical and quality review functions.
- CHNCT has 500+ employees.
- CHNCT recently received the Corporate Volunteerism Award from the CT Food Bank. Of our employees, 129 volunteered a total of 454 hours last year.

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HITRUST CSF Certified

urac ACCREDITED Health Utilization Management Expires 11/01/2021

urac ACCREDITED Disease Management Expires 08/01/2022

urac ACCREDITED Case Management Expires 08/01/2022

# How We Make a Difference Each Day

## Engagement

### Community Connection

We believe that community and human-to-human connection are essential to improving the health and lives of our members. That is why we are embedded within the community to provide assistance where people are: in their homes or in public.

- We engage with community organizations to build partnerships
- Our regionally-based care teams live in the communities where they work
- We work closely with local hospitals, community health centers, and providers
- Staff meet with members in the community

### Health Data

We take a data-driven approach to achieve high-value healthcare by improving the quality of clinical care and reducing costs. The data we use comes from three key places: our comprehensive claims database, the Health Risk Questionnaire, and inpatient and emergency department alerts from hospitals. We use this data to:

- Risk stratify members and identify gaps in care
- Conduct outreach to members who need care or other services
- Perform quality cost-benefit analyses
- Create various dashboards

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### Provider Network

We build personal relationships with providers to ensure our members have access to a broad network of providers. Our representatives visit practices each day to answer questions and collaborate on new ideas. This hands-on approach helps us secure the strongest provider network possible.

### Social Determinants of Health

We know that a person's health is affected by the social and economic influences on their lives. We use a systematic approach to screen members at each touch point and provide personalized referrals. Each day we help our members access healthy food, job and education opportunities, safe living conditions, and other social needs.

## Connection

### Care Management

Using motivational interviewing and assessing persons willingness to change we take a whole-person approach to prevention and care. Elements of our care management programs:

- Educate and coach to empower members
- Manage chronic conditions
- Assist with care transitions from the hospital or emergency department
- Multi-specialty teams (nurses, pharmacists, nutritionists, behavioral health clinician, and community health workers)

### Access to Care

Our goal is to help members access the right care, in the right place, at the right time. When a member calls, our staff identify the member's needs and connect them to the right resources or services. We also work with providers looking for services for their members. Our teams help members:

- Find providers and schedule appointments
- Get medical equipment, home care, and other care needs
- Access other benefits including behavioral health, dental, pharmacy, and transportation
- Participate in and take control of their health

# *Member & Provider Engagement*

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# *Supporting HUSKY Health Members*

- ✓ ***Since 2013, over 2 million member calls and 12,911 emails received by Member Engagement***

**In 2018…**

- More than 2.2 million health care reminder emails sent
- Over 1.3 million successful automated call health campaign messages delivered
- Over 10,000 referrals for assistance made regarding social determinants of health (SDOH) concerns
- Over 10,000 Health Risk Questionnaire referrals received for PCP assistance
- Over 11,000 referrals handled by the Escalation Unit to assist members with finding a provider or scheduling an appointment
- Over 3,800 member grievances received and addressed
  - Top 3 Reasons: *Quality of Provider Services, Balance Billing, Provider Access*
- Visited soup kitchens, community events and health fairs to engage with members

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# *Supporting HUSKY Health Members*

**Member Advisory Workgroup (MAW)**

- A diverse group of 15 to 17 individuals who meet monthly to discuss issues and provide feedback on the HUSKY Health program
  - Tested the first member on-line learning webinar and provided feedback on the technology and content
  - Tested the ease of registering for email subscriptions and provided feedback on the technology and content
  - Used as a beta group when new interventions or approaches to communicating with members are being evaluated

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# *Example of Initiative Reviewed by MAW: Teen Vaping Brochure*

There is reputable information out there on vaping. Consider speaking with a trusted adult at school or in your community, your parent or guardian or your doctor, or checking out these sites:

**Surgeon General**

www.hhs.gov/surgeongeneral

**Centers for Disease Control and Prevention**

www.cdc.gov

**U.S. Food and Drug Administration**

www.fda.gov

To scan, download a QR reader app to your smartphone, and use the app to scan the code ( ).

[1] https://www.cdc.gov/tobacco/data_statistics/sgr/e-cigarettes/pdfs/2016_sgr_entire_report_508.pdf

[2] https://www.drugabuse.gov/publications/research-reports/tobacco-nicotine-e-cigarettes/nicotine-addictive





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# *Example of Initiative Reviewed by MAW: Parent Vaping Brochure*

## More Information

**Surgeon General**
www.hhs.gov/surgeongeneral

**Department of Public Health**
www.portal.ct.gov/DPH

**Centers for Disease Control and Prevention**
www.cdc.gov

**U.S. Food and Drug Administration**
www.fda.gov

To scan, download a QR reader app to your smartphone, and use the app to scan the code ( ).

**Quitline**
**1.800.784.8669**
**1.800.QUITNOW**

For help & resources when you're trying to quit.

# VAPING
## Facts Parents Should Know

[1] https://e-cigarettes.surgeongeneral.gov/documents/surgeon-generals-advisory-on-e-cigarette-use-among-youth-2018.pdf

[2] https://e-cigarettes.surgeongeneral.gov/getthefacts.html

HUSKY HEALTH CONNECTICUT

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# Myths vs Facts

**Myth:** Vaping isn't that common.

**Fact:** In 2018, more than 3.6 million youths used vaping devices. This includes 1 in 5 high school students and 1 in 20 middle school students. For high school students, vaping increased 78% between 2017 and 2018.[1]

**Myth:** I don't smoke or vape so my kids aren't exposed to information about vaping.

**Fact:** Companies target young people with ads on social media, YouTube channels and in magazines, much like tobacco was marketed to previous generations. Companies also use sweet flavors to target youths. In 2018, more than 5 in 10 middle and high school students reported seeing advertisements.

**Myth:** Vapes can be nicotine-free, so that makes them safe, right?

**Fact:** No, many vapes contain nicotine. Some cartridges or "pods" contain as much nicotine as a pack of cigarettes. The aerosol inhaled can contain toxic chemicals like formaldehyde, heavy metals, benzene—found in car exhaust, and flavoring like diacetyl—a chemical linked to lung disease.

**Myth:** If my kids were vaping, I'd recognize vaping devices.

**Fact:** Many vaping devices don't look like something used for smoking. One of the most commonly sold devices looks just like a USB "flash" drive. Vaping devices can be used for nicotine, marijuana, alcohol or flavors.

**Myth:** If my kids were vaping I would smell it on their clothes.

**Fact:** Because vaping uses a battery to heat up a liquid and turn it into an aerosol, it can be virtually odorless.[2]

**Myth:** My kids are too young to buy devices or the juice (vape juice), so I don't have to be concerned right now.

**Fact:** Some kids purchase vapes and supplies online, from convenience stores, or obtain them from older friends or family members.

**Myth:** My kids can't afford it. Vaping is expensive—just like smoking cigarettes.

**Fact:** The average cost of a vape starting kit is about $35-40. The oil pods can cost around $5, which actually makes it cheaper than smoking traditional cigarettes.

## TALK TO YOUR TEEN ABOUT THE RISKS OF VAPING

- Know the facts about vaping and the risks of secondhand vaping.
- Set the tone for a discussion instead of a lecture. Practice the conversation.
- If needed, enlist another trusted adult to reinforce your message.
- Ask what your child(ren) already know about vaping.
- Start a conversation when you see or hear a news story about an injury, illness, or death from vaping.
- For more information, see the back of this brochure.

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# *Member Experience in 2018*

- 97.12% satisfaction rating from members after a call into the Member Engagement call center
- 94.6% satisfaction rating from members with the ICM program
- *Adult CAHPS® Health Plan Survey*: Among the nine composite measures, six measures improved compared to the previous year
- *Children CAHPS® Health Plan Survey*: Among the 14 composite measures, 10 measures improved compared to the previous year

✓ ***Since 2012, CHNCT has consistently exceeded its call center performance metrics***

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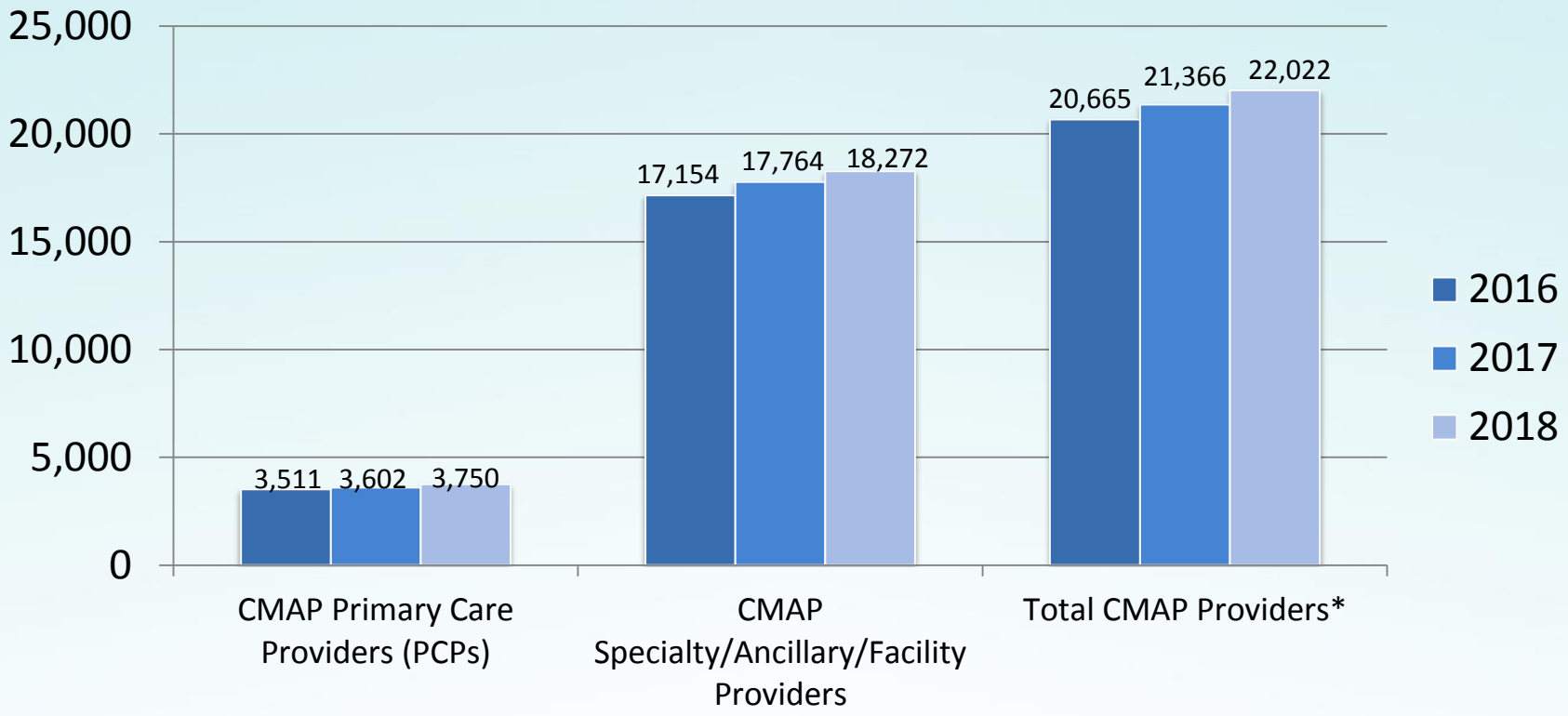
# Our Provider Network Continues to Grow

***From 2016 – 2018:***

✓ *PCPs have increased by 6.81%*

✓ *Specialists/other providers increased by 6.52%*




**Total CMAP Providers includes in-state and border providers only*

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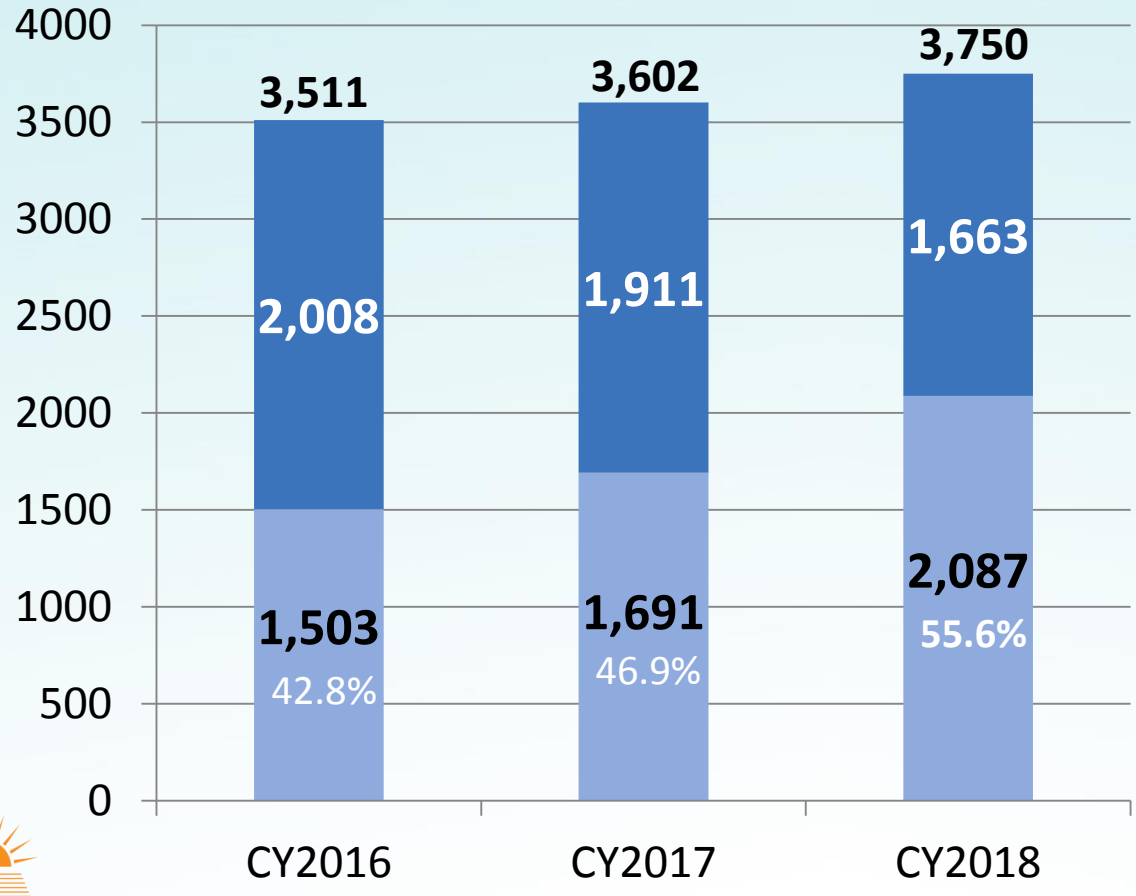
# *CMAP Primary Care Providers and Person-Centered Medical Homes (PCMH)*




- ✓ ***70.9% of attributed members receive care at a PCMH***

Non-PCMH Primary Care Providers

PCMH Primary Care Providers

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# *Supporting CMAP Providers to Improve Access*

✓ ***Approximately 350,000 provider calls received in the last six years***

- Outreached CMAP providers in 2018 who were:
  - Dis-enrolling (40.38% or 1,755 providers re-enrolled after 30 days)
  - Due to re-enroll within 120 days (77.69% or 4,606 providers re-enrolled after 30 days)
  - Newly enrolled to confirm PCP status (30.02% or 484 confirmed PCPs)
  - Enrolled as Ordering, Prescribing or Referring (OPR)* to encourage full CMAP enrollment (29.57% or 110 providers enrolled as full CMAP)
- 63 grievances received from providers in 2018
  - Top Reasons: *Appointment No-Shows, Inappropriate Behavior*

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*A provider enrolled as OPR may only order services for, prescribe or refer HUSKY Health members. They may not bill the HUSKY Health program for services or be reimbursed.

# *Provider Experience in 2018*

- 94.7% overall satisfaction rating from providers participating in the annual Provider Satisfaction Survey
- 98.33% satisfaction rating from providers after a call into the provider call center
- 96.9% satisfaction rating from providers who worked with CHNCT's ICM program

- ✓ ***In 2018, Provider Engagement representatives made over 5,000 visits to primary care providers and specialists***
- ✓ ***55% were routine check-in visits***

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# *Community Engagement*

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# *Community Engagement HUBs*

CHNCT created the Community Engagement HUBs program in 2017 to partner with communities. Our first HUB was established in Meriden.

- Community Engagement HUBs are mobile resource stations established at designated community settings that are highly-utilized and trusted by HUSKY Health members
- HUB is a central location for members who need **H**elp **U**nderstanding their **B**enefits
- We seek organizations in communities where HUSKY members reside and/or visit for community services and resources to become a HUB. Ideal HUB organizations have a high concentration of HUSKY members within their client population
- Community HUB partners commit to a pre-determined schedule during which someone from the Community Engagement Team will be on-site to provide HUSKY members with information regarding benefits and local community resources
- The program is supported by the Community Engagement Team (CET) and other personnel as needed (Intensive Care Management Nurses, Community Health Workers and Member Engagement Staff)
- HUSKY Health members who visit these HUB sites are empowered to improve their health outcomes and reduce their health risk factors by being introduced to resources to meet basic needs, finding a primary care provider, and increasing their knowledge about health maintenance and disease management

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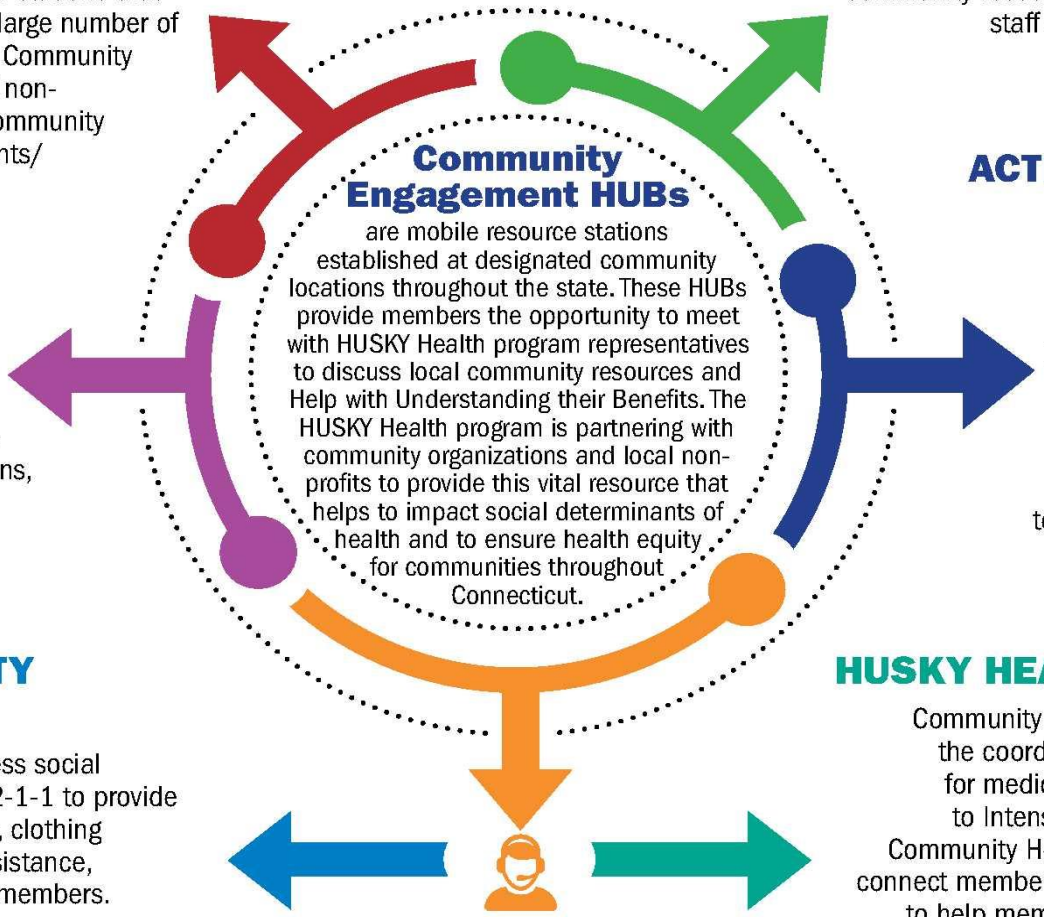
## COMMUNITY HUB PARTNERSHIPS

Community Health Network of Connecticut, Inc. (CHNCT), on behalf of the HUSKY Health Program, is forming community engagement partnerships with organizations that are actively involved in the communities they serve. These organizations collaborate with CHNCT to establish on-site HUB stations that provide additional resources to the large number of HUSKY Health members they serve. Community HUB Partners include schools, local non-profits, faith-based organizations, community organizations, and health departments/ organizations.

## COMMUNITY ENGAGEMENT FACILITATION

Community engagement staff are available during HUB station hours and scheduled community events to provide HUSKY Health members with key information on HUSKY Health benefits and local community resources. The community engagement staff serve as the primary contacts for Community HUB partners.




## HUSKY HEALTH MEMBER ENGAGEMENT

Community engagement staff and Community HUB Partners work to ensure that HUSKY Health members are aware of the HUB station locations, days, and hours as well as the resources provided by the HUB.

## ACTIVE COMMUNITY INVOLVEMENT

HUB stations establish pre-determined schedules of regular hours at each partner location to provide HUSKY Health members with frequent, reliable access to information. Stations will also be present during partner events such as parent-teacher groups, father groups, and community fairs.

## LOCAL COMMUNITY RESOURCES

Community engagement staff address social determinants of health by utilizing 2-1-1 to provide information regarding food pantries, clothing closets, utility assistance, rental assistance, employment services, and more to members.

## HUSKY HEALTH BENEFITS

Community engagement staff can assist with the coordination of transportation services for medical appointments; provide access to Intensive Care Management (ICM) and Community Health Worker (CHW) services; and connect members with Member Engagement staff to help members find a new provider, make a change in providers, or order new ID cards.

## VALUABLE RESOURCES

Community engagement staff will act as a liaison to provide important information to HUSKY Health members that will help to improve health equity by positively impacting social determinants of health including financial, personal, emotional, and physical well-being.

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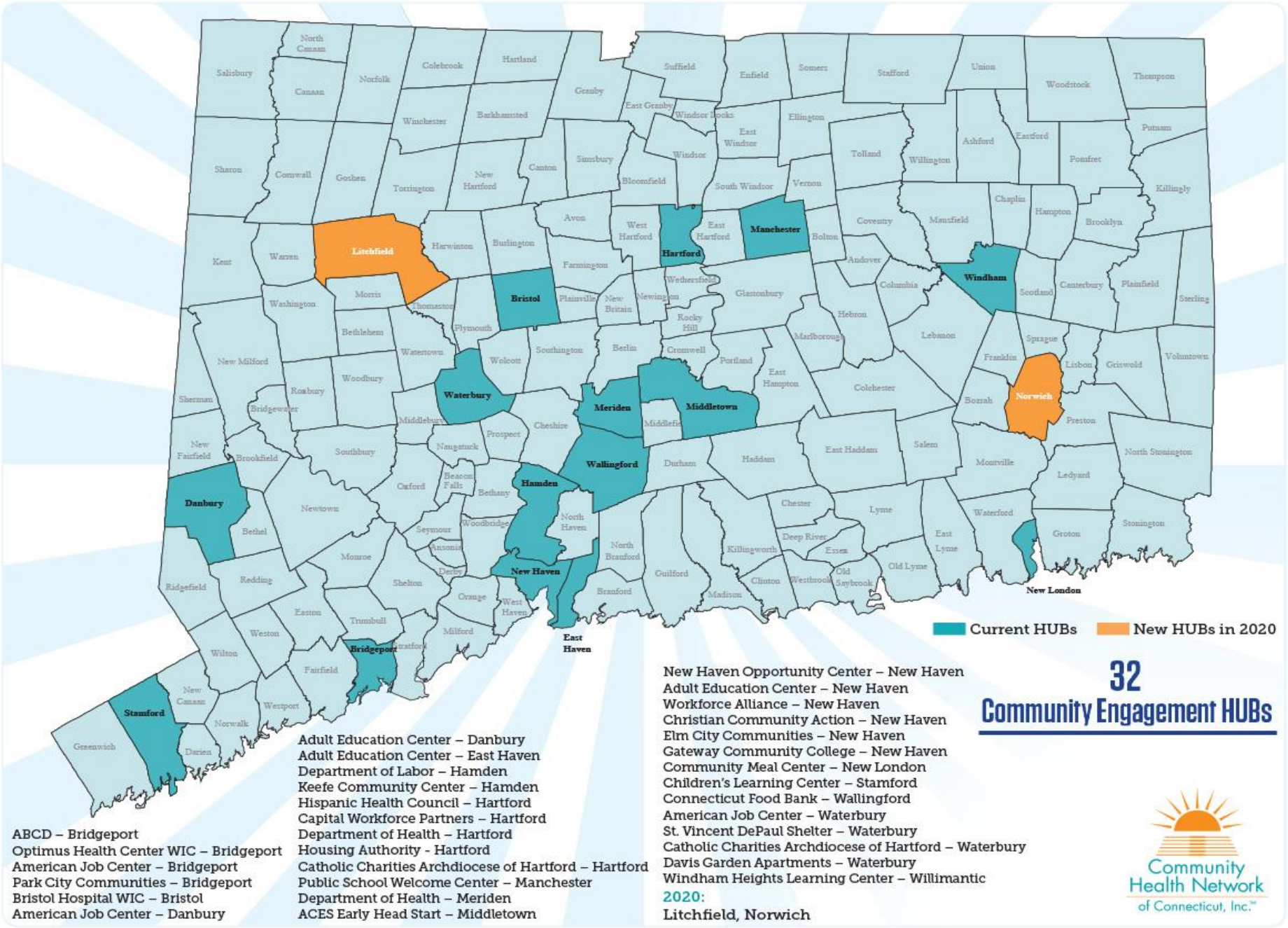


# 32 Community Engagement HUBs

ABCD – Bridgeport
Optimus Health Center WIC – Bridgeport
American Job Center – Bridgeport
Park City Communities – Bridgeport
Bristol Hospital WIC – Bristol
American Job Center – Danbury

Adult Education Center – Danbury
Adult Education Center – East Haven
Department of Labor – Hamden
Keefe Community Center – Hamden
Hispanic Health Council – Hartford
Capital Workforce Partners – Hartford
Department of Health – Hartford
Housing Authority - Hartford
Catholic Charities Archdiocese of Hartford – Hartford
Public School Welcome Center – Manchester
Department of Health – Meriden
ACES Early Head Start – Middletown

New Haven Opportunity Center – New Haven
Adult Education Center – New Haven
Workforce Alliance – New Haven
Christian Community Action – New Haven
Elm City Communities – New Haven
Gateway Community College – New Haven
Community Meal Center – New London
Children's Learning Center – Stamford
Connecticut Food Bank – Wallingford
American Job Center – Waterbury
St. Vincent DePaul Shelter – Waterbury
Catholic Charities Archdiocese of Hartford – Waterbury
Davis Garden Apartments – Waterbury
Windham Heights Learning Center – Willimantic

2020:
Litchfield, Norwich

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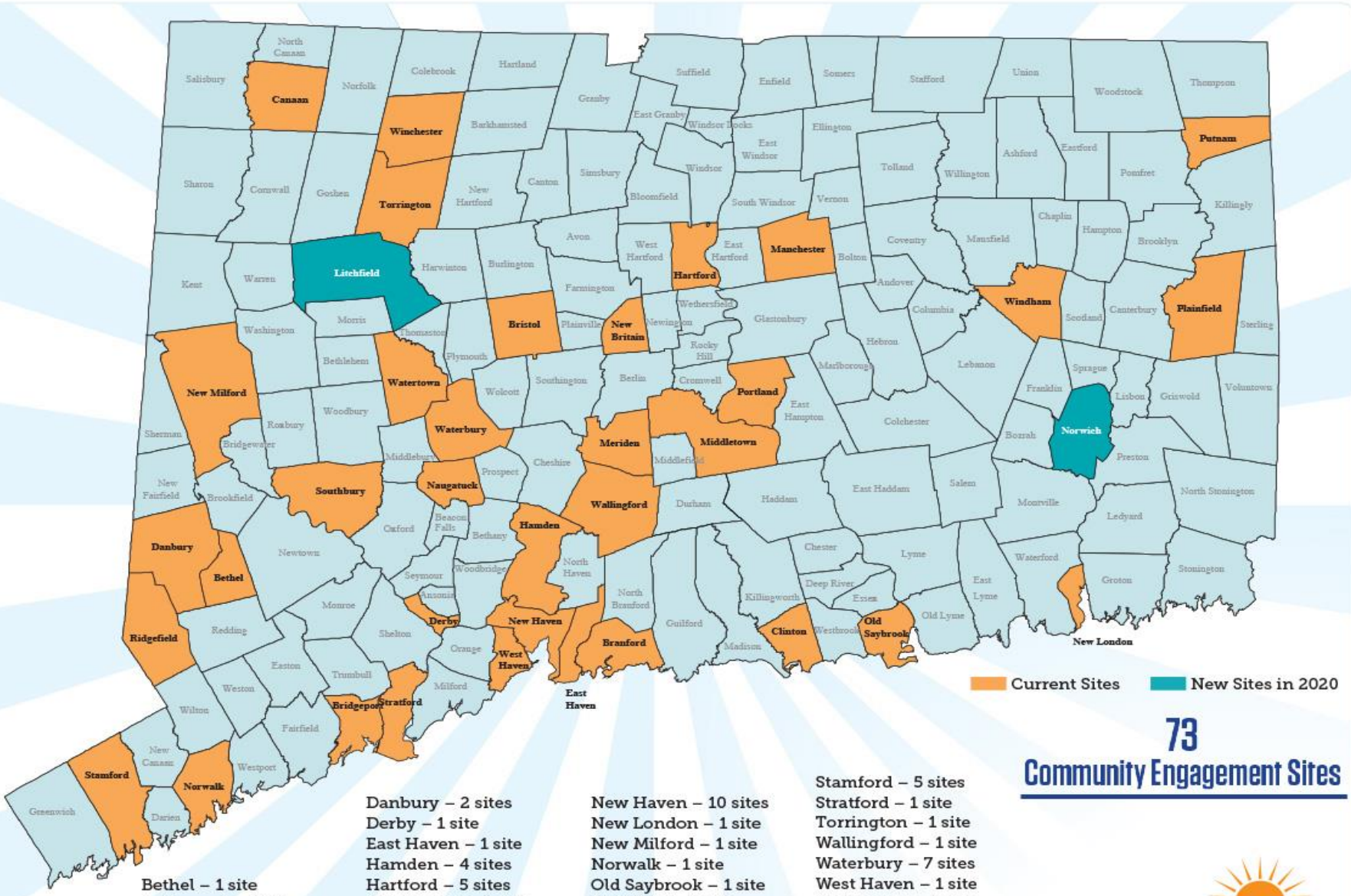


# 73
## Community Engagement Sites

Bethel – 1 site
Bridgeport – 8 sites
Branford – 1 site
Bristol – 1 site
Canaan – 1 site
Clinton – 1 site

Danbury – 2 sites
Derby – 1 site
East Haven – 1 site
Hamden – 4 sites
Hartford – 5 sites
Manchester – 1 site
Meriden – 3 sites
Middletown – 2 sites
Naugatuck – 1 site
New Britain – 2 sites

New Haven – 10 sites
New London – 1 site
New Milford – 1 site
Norwalk – 1 site
Old Saybrook – 1 site
Plainfield – 1 site
Portland – 1 site
Putnam – 1 site
Ridgefield – 1 site
Southbury – 1 site

Stamford – 5 sites
Stratford – 1 site
Torrington – 1 site
Wallingford – 1 site
Waterbury – 7 sites
West Haven – 1 site
Willimantic – 1 site
Winchester – 1 site
Winsted – 1 site
2020:
Litchfield, Norwich

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# *Care Management Programs*

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# *Care Management Programs*

- CHNCT provides a comprehensive group of care management programs. Person-centeredness provides the framework for CHNCT's care management programs:

  - ED Care Management (EDCM)
  - Intensive Discharge Care Management (IDCM)
  - Transitional Care Management (TCM)
  - Intensive Care Management (ICM)

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# *ED Care Management (EDCM)*

- Through the use of Admission, Discharge and Transfer (ADT) transactions and logic programmed by CHNCT instant notifications reports were developed to allow the EDCM nurses to identify members for focused care management

- EDCM nurses have real time contact with member and/or hospital ED staff to:
  - Assess and coordinate for post-discharge care and services
  - Arrange for ICM to visit with member while in the ED and/or refer members to ICM for community follow-up

✓ ***Since 2012, 20,256 members were managed by EDCM (through June 2019).***

✓ ***The 4,449 members managed by EDCM in CY 2018 experienced a 35.36% reduction in ED visits when comparing six months post EDCM to six months prior***

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# *Intensive Discharge Care Management (IDCM)*

- Focus on targeted chronic conditions or members at high risk for readmission
- IDCM nurses meet with members face-to-face at bedside or coordinate telephonically with the member and hospital staff
  - Perform a person-centered assessment
  - Identify and address SDOH, which may be a barrier to recovery upon discharge
  - Arrange post discharge services and appointments

✓ ***Since 2012, 26,014 members managed by IDCM (through June 2019)***

***For the 3,606 members managed by IDCM in CY 2018:***

✓ ***97.12% had a follow-up appointment scheduled***

✓ ***70.49% reduction in readmissions six months following IDCM assessment compared to six months prior***

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# *Transitional Care Management (TCM)*

- These nurses as well utilize ADT reports for real time hospital discharge notification to allow earliest outreach to members to:
  - Assess needs once member is home:
    - Review understanding of discharge plan including medications
    - Coordinate for any services now needed once home
  - Ensure follow-up appointments are in place or assist with scheduling

✓ ***Since 2012, 126,273 members successfully contacted (through June 2019)***

✓ ***For the 7,825 members successfully reached by TCM in CY 2018, 41.51% had a visit within seven days of hospital discharge***

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# *Intensive Care Management (ICM)*

- The ICM program goal is to assist members in reaching optimal health
- Regionally based teams of nurses, behavioral health (BH) clinician, community health workers (CHW), pharmacists, registered dieticians, physicians, certified educators in diabetes, childbirth, lactation and asthma
- Utilizing motivational interviewing, a comprehensive, person-centered holistic assessment is performed that includes members' barriers, strengths, perceptions of their health and SDOH

✓ ***Since 2012, 113,242 enrollments and 74,420 engagements with members in ICM (through June 2019)***

***For members engaged in ICM in CY 2018:***

✓ ***Hospital inpatient utilization decreased by 45.19%***

✓ ***ED utilization decreased by 21.17%***

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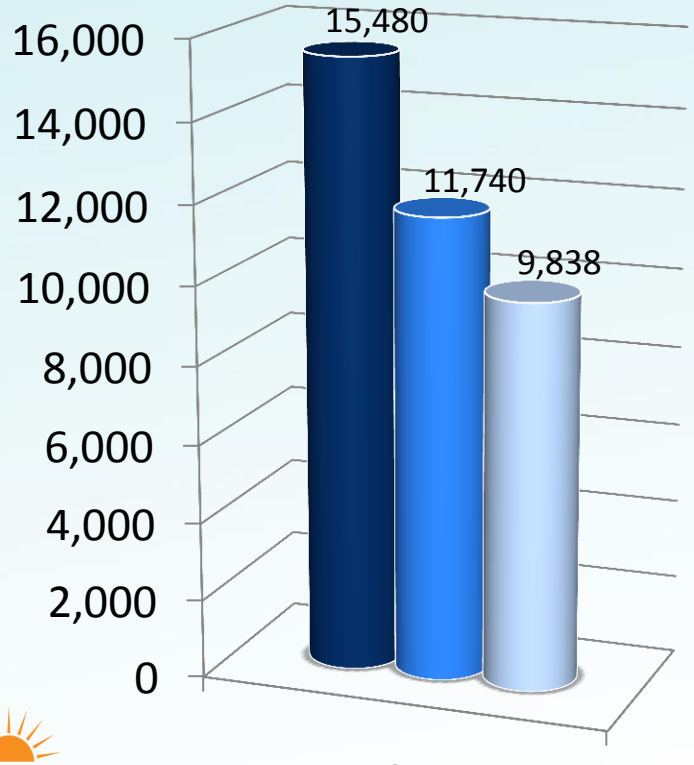
# *The Impact of Care Management*

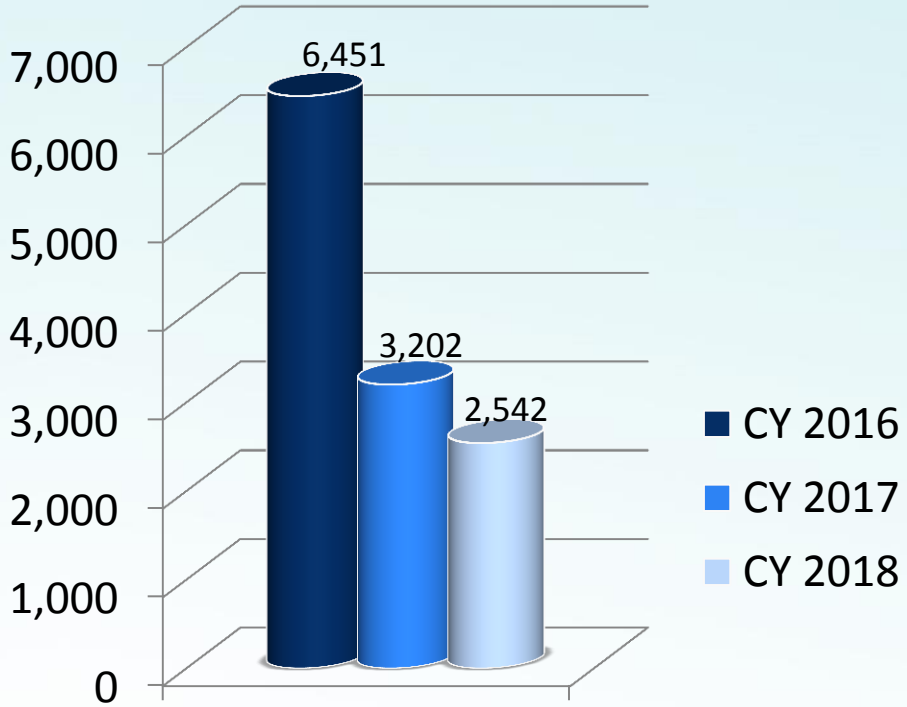
CHNCT assessed the long-term impact on the 5,602 members engaged in ICM in 2016 who were continuously enrolled in 2017 and 2018.

✓ ***36% decrease in ED visits 2016 vs. 2018***




ED Utilization

✓ ***60% decrease in admissions 2016 vs. 2018***




Inpatient Utilization

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# *A Focus on Health Inequity*

- DSS and CHNCT collectively determined targets for certain measures where a disparity existed
- CHNCT Care Management teams, Clinical Pharmacist and Member Engagement utilized targeted analytics to identify members for focused outreach to address health inequities
- As a result of our interventions, in CY 2016 and CY 2017, CHNCT achieved:
  - An increase in asthma medication management for both Black/African Americans (BAA) and Hispanic members
  - An increase in the number of BAA children ages 0-15 months who had as least 6 well child visits
  - A reduction in the readmission rate for BAA members
- Opportunities still exist in reducing the disparity in rates by race for BAA children and adult members as compared to the other races for certain measures

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# *Innovative Pilots for Targeted Populations*

## American Heart Association's Empowered to Serve™ (ETS) Pilot

- Offers a way to engage and motivate community members to take steps towards creating a culture of health through a series of health lessons built upon key evidence based principles:
  - Self-monitoring and tracking of BP readings at home or outside of the provider office
  - Use of health mentors to motivate and encourage participants
- CHNCT added physical activity and nutrition education into the pilot
- A total of 28 HUSKY Health members diagnosed with hypertension participated in four programs and showed the following outcomes during their last session compared to their initial session:
  - 71.43% had a lower systolic blood pressure
  - 100% had a follow-up PCP visit for ongoing management of their health
  - 96.43% reported having confidence in their ability to manage their HTN

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# *Innovative Pilots for Targeted Populations (cont.)*

## Diabetes Prevention Program (DPP) Pilot

- DPP is a national evidence-based program that is proven to help individuals reduce their risk of developing type 2 diabetes through achieving weight loss and increasing physical activity
- In late July 2018, CHNCT implemented a DPP pilot utilizing a CDC-approved curriculum, which includes coaching on lowering calories, increasing physical activity, self-monitoring, maintaining healthy lifestyle behaviors, and psychological, social, and motivational challenges through 25 sessions throughout a 12-month period
- The DPP pilot enrolled 62 members (42% used in-person classes and 58% used virtual classes) to achieve a 2.9% average weight loss
- DSS secured legislative funding and approval for a statewide DPP which CHNCT implemented in July 2019

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# *Population Health Management*

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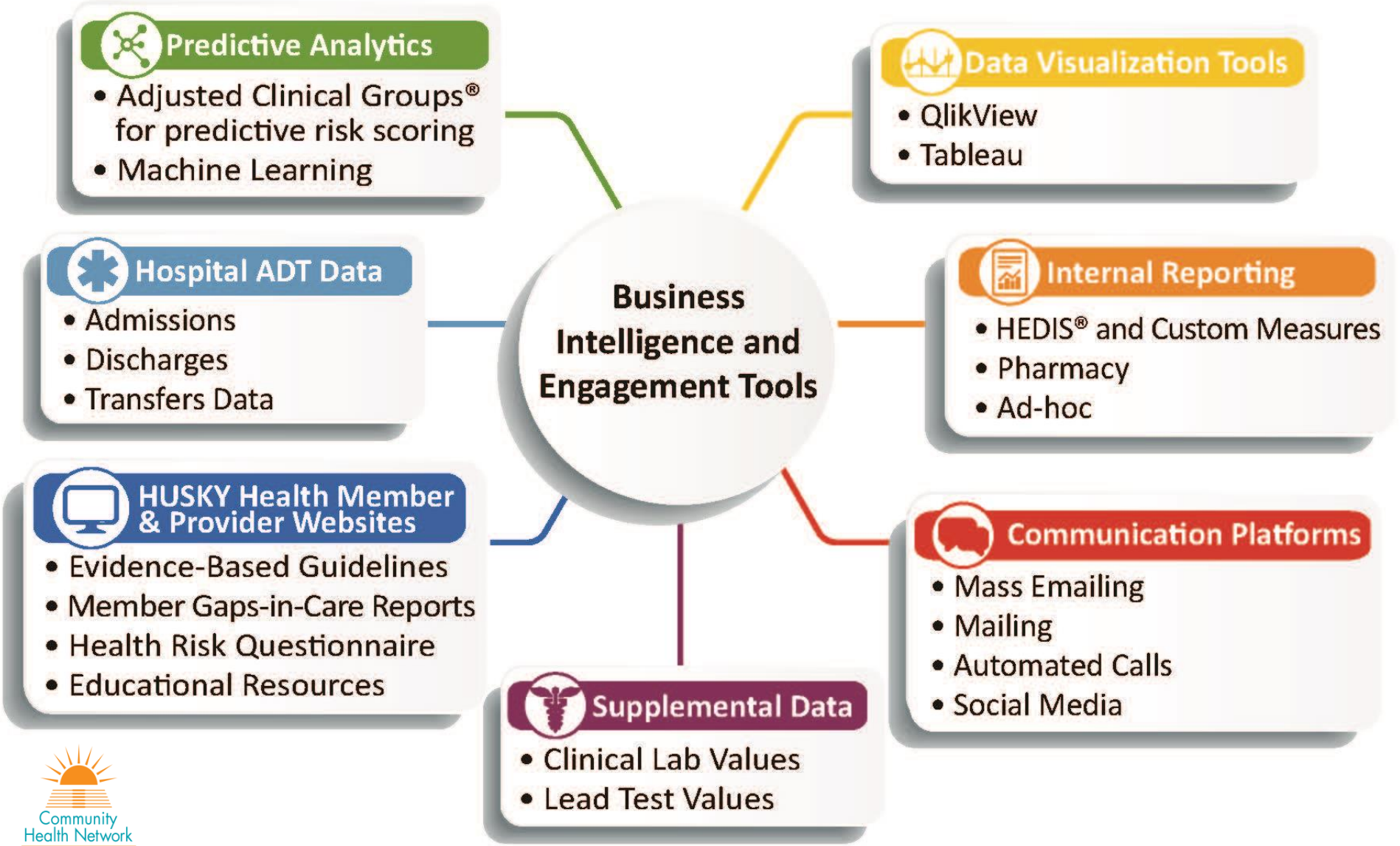
# How We Use Information to Improve Health Outcomes

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# Top Conditions

| Condition | 2017 # Members | 2017 Rate/1000 Members | 2018 # Members | 2018 Rate/1000 Members | Difference Rate/1000 Members | % Change Rate/1000 Members |
|---|---|---|---|---|---|---|
| Asthma | 94,241 | 130.75 | 99,858 | 131.28 | 0.53 | 0.4% |
| Behavioral Health | 252,751 | 350.67 | 275,741 | 362.52 | 11.85 | 3.4% |
| Cancer - Breast - Female | 1,962 | 5.12 | 2,100 | 5.24 | 0.12 | 2.3% |
| Cancer - Colon | 828 | 1.15 | 929 | 1.22 | 0.07 | 6.3% |
| Cancer - Prostate | 575 | 1.70 | 655 | 1.82 | 0.12 | 7.0% |
| Cancer Other | 6,782 | 9.41 | 7,322 | 9.63 | 0.22 | 2.3% |
| Chronic Heart Failure (CHF) | 6,647 | 9.22 | 7,581 | 9.97 | 0.74 | 8.1% |
| COPD | 13,293 | 18.44 | 14,140 | 18.59 | 0.15 | 0.8% |
| Coronary Artery Disease (CAD) | 10,894 | 15.11 | 11,945 | 15.70 | 0.59 | 3.9% |
| Diabetes | 42,588 | 59.09 | 44,971 | 59.12 | 0.04 | 0.1% |
| HIV | 3,281 | 4.55 | 3,546 | 4.66 | 0.11 | 2.4% |
| Hypertension | 81,753 | 113.43 | 87,095 | 114.50 | 1.08 | 1.0% |
| Sickle Cell | 1,214 | 1.68 | 1366 | 1.80 | 0.11 | 6.6% |
| **Grand Total** | **516,809** | | **557,249** | | | |

- ✓ The increase in disease prevalence for HIV and sickle cell is largely due to new members enrolled in 2018 with the condition (55 and 58%, respectively).
- ✓ For other conditions, new members accounted for 25 – 40% of the incidence, while the rest of the increase was seen in members eligible in both 2017 and 2018.
- ✓ HUSKY D has a disease prevalence that is much higher than other programs, except for sickle cell, where HUSKY C has the highest prevalence.

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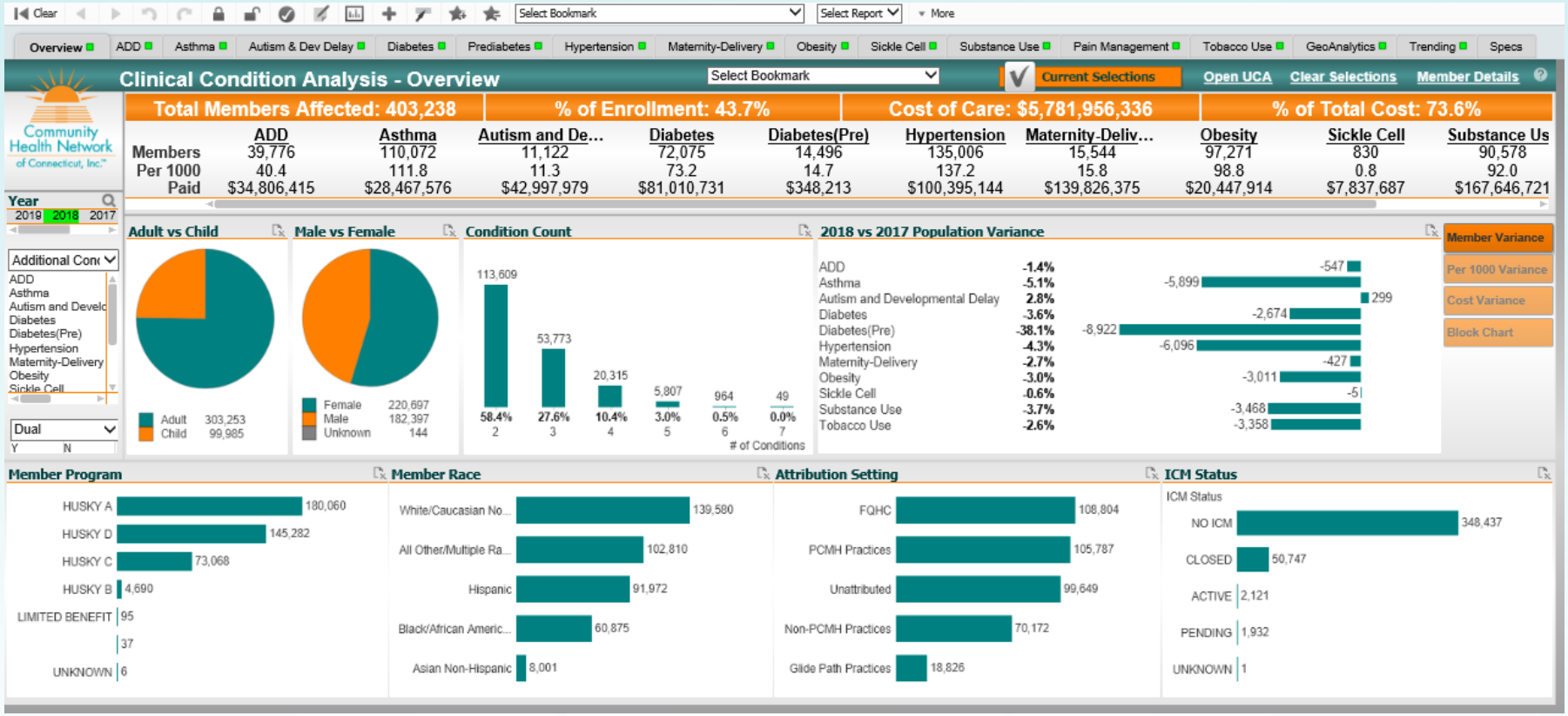
***Source: CHNCT Claims Data Warehouse***

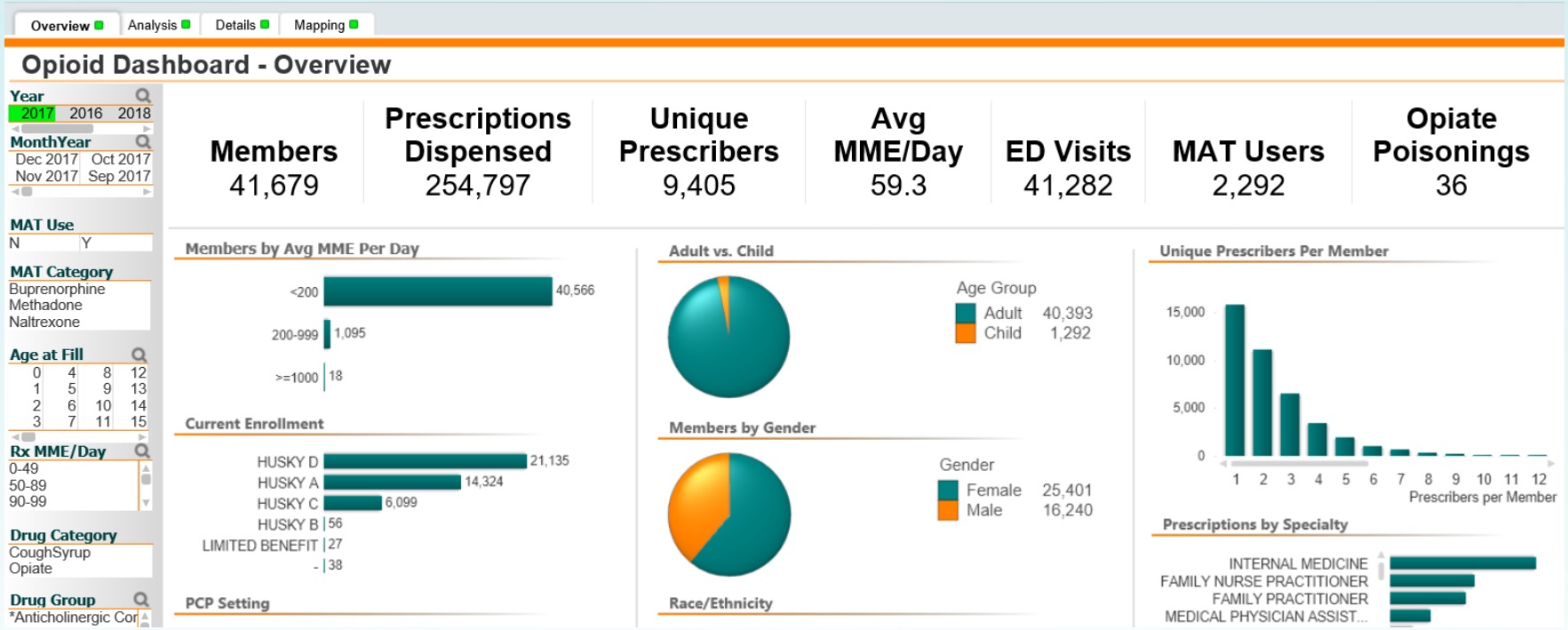
# HealthView

The HealthView Dashboard can be used to view high level metrics based upon members who are identified as having one or more clinical conditions. Users can also view high level metrics specific to each of the clinical conditions on any of the individual condition tabs. Additionally, detailed member level information can be viewed and exported for additional analysis and follow-up.



# Opioid Dashboard

The Opioid Dashboard provides a way to monitor key metrics for members who have been prescribed an opioid. High level summaries are provided that align with performance targets and key performance indicators. Deeper analysis is available to see current trends of opioid prescriptions. Users can also drill down to member, claim, and prescriber details for low level analysis.

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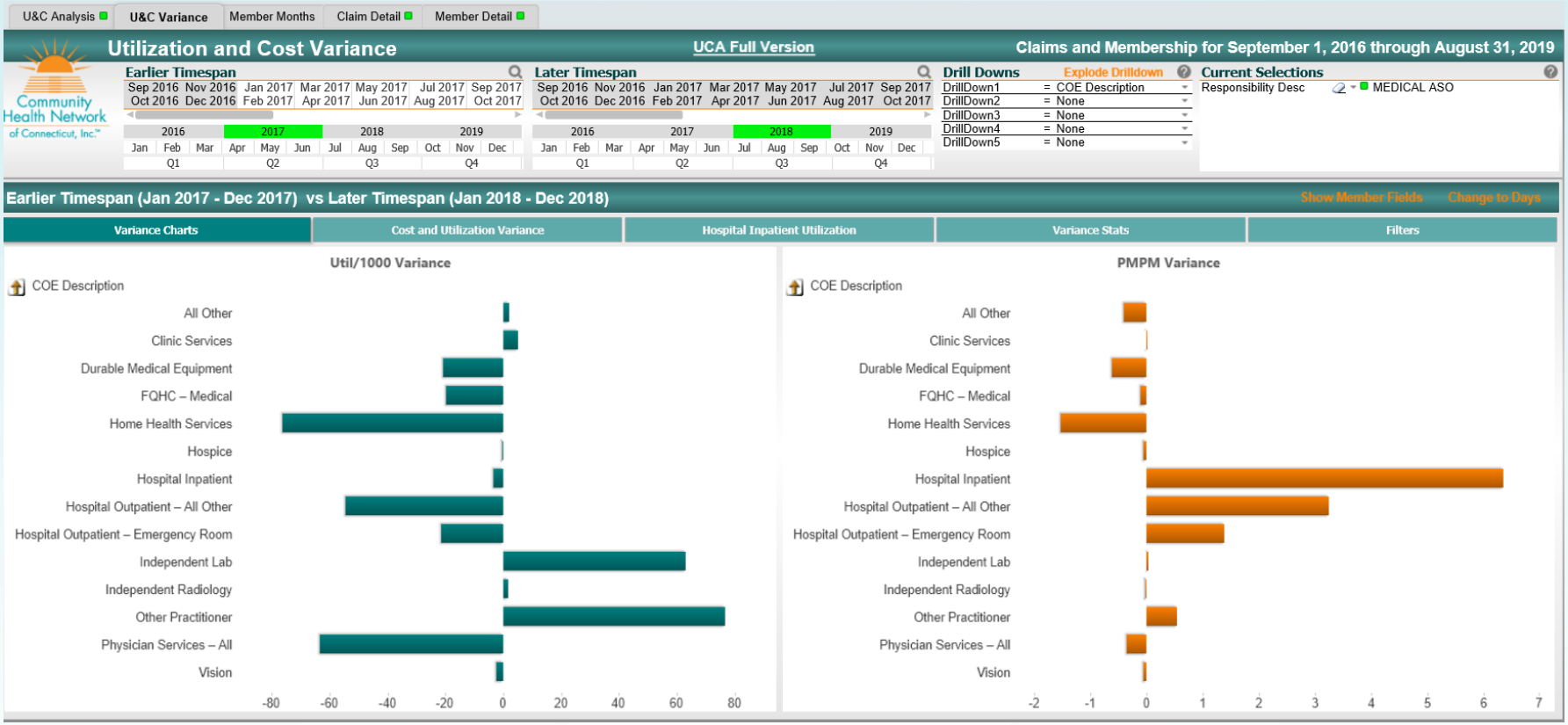
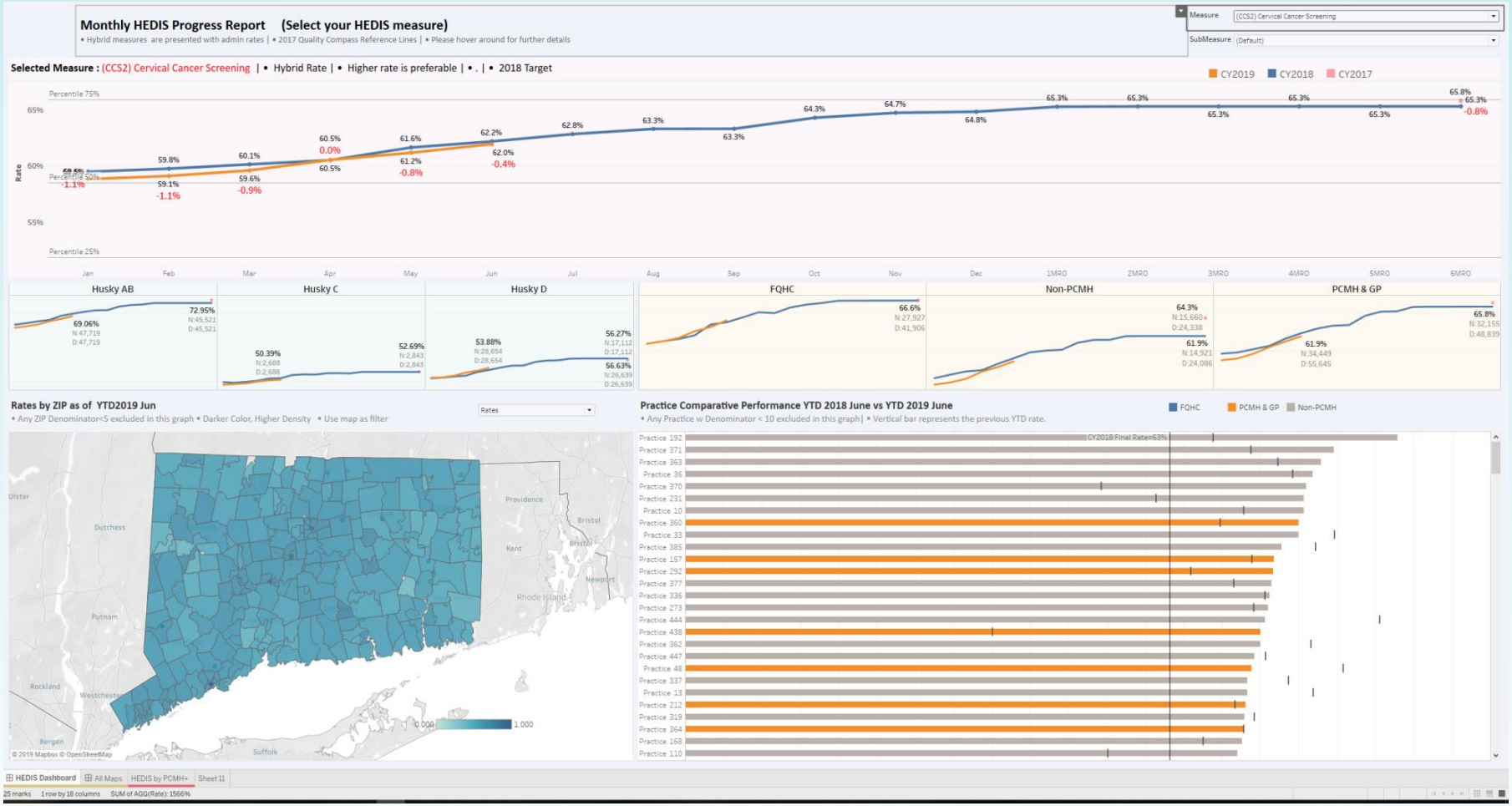
# *Utilization and Cost Analyzer (UCA)*

The UCA application provides cost and utilization metrics based on enrollment and claims data from 2012 through the current year. Users can compare how cost and utilization change over time based on a variety of claims, provider, and membership filters. Information results can be exported to Excel for further analysis and distribution.



# Gaps In Care Dashboard

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# *Population Health*
# *CY 2018 HEDIS® Measures: Level of Improvement*

| Level of Improvement | # of Measures/Sub-measures | | |
|---|---|---|---|
| | HUSKY A and B | HUSKY C | HUSKY D |
| | | | |
| **Rates improved by at least 2%** | 35 | 16 | 13 |
| **Rates improved by 1.1 to 1.9%** | 3 | 1 | 2 |
| **Rates remained the same (-1% to 1%)** | 18 | 20 | 14 |
| **Rates that worsened by -1.1 to -1.9%** | 17 | 6 | 6 |
| **Rates that worsened by at least 2%** | 43 | 22 | 32 |



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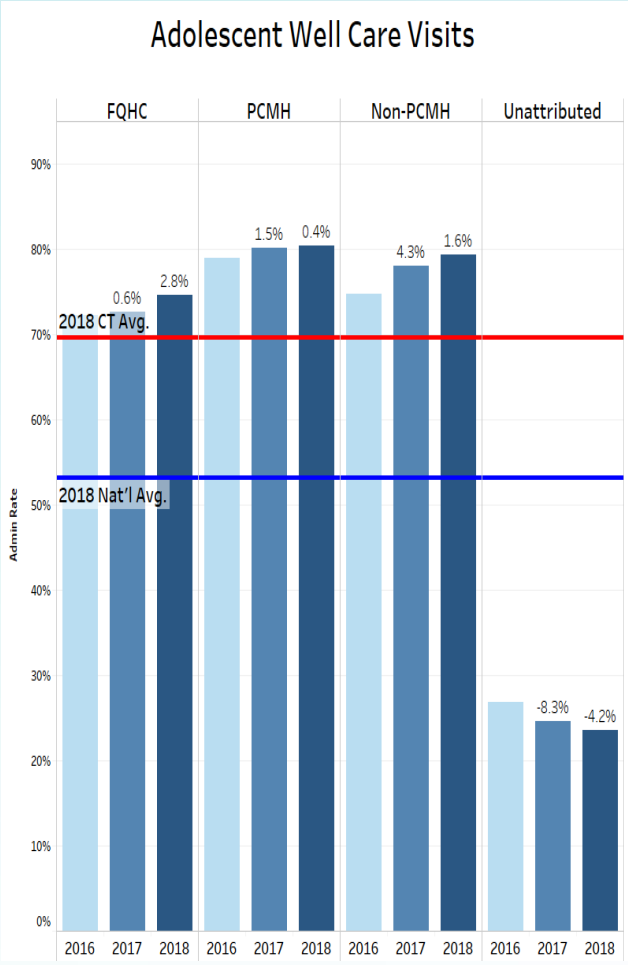
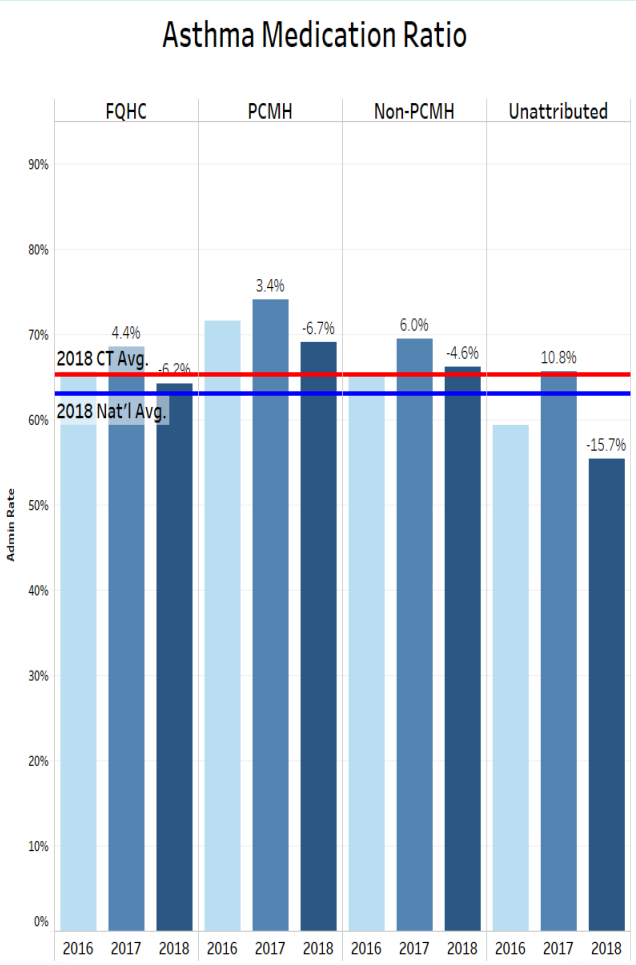
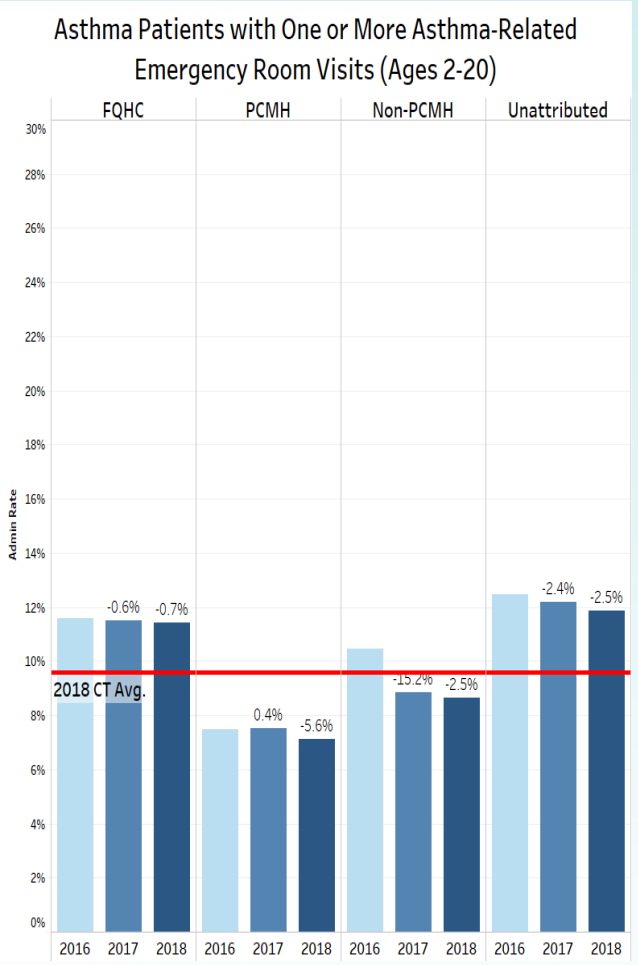
# *Population Health Outcomes*

## Outcomes by Practice Setting

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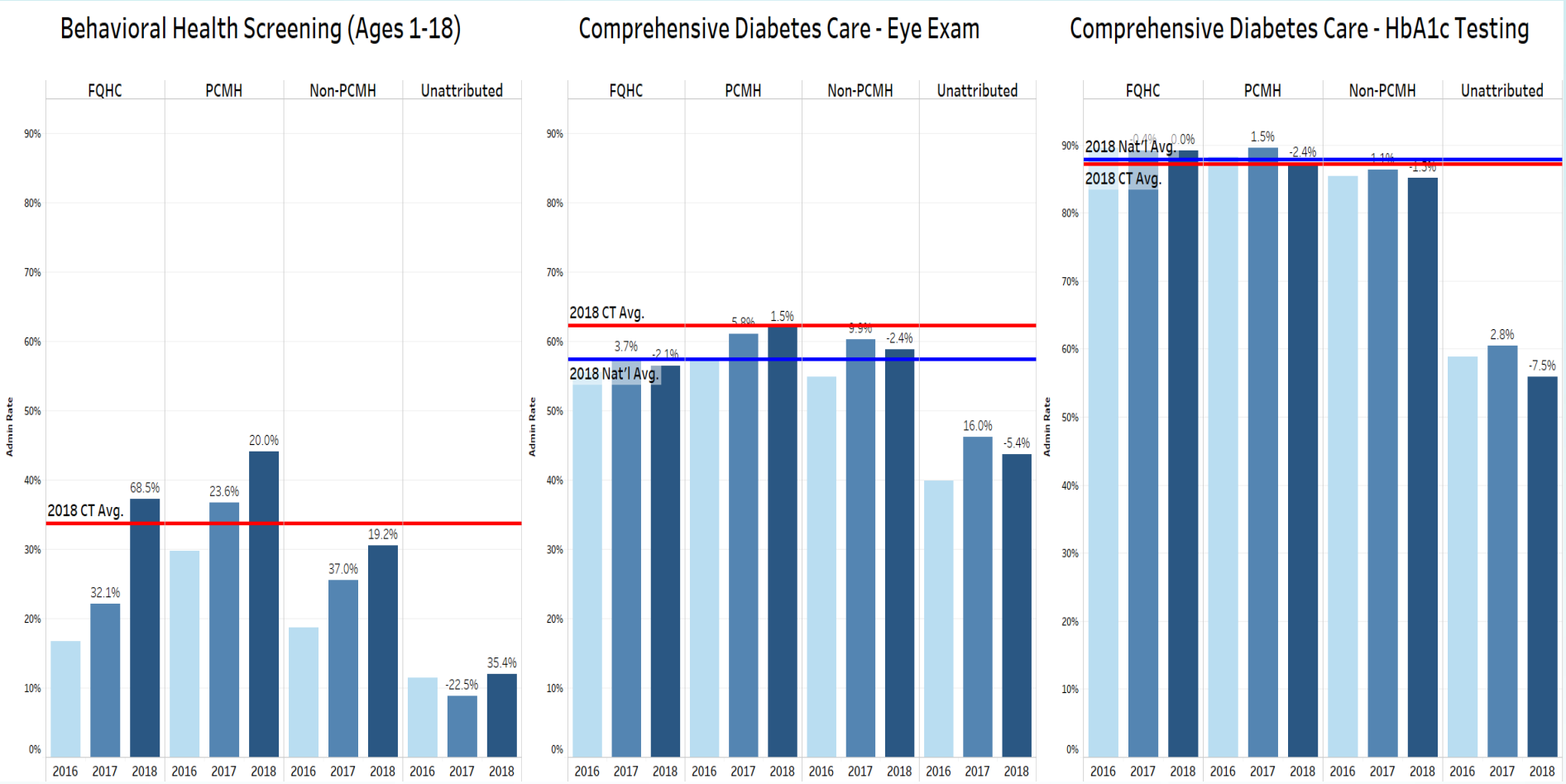
# *Population Health Outcomes*

## Outcomes by Practice Setting

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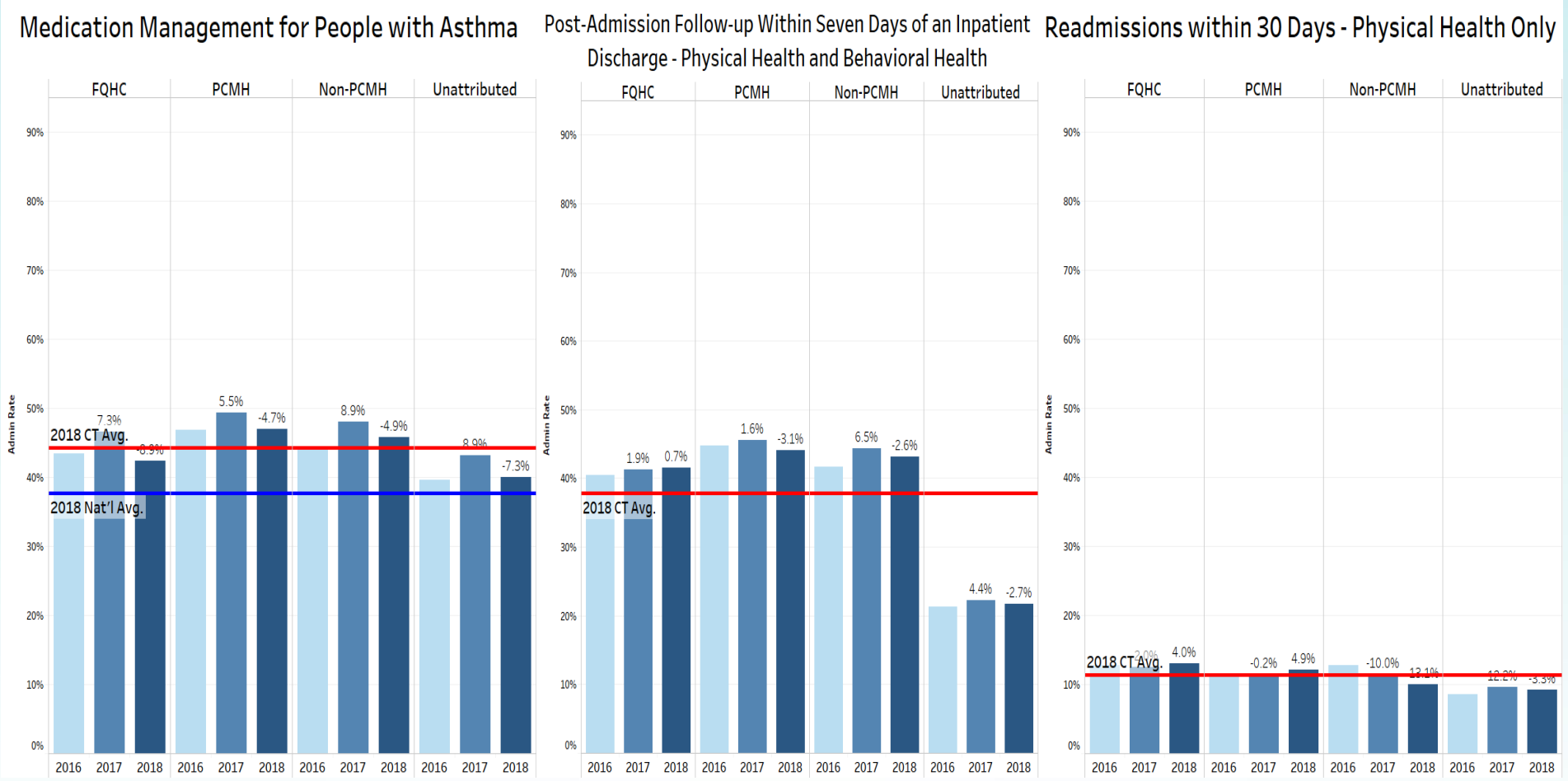
# *Population Health Outcomes*

## Outcomes by Practice Setting

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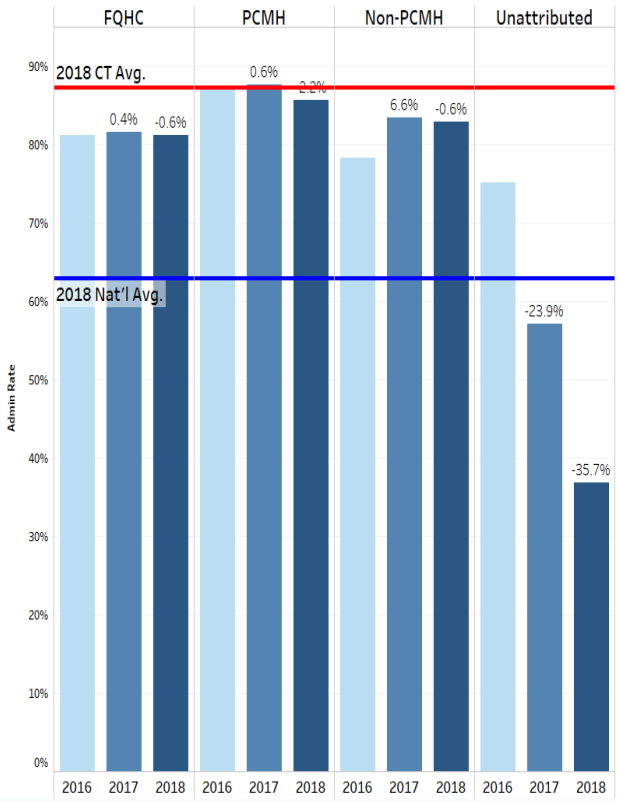
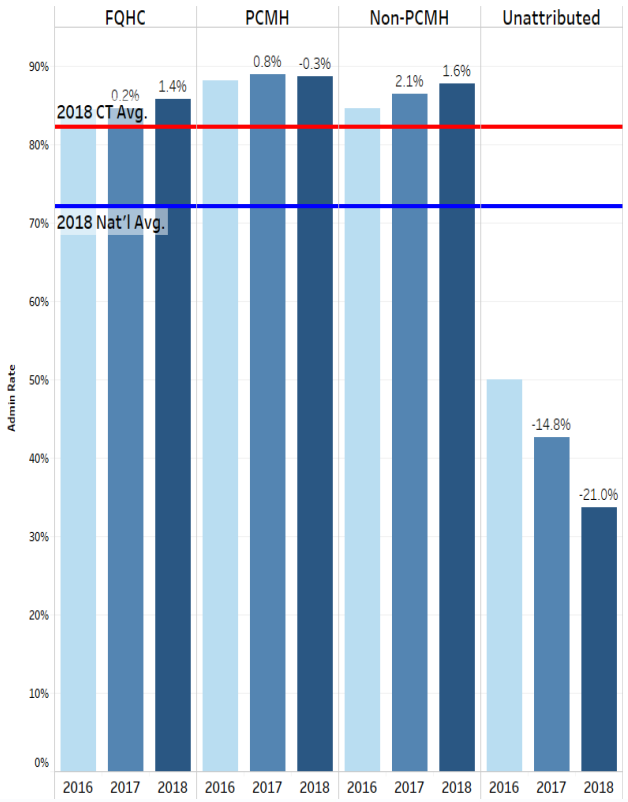
# *Population Health Outcomes*

## Outcomes by Practice Setting

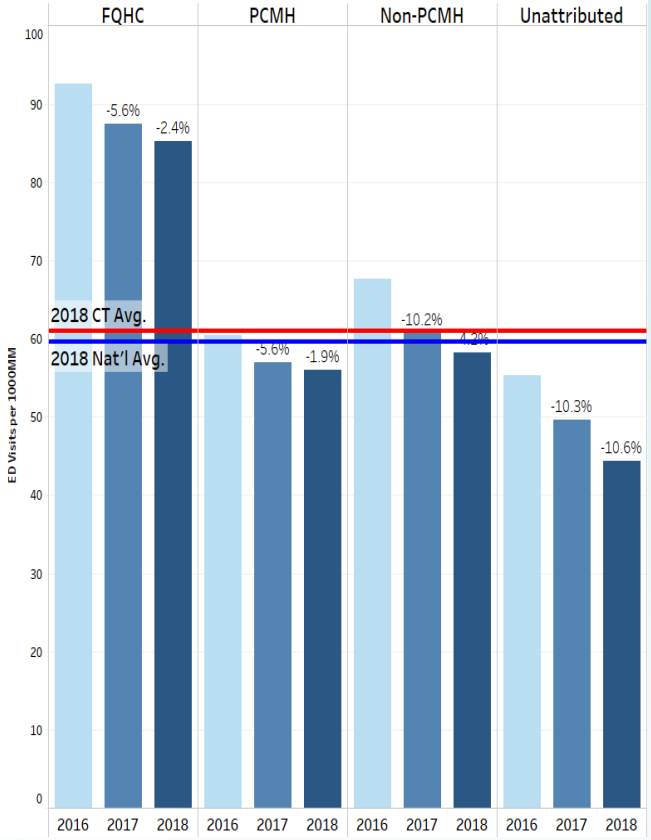
Well-Child Visits in the First 15 Months of Life - 6 or More Visits




Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life




Ambulatory Care - ED Visits per 1000 MM

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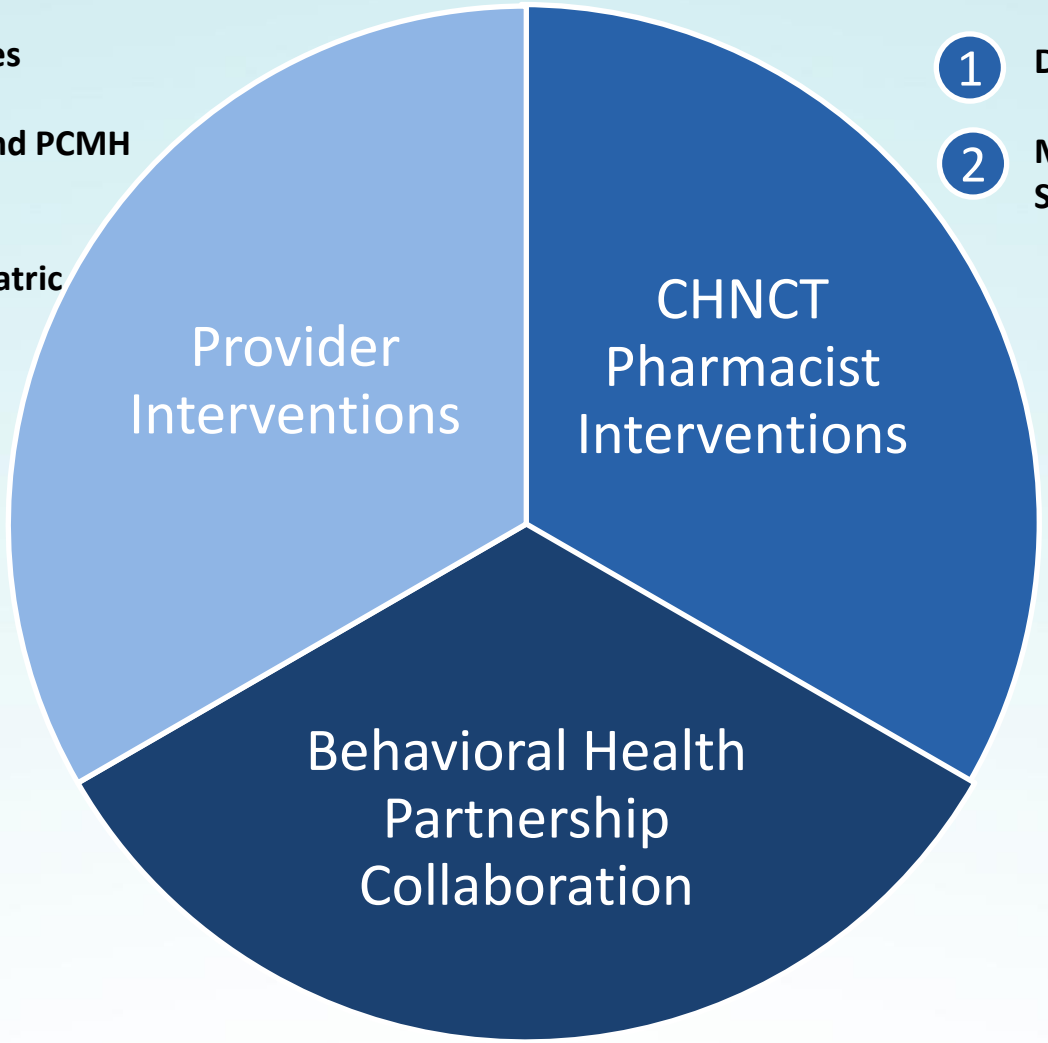
# Population Health Interventions

1. Reporting capabilities
2. Population health and PCMH team
3. Project ECHO®: Pediatric Complex Care




1. Drug Utilization Review
2. Medication Management Support

1. HEDIS behavioral health measures
2. Opioid use disorder

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# *Our Successes*

- Improved health outcomes while reducing costs through our care coordination programs, interventions and utilization management
  - For ASO medical only, HUSKY Health saw a savings in hospital inpatient, emergent and all other outpatient services from 2013 through 2018, due to lower utilization
- Dedicated to continuously improving the members' and providers' experience, as evidenced through satisfaction ratings well above 90% since 2012
- Implemented and support the PCMH program
- Developed and implemented innovative pilots and scaled successes to targeted populations:
  - ADT Pilots
  - Diabetes Prevention Program (DPP) Pilot
  - American Heart Association's Empowered to Serve™ Pilot

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# *Our Opportunities*

- Develop additional focused strategies to:
  - Engage the unattributed members into primary care
  - Improve the health of members with certain conditions and understand/address the impacts of race and ethnicity on health outcomes

- Conduct analysis by locality on how SDOH drives health inequities and collaborate with additional community-based organizations to address unmet needs

- Provide analytics and recommendations to DSS to support alternative payment models to further improve quality

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# *A Member Story*

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