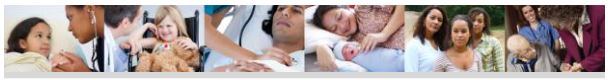
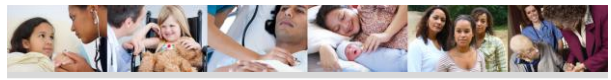


ACAP

1



QUALITY

2

SHARING

3

INITIATIVE

4

Wellness and Obesity Programs

The Plan

- Location: Massachusetts - State wide
- Who We Serve:
  - Medicaid product: approximately 182,000 members (NCQA excellent accreditation)
  - Medicaid Product recently ranked #4 nationally by NCQA 2010-2011
  - Commonwealth Care: approximately 59,500 members

The Approach

- There is a concerning increase in obesity among all populations which is leading to further health complications.
- BMC HealthNet Plan created a multi-pronged approach to wellness and obesity programs to provide more education to members and supply resources to help members improve their overall health and reduce the risk of further health complications.
- The goal of the programs is to improve members' knowledge of how to be healthy and avoid or address obesity.
- These initiatives/programs are focused on all members including members in Care Management.

Member and Plan Interventions

- Wellness Guide sent to all members
- Wellness webpage available on the Plan's website www.bmchp.org
- Pedometers distributed to members that visit the Plan's website.
- Obesity Care Management program
- Collection and monitoring of BMI scores for members in Care Management.
- Distribution of scales to members to effectively monitor weight.

Wellness Guide

Wellness Webpage

Obesity Care Management

- The Plan identifies members with obesity through many portals including:
  - Claims for morbid obesity or bariatric surgery procedures.
  - Self referrals or referrals from providers or internal staff.
- Members in Care Management for obesity and other conditions are offered a scale to monitor their weight effectively at home.
- Members receive nutritional counseling and advice about how to be active from the Plan's care management staff.

Expected Outcomes

- BMC HealthNet Plan is monitoring the utilization of the webpage as well as the trend of BMI scores to determine the effectiveness of the variety of programs.
- The expected outcome is a decrease in the BMI scores and an increased utilization of the wellness resources to help support a healthy lifestyle.

Next Steps

- The Plan will continue to monitor and create culturally competent programs to meet the needs of the membership.

For More Information Contact:

Cindi Scollins, RN, MPH
Director Health Care Coordination
BMC HealthNet Plan
Two Copley Place
Suite 600
Boston, MA 02116
Phone: 617-748-6434

Ana Berridge, MHA
Quality Project Manager
BMC HealthNet Plan
Two Copley Place
Suite 600
Boston, MA 02116
Phone: 617-748-6448

Children's Mercy FAMILY HEALTH PARTNERS www.fhp.org

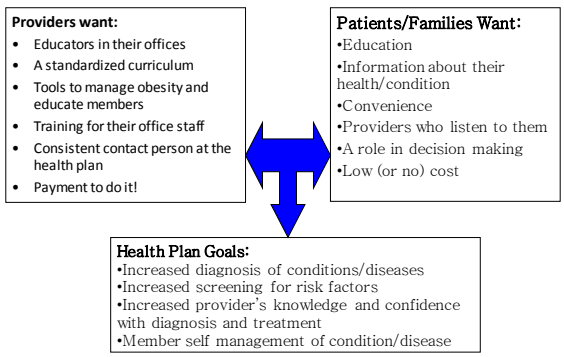
Healthy Lifestyles Program

ACAP Quality Sharing

A little bit about our health plan

- Where: Kansas City, MO
- Who: Title 19 and 21 Participants in Kansas and Missouri
- Number of members: ~180,000
- We have experienced moderate expansion over the last few years and expect to see this trend continue.

Putting it all together



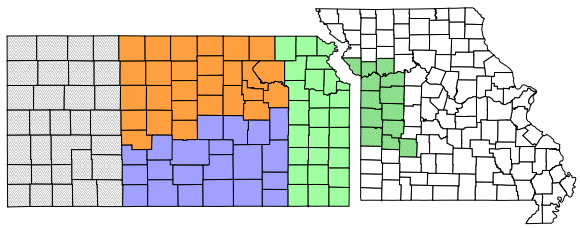
Goals of Initiative

- Goals:
  - Increase provider measurement and documentation of BMI and BMI%ile
  - Increase provider screening and education for healthy lifestyles (obesity treatment)
  - Increase diagnosis of overweight and obesity.
  - Support and document member behavior change using standardized assessment tool.
- Target population
  - PCP's participating in CMFHP
  - CMFHP Members (~80% children)

Details

- Education Component:
  - 4 1-hour modules:
    - DX, Obesity Risk Factors, Motivational Interviewing, Prevention
  - additional $25 for healthy lifestyles education
  - follow up
- Health Coaching:
  - In person or telephonic
  - Empower patients to identify goals and to focus on one behavior at a time for sustainable change.
- Community Partnerships
  - Pay for Stage III Weight Management Programs
    - PHIT Kids (Children's Mercy Hospital)
    - Healthy Hawks (University of Kansas)
    - Shapedown (North KC Hospital, Wichita Clinc)
  - Partner with school health screening programs:
  - Partnership with YMCAs

Physician Participation



144 Physicians Treating 24,918 Members

90 Physicians Treating 19,213 Members

Children's Mercy FAMILY HEALTH PARTNERS www.fhp.org

We bring it all together for you

Lessons Learned

- Partnering with Provider Relations Representatives
- Involving the entire clinic facilitates system change.
- Clinic specific outcomes motivate change within the practice.
- Every clinic will not adopt all practice changes.

Next Steps

- Continue to expand into new clinics and work with existing clinics.
- Continue to expand reach of health coaches to increase face-to-face interaction.
- Monitor implementation of the Affordable Care Act as it relates to obesity.

For more information, contact:

- Name: Beth McElwain
- Email: bwilkes@fhp.org
- Number: 816.559.9524

Choices
a CHNCT initiative

Eat Fresh from the Earth

Community Health Network of Connecticut, Inc.

ACAP Quality Sharing

Choices® began in 1996 as a partnership between the State of Connecticut Department of Public Health with the goal of getting kids to eat more fruits and vegetables.

Choices® has been well received throughout the State of Connecticut and each year we present to an average of 1500 people through various health promotional workshops and health fairs.

Choices® Cooking Classes
Are part of a program that provides high-quality, culturally appropriate nutrition and health education to our members. Through this program, we seek to increase healthy behaviors and aid in positive lifestyle changes.

Community Health Network of Connecticut, Inc.

Through this two-hour instructional cooking classes, members learn the basics of the five food groups and how their health is impacted by the foods they eat.

Other topics discussed are:

- **Your Daily Calorie Requirements**
- **Good and Bad Fats**
- **Salt, Sugar and Your Health**
- **Healthy Alternatives to Your Favorite Foods**
- **Monosodium Glutamate (MSG)**
- **The Dirty Dozen: Which Organic Foods to Choose**

Community Health Network of Connecticut, Inc.

About our Health Plan

- We are located in Wallingford, CT
- We serve Connecticut's Medicaid Managed Care, CHIP & Charter Oak (Uninsured Adult) populations
- Total Membership: 260,000
- We believe our membership will remain stable in the near term with expansion occurring with the implementation of healthcare reform

Community Health Network of Connecticut, Inc.

Purpose/Goals of Initiative

Childhood and Adult Obesity levels are now at epidemic proportions in the U.S. leading to disease and premature death. In the State of Connecticut - **20.6%** of residents suffer from obesity

At present, CHNCT has a total of **5288** members living with Diabetes. In 2009, CHNCT performed outreach to **302** members with Diabetes; In 2010 (3rd Quarter) we have performed outreach to **1,671** members with Diabetes.

The **purpose** of the initiative is to provide a forum to see, hear, smell, touch and learn about choices for a healthy family-based lifestyle through good nutrition.

Our **goal** is to offer options to practice self-management life skills in food selection, food access, eating habits, physical activity and disease prevention.

There is an incentive attached to the program:

Reusable CHNCT Choices grocery bag containing $25 worth of groceries to each participating family. Groceries include alternatives to unhealthy items discussed during the class session…

Lessons Learned:

The Good, The Bad, and the Ugly

- Parents are more apt to become engaged when the see their younger children or teens participating
- Don't assume that everyone is starting at the same point on the learning curve; It's amazing how many people don't have a basic understanding of what a processed food is as well as other simple nutrition facts or the names of fruits and vegetables;
- Workshops of 25 or more people are not recommended; smaller groups lend to greater participation and fewer distractions

Reducing Health Disparities: Pediatric Obesity in Hispanic Children

Contra Costa Health Plan

ACAP Quality Sharing

About our health plan

- Located in Contra Costa County, Martinez CA (SF Bay Area)
- We serve residents including the medically indigent, medically uninsurable, low income populations, Medi-Cal, Medicare, private individuals and small and large businesses.
- 90,685 members

Purpose/Goals of Initiative

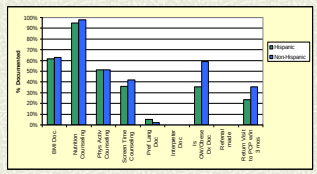
- Childhood obesity rates in Contra Costa County have risen dramatically over the past 30 years, with rapid increases among low-income Hispanic youth.
- Goals
  - To improve overall rate of monitoring overweight and obese children and
  - To improve communication and provide appropriate counseling and support to Hispanic families.
- Targeted population-Hispanic Children ages 3-11 & addressing the obesity disparity affecting Hispanic and Spanish speaking patients.

Project Details

- CCHP piloted its project in the Depts of Family Medicine & Pediatrics.
  - Chart reviews established a baseline measurement of the quality of counseling, language/interpreter use, and follow-up services.
  - We presented findings to medical providers and prioritized areas for improvement.
- Surveyed families on satisfaction with and impact of child's visit.
- New tools were introduced to medical staff for better diagnosis of BMI percentile.
  - kidshealth.org
  - http://apps.nccd.cdc.gov/dnpabmi/
- New well child forms were developed to increase diagnosis rate of overweight and obese children.
- We reviewed and modified interpreter policies and practices within clinic sites.

Project Outcome

- We reviewed 81 charts to establish a baseline measurement of the following documentation:
  - BMI percentile
  - nutrition counseling
  - physical activity counseling
  - screen time counseling
  - preferred language
  - Interpreter documentation
  - diagnosis of "overweight" or "obese" (if appropriate)
  - referrals (if appropriate)
  - return visit to PCP within 3 months (if appropriate)
- Patient satisfaction surveys were used to measure patient education and provider/patient communication.



Lessons Learned

- Developing our aim statement and measurement plan took longer than expected.
- We learned that there are many other factors that affect a successful outcome, e.g. interpreter policies may not match day to day practices.
- Might have gotten a better response rate to surveys if done in multiple settings and modalities.
- We would have liked to pilot test our survey with patients.
- Difficult to sustain the chart review process as it is very time consuming.
- There is a lack of community resources for obesity prevention.

Next Steps

- Nurses are being trained on calculating BMI percentile.
- New well child visit forms will be used.
- Annual HEDIS scores will continue to measure improvements or changes.
- Physicians are being trained on language policies and available interpretation services.
- Follow-up chart reviews are being conducted to track improvement.

For more information, contact:

Catherine Harrell
925-313-6231
Catherine.harrell@hsd.cccounty.us

Pediatric Obesity—A Health Disparity-
And
Shapedown:
A Program to Address the Need

Mary D. Giammona, MD, MPH
Medical Director
HPSM
for
ACAP
November 16, 2010

HPSM

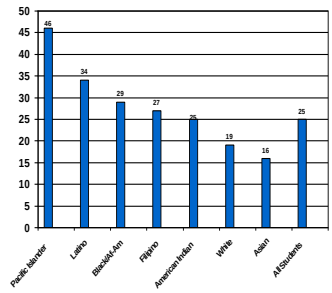
- Medi-Cal Managed Care
- Healthy Families (CHIP)
- Healthy Kids (Children's Health Initiative)
- **********
- Medicare Special Needs Plan
- HealthWorx
- ACE—county indigents--TPA

Shapedown Program

- **Developed by UCSF Nutritionist**
  - **Proven by her research to improve fitness, reduce BMI**
- **Adopted by HPSM as its key weight management intervention program for children**
  - **Series of 8 weekly classes with child/teen and parent**
  - **Six workbooks for child/teen and parent to reinforce lessons discussed in weekly sessions**
  - **Majority of participants are referred by Primary Care Provider (PCP)**

Shapedown in Spanish

- **Why?**
  - PCPs wanted it—felt pts needed it
  - Data supported that.
  - Scheduler got 3x as many Spanish requests for Shapedown as Eng.



Shapedown in Spanish

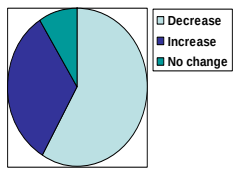
- **How?**
  - Fundraising—needed $150k to professionally translate the 6 workbooks.
  - Went to community foundations
  - Took 18 months
  - Even got the translation vendor to donate money
  - Ultimately got the final $60k needed, and the project was completed!

Shapedown en Español—one year

- Since May 2009, 14 classes offered
- Over 100 members, plus parents, participated—goal for funders was to have 50 members
- Just finished 5 classes going, with 50 families (child/parent dyad) participating
- Another 4 classes starting in January with 40 more families
- Publisher stated he has never had any of his sites (including big centers like Children's Hosp of Denver) reach 100 pts/yr

Shapedown en Español—one year

- Overall an even age distribution of children who participated; however more teens than <13 yos
- 58% of participants decreased in BMI and 9% had no change; the remaining 33% had some degree of increase.



Next Steps

- Implementing a new reporting system so can get aggregate reports and follow trends over time
- Develop follow-up component to continue support--#1 request at end of class on evals.
- Increase outreach to English speakers
- Work with Pacific Islander community to see how to best involve this community, since they remain the highest group at risk.

HealthPlus

Turning the Tide: Neighborhood Collaborative to Assist Overweight Adolescents in Sunset Park, New York

About HealthPlus

- Health Plus is one of the fastest growing managed care organizations in New York City. Established in 1984 by Lutheran Medical Center (LMC) to provide coordinated quality healthcare and improve access to care for a diverse and growing number of uninsured New Yorkers in Southwest Brooklyn, Health Plus now serves the five boroughs of New York and Nassau County and covers over 300,000 members.
- The history and vision of Health Plus are eloquent testimony to the company's commitment to. serving its constituency

Project Description

- Comprehensive program in conjunction with Lutheran Health System to identify and address the medical, nutritional and physical activity needs of overweight and obese adolescents
- Program will take place at the Lutheran Family Health Center (LFHC) clinics in the Sunset Park area of Brooklyn and five elementary/middle schools in Sunset Park
- Sunset Park area is predominately Hispanic with a high rate of obesity
  - In one area school where BMI was taken over fifty percent of the children have a BMI over the 85Th percentile

Eligible Participants

- Children and adolescents ages 10-19
- Identified as being overweight (BMI >85th %) or obese (BMI>95th %)
- Either Health Plus members, are LFHC patients, or are in the LFHC School Health Program
- Registered as patients in the Lutheran Family Health Center medical sites

LFHC School Health Program

- School health nurse will take height, weight and BMI
- Children above the 85th percentile BMI will be referred to the LFHC or primary care provider for complete evaluation and follow-up
- After-school exercise program using "Dance-Dance Revolution"

LFHC Network Identification

- BMI taken yearly for every child and adolescent
- Train LFHC PCPs in BMI measurement and application of overweigh/obesity protocols
- Increase use of nutritionists in LFHC
- Offer after school exercise program for obese children
- Immediate referral to endocrinologist for children diagnosed with diabetes
- Monitoring system will track outreach to non-compliant patients

Medical modalities based on risk factors

- Labs (HbA1c, FBS, Lipid profile ,etc.)
- PCP appointment
- Nutritional consult
- Behavioral consult
- Endocrine consult
- Exercise/physical activity program
- Parental support group
- Education sessions
- Referral to Maimonides Kids Weight Down Program

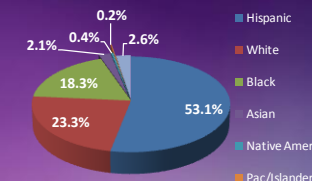
Health Plus Outreach and Education

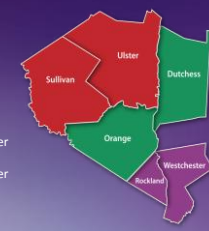
- Conduct outreach to overweight members cared for by LFHC to recommend and schedule nutritionist visits
- Identify members whose parents have diabetes and arrange for primary care visits and assessment for overweight/obesity program
- Participate in compliance monitoring program
- Education for all HP PCPs on taking, recording and advising on BMI, nutrition and exercise
- All HP PCPs received BMI wheels

It's A Family Affair: Hudson Health Plan Pediatric Obesity Project

- Not-for-profit New York State Medicaid Managed Care organization
- Founded in Westchester County in 1985 by a group of community health centers.
- Offers three state-subsidized managed care programs - Medicaid, Family Health Plus and Child Health Plus.
- Serving over 100,000 members

Hudson Health Plan Demographics





Hispanic	White	Black	Asian	Native American	Pac/Islander	Unknown
53.1%	23.3%	18.3%	2.1%	0.4%	0.2%	2.6%

Pediatric Obesity PIP Goals

1. Improve PCP documentation of BMI percentile for members aged 2-17 years
2. Improve identification of overweight, obese and morbidly obese members aged 2-17
3. Provide physicians with tools to identify overweight children and to assist in counseling patients or parents.
4. Doubled referral for nutritional counseling for overweight & obese children
5. Promote nutrition , educational , and physical activities through community events.

Toolkit for Affiliated Pediatricians & Family Practices

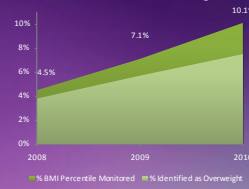
1. Welcome letter from Chief Medical Officer
2. Obesity management expert recommendations & a Guide for coding obesity diagnosis and treatment
3. BMI calculation wheel
4. Gender-specific percentile charts
5. Patient assessment tools
6. Children's portion plate (modified from NYCDOHMH)
7. List of plan nutritionists
8. Hudson Health Plan height assessment wall chart

Community Interventions

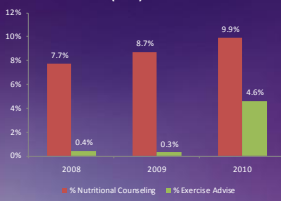
- **Nutrition-Based Presentations**
  - Deconstructing "food"
  - Natural to processed food review
  - Food groups
  - Carbohydrates and proteins
  - Nutritional label reviews
  - Sugar content Demonstrations (soda)
- **Collaborations on physical activity events**
  - Bike "rodeos" – upper counties
  - Family Service of Westchester event
  - Yonkers Fall events
- **Collaborations on Cooking Classes**
  - Ossining Community Action Project, Open Door Family Medical Ctr & Presbyterian Church

Outcomes

BMI Percentile Assessment for Children and Adolescents (3-17) Identified as Obese/Overweight



Counseling Hudson's Children and Adolescents (3-17) Identified as Obese



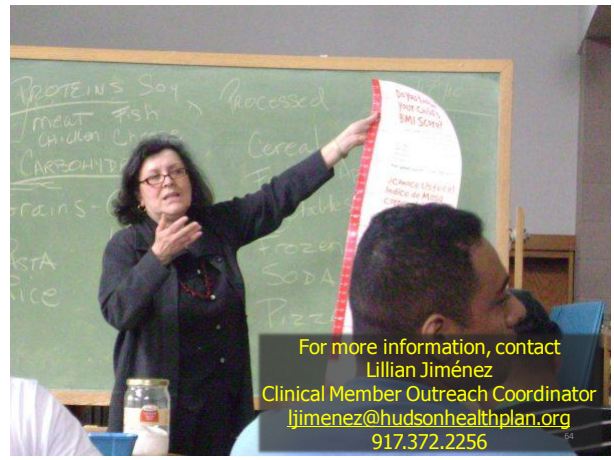
Six months after outreach began:
42% increase in rate of BMI screening, from 7.1% to 10.1% of all members screened
14% increase in rate of referral for nutritional counseling, from 8.7% to 9.9% of overweight children
15- fold increase in rate for referral for exercise, from 0.3% to 4.6% of overweight children

Evaluation of basic nutritional concepts pending; survey tool developed and pilot tested on cooking class participants

Do not expect to see ROI; if anything we expect costs to increase if members receive more counseling

Hudson Pediatric Obesity Project:

- Challenges:
  - patients have limited personal and community resources
    - "junk" food is plentiful and cheap
    - hard to find the will, the time and the place to exercise
  - no proven effective standard of care for obesity
    - Clinicians discouraged about making a difference
    - Limited time & training in psycho-social issues and motivational interviewing
- Lessons Learned:
  - low literacy can be mistaken for "non-compliance"
  - messages should be clear, direct, actionable
    - For varied educational levels and cultural backgrounds
  - empower clinicians and patients
    - Members are resourceful & interested in nutrition
    - Clinicians want to help patients
- Next Steps:
  - Distribute additional tools for clinicians (portion plate tear-off pads)
  - Continue community presentations
  - Evaluation:
    - Claims data analysis plan-wide through the beginning of 2011
    - Electronic Health Record data analysis at focal interventions site, Open Door Family Ctr
    - Survey data of attendees at community outreach classes



Super Nutricia!

A New Campaign to Fight Childhood Obesity

Inland Empire Health Plan (IEHP)

ACAP Quality Sharing

Background on IEHP

- IEHP is located in Southern California. The Plan serves Riverside and San Bernardino Counties.
- IEHP's lines of business include Medi-Cal, Medicare, Healthy Families (SCHP) and Healthy Kids.
- As of November 2010, there are 466,984 Members.
- It is anticipated that IEHP will double its membership by 2015.

Goal of the Super Nutricia Campaign

- Problem: Obesity is highly prevalent among IEHP child Members and the community at large.
- Purpose/Goal: Promoting a healthy living and eating lifestyle by using a community based, and participant friendly approach. Make the topic of healthy eating and active living fun and interesting for kids!
- Target Population: Children of all ages (both members and non-members)

Program Description

- Super Nutricia:
  - Is a comic superhero character that kids can relate to
  - Fights the Junk Food Junkies; Soda Jerk, Munchie Maven, and Sugar Loafer
  - Teaches kids to eat healthy foods, and be active
- Educational Materials:
  - 16-page Comic Book
  - 11x17 and 24x36 Colorful Posters
  - Coloring Book & Book Mark
  - www.supernutricia.com
- Appearances at Community Events and Schools:
  - Performs a live show (enacting of a scene from comic book)
  - Partners with Health Education team to talk to kids and parents about healthy eating
  - Autographs comic book and posters and takes pictures with kids
  - Gives out trading cards, stickers, book marks, and other promotional materials
  - Local Television exposure

Outcomes

- Program effectiveness is evaluated by the receptiveness and response of the community.
  - Media/Press Attention
  - Thank you letters from agency partners
  - Letters from children
  - The request volume for materials from schools, churches, CBOs, etc.
  - Website Traffic
  - Awards

Lessons Learned

- What worked well – The interactive nature of program was critical to engage kids in the learning process.
- Using a multi-prong approach we were able to get the new campaign out far and wide: Members, Community, Schools, Partner Agencies, Media, etc.

- Challenge - It continues to be a challenge to measure true effectiveness and link behavior change to an awareness campaign.
- Parents ultimately teach eating habits to children whether direct, or indirect. Engaging the parents to change their food behaviors is key in making a real impact on kids.

Next Steps

- IEHP is in the process of forging new relationships with community agencies and schools who are interested in bringing the Super Nutricia Campaign to their families.
- We continue to seek a way to use the Super Nutricia character to have a higher impact on kids eating and physical activity patterns.

Contact Information

- Name: Marci Aguirre, MPH
- Email: Aguirre-m@iehp.org
- Number: (909) 890-2760

L.A. Care HEALTH PLAN

Improving Prevention and Management of Overweight and Obesity in a Medicaid Population

11/9/2010

L.A. Care Health Plan

- Largest public health plan in the nation with over 800,000 members
- Subcontracts with 4 health plans
- Serves vulnerable populations in Los Angeles County
- L.A. Care lines of business
  - ❖ Medicaid
  - ❖ Medicare Advantage HMO
  - ❖ SCHIP
  - ❖ Healthy Kids
- Provides information and resources in10 threshold languages:
  English, Spanish, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, Vietnamese

Impact of Obesity/Overweight in Los Angeles County

The Problem[1]

- 19.3% of Los Angeles County adults are obese
- An additional 35% of Los Angeles County adults are overweight
- The prevalence of obesity is increasing in both men and women in multiple racial/ethnic groups

The Goals

- Increase the number of providers who address weight in their practice
- Increase member knowledge of healthy weight, nutrition and physical activity
- Increase member access to weight management programs
- Track prevalence of overweight/obesity among L.A. Care members

[1] Los Angeles County Department of Health Services Los Angeles Almanac Obesity & Physical Activity in Los Angeles County retrieved from http://www.laalmanac.com/health/he06.htm on 11/4/10.

Provider Interventions

Provider Education

From March 2004 – September 2007 L.A. Care hosted:

- 6 large-scale provider conferences covering:
  - Obesity screening
  - Treatment and intervention strategies
- More than 2,200 health professionals attended

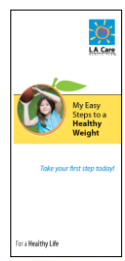
From November 2008 – December 2009 L.A. Care hosted:

- 4 seminars targeted to primary care providers covering:
  - BMI measurement
  - Use of a family "lifestyle log" to assess readiness change and guide counseling discussions
- 100 primary care physicians attended

Provider Resources

L.A. Care developed and distributed:

- Pediatric and adult weight management toolkits
- BMI wheels
- Health education materials
- Online community resource directory



Member Interventions

Healthy Eating Lifestyle Program (H.E.L.P.)

- **June 2009 – October 2010**
  - H.E.L.P. is a 6 session nutrition/exercise program targeting overweight children 5-12 years old and their families
  - HELP is taught by bilingual Spanish *promotoras*
  - Participants who complete the program receive a one-year free membership to a local recreation/sports center
  - Offered in partnership with a local hospital

Weight Watchers® Incentive

- **September 2008 - Present**
  - Eligible members receive 20 free weekly meeting coupons
  - Eligibility criteria:
    - Adult Medicaid members
    - BMI ≥25
    - Readiness to change score at least 7 on 10 point Likert scale
  - Members may receive 20 additional coupons if the member demonstrates weight loss and improvement in weight-related conditions; physician must confirm.

Community Interventions

Family Resource Centers

- L.A. Care operates two resource centers in South Los Angeles
- Locations were selected because they have:
  - A high concentration of L.A. Care members
  - The highest obesity rate in the County
- Health education services include:
  - FREE community classes
    - Nutrition
    - Pilates
    - Salsa aerobics
    - Line dancing
    - Cardiovascular health
    - Diabetes
    - Healthy cooking demonstrations

Exercise/Nutrition Presentations

- L.A. Care funded training for members to become *Promotores* (Health Promoters), reaching thousands of community members with nutrition and exercise presentations
- Nutrition/exercise presentations were given at each of L.A. Care Health Plan's 11 member-based Regional Community Advisory Committees
- Healthy snacking seminar was presented in June 2010 at an elementary school in downtown Los Angeles

Evaluation

Healthy Eating Lifestyle Program (H.E.L.P.)

- 21 members participated from June 2009 – October 2010
- On average, program completers reduced their BMI percentile from the 98th percentile to the 97th.

Weight Watchers®

- 241 members have participated to date
- On average participants lost 13 lbs

HEDIS 2009 - Weight Assessment and Counseling on Nutrition and Physical Activity

- 413 pediatric charts were analyzed for the 2009 measurement year
- L.A. Care met the "High Performance Level" for all three categories
  - 59.1% of records had a documented BMI
  - 65.9% of records had documented nutrition counseling
  - 54.2% of records had documented physical activity counseling

Challenges

- There was a high member "no-show" rate (40%) for H.E.L.P. and Weight Watchers ®
- Socioeconomic and cultural barriers limit readiness to change and family engagement

Next Steps

- Bilingual health educators to offer phone nutrition counseling for families in areas not served by classes or Family Resource Centers.
- Weight Watchers® to be extended to Medicare Advantage HMO members in 2011

For More Information

Elaine Batchlor, M.D., MPH
Chief Medical Officer
ebatchlor@lacare.org

Thumbs up for Healthy Choices

An approach to childhood obesity

nhp.org

Neighborhood Health Plan
Your health. Our promise.

A multimedia approach to nutrition education

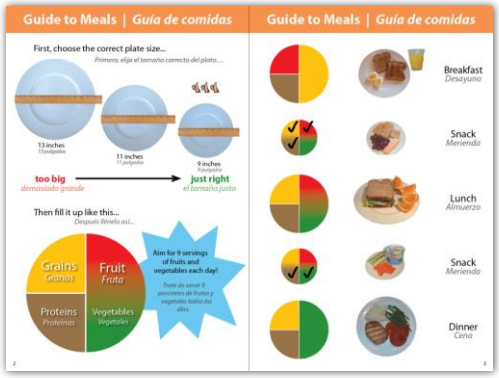
- Reach populations with low literacy and language barriers
- Make nutrition education interesting and entertaining

90 Minute DVD

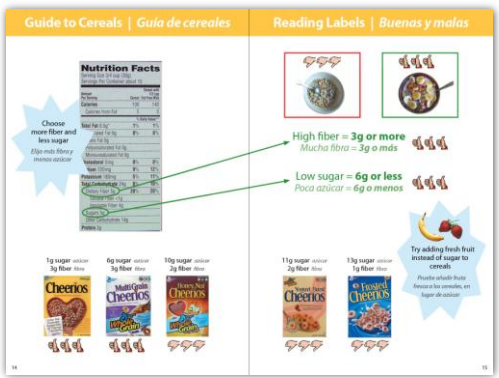
- Targeting overweight school children
- Provides basic nutrition education
- With a special focus on sugared beverages and foods contributing to childhood obesity

34 Page Booklet

- English and Spanish
- Guide to eating
- Guide to food shopping
- Educational tool for clinicians
- Resource for parents
- Simple language with visuals


Guide to Meals | Guía de comidas
First, choose the correct plate size...
Primero, elija el tamaño correcto del plato...
13 inches
11 inches
9 inches
too big
demasiado grande
just right
el tamaño justo
Then fill it up like this...
Después llénelo así...
Grains
Granos
Fruit
Fruta
Proteins
Proteínas
Vegetables
Vegetales
Aim for 9 servings of fruits and vegetables each day!
Guide to Meals | Guía de comidas
Breakfast
Desayuno
Snack
Merienda
Lunch
Almuerzo
Snack
Merienda
Dinner
Cena


Guide to Snacks | Guía de meriendas
How to mix it up for a healthy snack...
Cómo servir refrigerios saludables...
Start with a protein...
Empiece con una proteína...
Snack Proteins
Meriendas de Proteínas
Add fruit...
Añada fruta...
Snack Fruit
Meriendas de Frutas
Guide to Snacks | Guía de meriendas
Aim for 200-300 calories per snack
Trate de que cada refrigerio tenga entre 200 y 300 calorías
Snack Vegetables
Meriendas de Vegetales
Or Vegetables...
O vegetales...
Or Grains... for the perfect snack
Snack Grains
Meriendas de Granos
O granos... para el refrigerio perfecto


Guide to Cereals | Guía de cereales
Nutrition Facts
Choose more fiber and less sugar
Elija más fibra y menos azúcar
1g sugar
3g fiber
6g sugar
3g fiber
10g sugar
2g fiber
Cheerios
MultiGrain Cheerios
Honey Nut Cheerios
Reading Labels | Buenas y malas
High fiber = 3g or more
Mucha fibra = 3g o más
Low sugar = 6g or less
Poca azúcar = 6g o menos
11g sugar
2g fiber
13g sugar
1g fiber
Frosted Cheerios
Try adding fresh fruit instead of sugar to cereals
Pruebe añadir fruta fresca a los cereales, en lugar de azúcar


Frozen Treats | Antojitos Congelados
Choose Low-Fat → 2g of fat or less
Choose Low-Calorie → 130 calories or less
Elija con poca grasa → 2g de grasa o menos
Elija con pocas calorías → 130 calorías o menos
Goals | Metas
Small Changes Make a Big Difference
Los cambios pequeños tienen un gran impacto
My Healthy Choices:
I will drink water or diet drinks instead of soda
I will eat a cereal with fruit for breakfast
I will move my body for one hour each day
I will turn off the TV after just one show
I will limit juice to one small cup each day
I will eat at the table, not in front of the TV
I will get plenty of sleep
I will take the stairs every chance I get
I will eat breakfast everyday
I will limit total TV, video games, and computer to 2 hours or less
I will take a walk every day
I will _____
I will _____
I will _____
I will _____
I will _____
I will _____
Mis opciones saludables:
Beberé agua o bebidas dietéticas en lugar de refrescos
Comeré un cereal con fruta para el desayuno
Me moveré mi cuerpo una hora por día
Apagaré la tele después de un solo programa
Limitaré el jugo a un vaso pequeño diario
Comeré en la mesa, en lugar de frente a la tele
Dormiré lo suficiente
Subiré y bajaré por las escaleras en todas las oportunidades
Descansaré todos los días
Limitaré las horas que paso frente a la tele, jugando juegos de video, y en la computadora a 2 horas o menos
Caminaré o correré todos los días
Otras cosas que haré _____
Otras cosas que haré _____
Otras cosas que haré _____
Otras cosas que haré _____
Otras cosas que haré _____

Chantix (Varenicline) in the Managed Care Setting:
A Real World Experience

DENVER HEALTH MANAGED CARE

89

A Little Bit About Our Health Plans

- Location: Denver, Colorado
- Number of Members:
  - Medicaid Choice @ 46,000
  - Medicare @ 3,000
  - Commercial @ 9,000
- Primary Care provided in 8 Denver Health FQHCs

90

Goal

- To implement and evaluate a potentially cost effective approach to the use of Chantix for our Managed Care populations.

91

Chantix Protocol

- Chantix is nonformulary but can be approved through the prior authorization review process provided that the member has:
  1. Tried nicotine replacement therapy and/or Wellbutrin in the past
  2. Set a quit date
  3. Agreed to participate in a smoking cessation program through the quite line, etc.
- The initial approval was only for the 1 month starter kit.

92

Chantix Protocol

- Members could receive up to 2 additional months of Chantix if they contacted our Care Management Department and verified that they have quit smoking and were participating in a smoking cessation program.
- Chantix had to be obtained at a Denver Health Pharmacy in order to take advantage of 340 B pricing.
- 6 month self-report quit rates were assessed by phone

93

Outcomes

- Since January 2008, 236 members filled the 1 month Chantix starter kit
- 76 members (32%) contacted our Care Management department to request 2 months of maintenance Chantix
  - Medicaid Choice-14
  - Medicare-9
  - Commercial Members-53
- Of the 76 members who contacted us at 1 month 63 (83%) reported quitting including 12 of the 14 Medicaid Choice members (86%).
- 6 month quit rate follow up assessed for 65 members:
  - 15 reported not smoking (23%)
  - 19 unable to contact (29%)
  - 31 still smoking (48%)
- Total cost of Chantix since January 2008 has been $35,148.

94

Lessons Learned

- While 1 month self reported quit rates were 32% we could only document that 5% of the total number of members who filled a prescription for Chantix had quit smoking at 6 months.
- It is possible that the actual number of quitters is higher: members who quit during the first month may have felt that they no longer needed Chantix and therefore never bothered to contact us for refills

95

Lessons Learned

- Chantix should not be approved unless the member has tried other less expensive medications, set a quit date, and agreed to participate in a smoking cessation program
- In the future we may consider either verifying participation in the smoking cessation program or providing smoking cessation counseling ourselves.

96

Eradicator!

A Superhero Against Smoking!

Inland Empire Health Plan (IEHP)

ACAP Quality Sharing

Background on IEHP

- IEHP is located in Southern California. The Plan serves Riverside and San Bernardino Counties.
- IEHP's lines of business include Medi-Cal, Medicare, Healthy Families (SCHP) and Healthy Kids.
- As of November 2010, there are 466,984 Members.
- It is anticipated that IEHP will double its membership by 2015.

Goal of the Eradicator Campaign

- Problem: Smoking is highly prevalent among IEHP child Members and the community at large. Smoking among young adults leads to a lifelong habit and high risk for many health issues.
- Purpose/Goal: Awareness of Dangers of Smoking using a community based, and participant friendly approach. Make the topic of "just say no" fun and interesting for kids! It's cool to not smoke.
- Target Population: Children of all ages (both members and non-members)

Program Description

- The Eradicator:
  - Is a comic superhero character that kids can relate to
  - Big Tobacco's Worst Nightmare
  - Teaches kids the dangers of smoking, and to say no!
- Educational Materials:
  - 16-page Comic Book
  - 11x17 and 24x36 Colorful Posters and bookmarks
  - www.supernutricia.com
- Appearances at Community Events and Schools:
  - Autographs comic book and posters and takes pictures with kids
  - Gives out book marks, and other promotional materials
  - Local Television exposure

Outcomes

- Program effectiveness is evaluated by the receptiveness and response of the community.
  - Media/Press Attention
  - The request volume for materials from schools, churches, CBOs, etc.
  - Website Traffic

Lessons Learned

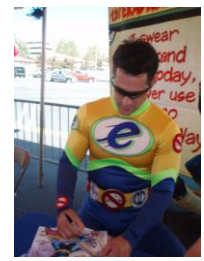
- What worked well – The interactive nature of program was critical to engage kids in the learning process.
- Using a multi-prong approach we were able to get the new campaign out far and wide: Members, Community, Schools, Partner Agencies, Media, etc.
- Challenge - It continues to be a challenge to measure true effectiveness and link behavior change to an awareness campaign.

Next Steps

- IEHP is in the process of forging new relationships with community agencies and schools who are interested in bringing the Eradicator Campaign to their families.
- We continue to seek a way to use the Eradicator character to have a higher impact on preventing children and youth from smoking.

Contact Information

- Name: Marci Aguirre, MPH
- Email: Aguirre-m@iehp.org
- Number: (909) 890-2760



Smoking Cessation Program at Neighborhood Health Plan

nhp.org

Cigarette Smoking in Massachusetts

- Smoking prevalence has declined from 21% in 1993 to 15% in 2009.
- Approximately 750,000 adults still smoke.
- Nearly twice as many Medicaid enrollees smoke compared with the general population.
- NHP has offered smoking cessation counseling as an integral component of its care management program since 2004.

NHP Smoking Cessation Counseling Program

- Performed by a Masters Certified Tobacco Treatment Specialist.
- Counselor is bilingual and bicultural.
- Collaborates with other members of the care management team including behavioral health.
- Priority focus on high risk members, e.g. diabetes, asthma, pregnancy.
- Referrals received from initial health assessments, other care managers, member services phone lines, providers, and directly from members.

Smoking Cessation Counselor as a Care Management Team Member

- Provides an integrated approach to tobacco treatment within the care management program.
- Members stratified and assessed according to risk.
- Access facilitated to all FDA -approved cessation medications.
- Ability to assess and refer members for medical, social and behavioral health care management needs.

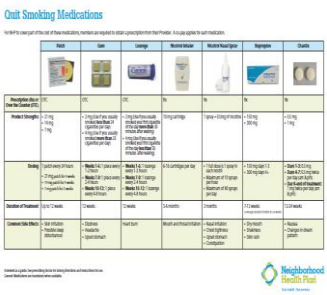
NHP Smoking Cessation Program Offers:

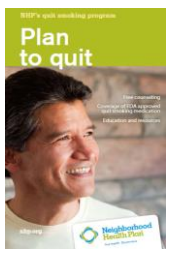
- Telephonic cessation support
- Educational literature
- Facilitated access to cessation medication
- Ongoing encouragement/support
- Establishing quit dates
- Teaching coping skills

Care Management System Provides Support to the Counselor

- Automated mailings to members.
- Tobacco assessment embedded into the system.
- System includes two referral queues-initial health needs assessments and referrals from other care managers.
- Enables reporting: cases opened/ assessments.
- Task setting – ensures appropriate communication and follow-up.
- Referral Form-allows for counselor to send referrals to other medical and behavioral health care managers.

Cessation Literature


Quit Smoking Medications



NHP Smoking Cessation Program Statistics

- 40-70 members per month managed by counselor.
- Goal of 27 new assessments per month.
- Members outreached within 24 hours.
- Approximately 25% of members enrolled successfully quit.

Driscoll Children's HEALTH PLAN

ACAP Quality Sharing

Presented by:
Mary Dale Peterson, M.D., MHA, FACHE
President and CEO

Driscoll Children's Health Plan

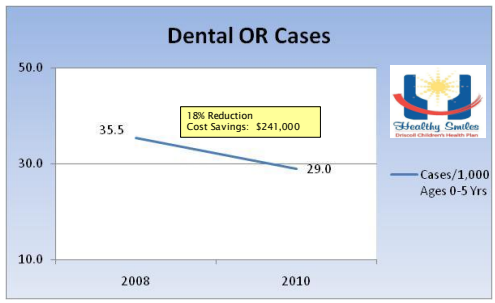
- Founded in the mid-1990's by the Driscoll Foundation
- Located in Corpus Christi, Texas
- Currently serving Medicaid and SCHIP members (Medicaid – 9 counties, and SCHIP – 14 counties)
- October 2010, 45,000 Medicaid and 15,000 SCHIP
- Looking to expand Medicaid and SCHIP into the Rio Grande Valley (near the Mexican border) early 2012
- Largest South Texas non-profit HMO that is locally owned and operated

Community Based Initiatives

- Cadena de Madres (Network of Mothers)
- Dental Project (Healthy Smiles)

Healthy Smiles
Driscoll Children's Health Plan

- The goal of partnering pediatric practices with initial and continual support from Driscoll Children's Health Plan emphasizing early oral screenings, counseling, dental home referrals and the application of fluoride varnish to babies (6 mths-36 mths) was very successful. Initially resistant to the project citing time constraints, patient overload and non-compliance, implementing supportive strategies to help introduce a new element in busy practices eased the transition for physicians and staff.
- The local dental society has been integral as well as supportive and communicative in this effort of eliminating of early childhood decay beginning in the medical home.



Of those children who received fluoride varnish, only 0.17% OR cases/1,000 member 0-5 years

Driscoll Children's HEALTH PLAN

Cadena de Madres
Driscoll Children's HEALTH PLAN
Network of Mothers

The project aims to improve the health of infants and women in our community by decreasing the incidence of premature birth

Components of the model

1)Community Baby Showers

- Led by a lay health worker in a small group setting at various sites in Nueces and San Patricio County
- Presented in 3 sessions focused on decreasing pre term deliveries
- A supportive environment for pregnant women to promote positive behaviors and distinguish healthy choices during their pregnancy
- Learn the signs of pre-term labor and when medical intervention is needed
- Promotion of breastfeeding as the optimal source of infant nutrition by an International Board Certified Lactation Consultant
- Provide referral and knowledge about gestational diabetes and nutrition by a Registered Dietician

2)Hospital visitation

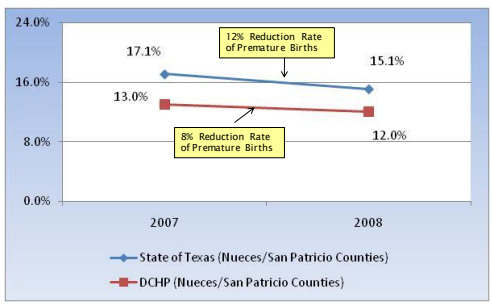
Home visitation for the first 3 months to address mother-baby concerns: cord care, jaundice, SIDS, post partum depression, fever, immunizations, birth spacing

3)Back to work or school support for breast feeding mothers

Driscoll Children's HEALTH PLAN

Cadena de Madres
Driscoll Children's HEALTH PLAN
Network of Mothers

Reduction Rate of Premature Births



HEALTH PLUS' PARTNERSHIP WITH "SAFETY FROM THE START" Program Safe Kids NYC

- Collaboration with NYCDOT & NYCDOHMH
- Focus on injury prevention, poison prevention and home safety
- Target audience: low-income pregnant or new mothers living in the five boroughs of NYC

Safety Shower workshops include:

- Educational information
- Safety products to use in the home
- Raffle or Vouchers for FREE car seats

Partnership with Health Plus: Safety Showers

2008- 2010
# of workshops: 23
# of Participants: 449

Languages:
English, Spanish and Chinese

Workshop Sites:
Health Plus Offices Citywide, Health Centers and WIC Offices

Safety Shower
Health Plus Office 37th Street
Brooklyn NY, November 2007

Safety Shower
Health Plus Office 37th Street
Brooklyn NY, December 2008

Safety Shower
Morris Heights Health Center
Bronx NY, June 2009

Safety Shower
Lutheran Family Health Center ,WIC Program
Brooklyn NY, April 2010

Testimonials from Health Plus Members

- **"I would like to thank you for your interest in our kid's safety, and you care for them. May God bless you all. My baby is not born yet, but when he comes I'll practice everything to make sure he is safe. "**

"After attending this workshop, I understand what is the Poison Control Center. I learned a lot how to prevent poison at home, prevent carbon monoxide and plant poison. "

"Everything in the presentation was very educational; I'm very grateful that Health Plus is dedicated in wanting to teach their clients educational information regarding health and safety. I've made sure to put non-food items far away from food items. "

Inland Empire Disabilities Collaborative

Inland Empire Health Plan

INLAND EMPIRE DISABILITIES COLLABORATIVE
www.iedisabilitiescollaborative.org

About IEHP

- IEHP serves Riverside and San Bernardino Counties.
- Lines of business include Medi-Cal, Medicare, Healthy Families (SCHIP), and Healthy Kids.
- Current enrollment is 466,984 as of November 2010
- It is anticipated that IEHP will double its membership by 2015.

Purpose / Goals

- Problem: Fragmented resources in a large geographic area.
- Purpose: Launched as a networking tool by IEHP, the collaborative brings together over 260 service providers that serve people with disabilities and seniors.
- Goal: Build and maintain meaningful relationships with community based organizations.

Collaborative Initiatives

- Monthly meetings with distinguished presenters; Regional Director of CMS, Director of the State Office on Aging, State Director of Fair Employment and Housing, Executive Director for California Foundation for Independent Living Centers.
- Disability Resources Expo
- Advocacy Conference.
- Disability Mentoring Day

Outcomes

- Increased capacity to serve members with disabilities.
- Helps health plan care managers connect members to community resources.
- Provides a vehicle for community-based care coordination.
- Increases opportunities to promote independent living options.
- Recognized by Disability Rights California for uniting and mobilizing organizations to better serve people with disabilities.
- Built trust between community agencies and health plan.
- Over 23,000 Members with a disability have voluntarily enrolled in IEHP.

Lessons Learned

- The collaborative has facilitated building meaningful relationships with CBOs.
- Requires time commitment coordinating meetings and organizing events.
- Challenge to have others take the lead.

Next Step

- IEHP Will continue to take an active role in further development of the collaborative.
- Solicit more business partners to maintain funding.
- Continue to support monthly educational presentations, Resources Expo, Advocacy Conference, and Disability Mentoring Day.
- Aging Well with a Disability Initiative in 2011

For more information, contact:

Ben Jauregui, Disability Program Manager
jauregui-b@iehp.org
(909) 890-5833 Voice
(909) 890-1623 TTY
(909) 693-4055 Video Phone

"Healthy Beginnings" Prenatal Care Program

Monroe Plan for Medical Care

A little bit about our health plan

- Located in Upstate New York
- Medicaid managed care, Child Health Plus, Family Health Plus
- 131,000 Managed Care
- Anticipated Expansion to Western New York

Purpose/Goals of Initiative

- Poor Birth Outcomes
- Enhance Prenatal Care through Care Coordination and Patient Engagement
- Goals:
  - Decrease NICU Admits
  - Decrease Rate of Low Birth Weight Babies
- High-Risk Pregnant Women

Details

- Identify and Stratify High-Risk Pregnant Women through Submission of Risk Assessment Tool by Practitioners
- Social Outreach along with Medical Case Management
- Recently Added "Baby Basics" Program Distributing Prenatal Care Book (4th Grade Literacy Level) with Planner through OB Practices

Outcome (Actual and/or Expected)

- Low Birth Weight Rate = 5.7% (NY State Average = 7.5)
- NICU Admission Rates in 6-7% of Births
- Consistently Greater than 1.5 to 1

Lessons Learned

- Community-Based Programs Work Best
- Need to Incent Practitioners to Submit Prenatal Health Risk Assessments

Next Steps

- Incorporating Baby Basics as Routine Part of Prenatal Care at Large Volume OB Practices
- Continue Aggressive Social Outreach

For more information, contact:

- Lisa Pfeifer
- lpfeifer@monroeplan.com
- (585) 256-8402

Diabetes Care

Monroe Plan for Medical Care

ACAP Quality Sharing

A little bit about our health plan

- Located in Upstate New York
- Medicaid managed care, Child Health Plus, Family Health Plus
- 131,000 Managed Care
- Anticipated Expansion to Western New York

Purpose/Goals of Initiative

- Need to Improve Diabetes Care and Decrease Rates for Preventive Quality Indicators (PQIs)
- Encourage PCPs to Achieve NCQA's Diabetes Recognition Program Designation
- Improve Diabetes HEDIS Measures and PQIs
- PCPs Caring for Adults 18 Years and Older who have Diabetes

Details

- Monroe Plan (MP) Provides PCPs and Enrollees with Diabetes with Gaps in Care Information (Mailings, Any Customer Service Call by Member, Outreach)
- MP Provides Care Management Fee of $8.50 pmpm to PCPs with the NCQA Recognition for each Member with Diabetes
- MP and American Diabetes Association Developed Toolkit and Technical Assistance for PCPs to Institute Medical Group Visits for Diabetes
- MP Provides Assistance to PCPs to Achieve NCQA Recognition

Outcome (Actual and/or Expected)

- In 3 Years Over 50 PCPs Achieved the NCQA Diabetes Recognition Program Designation
- Diabetes HEDIS Scores Have Improved: Rate of Diabetes Out of Control Comparable to Commercially Insured Diabetics
- Rate of PQIs for PCPs with NCQA Recognition is 35% Lower When Compared to All other MDs
- Medical Cost Trends for MP Diabetics is Flat Compared to 5-6% Increase for All Enrollees

Lessons Learned

- Providing Outreach, Assistance, and Care Management Fee Worked Well
- Most Physicians are Challenged with Many Bureaucratic Distractions to Focus on Improving Care Processes for Diabetes Treatment Achieving NCQA Recognition

Next Steps

- Expanding Program to Encourage PCP Achievement of NCQA Diabetes Recognition Throughout all of Upstate NY
- Continue Outreach and Practice Support Efforts

For more information, contact:

- Mary Jo Muscolino
- mmuscolino@monroeplan.com
- (585) 256-8452

- Laura Weisbein, PhD
- lweisbsin@monroeplan.com
- (585) 256-8463