



Improving Access and Quality of Care

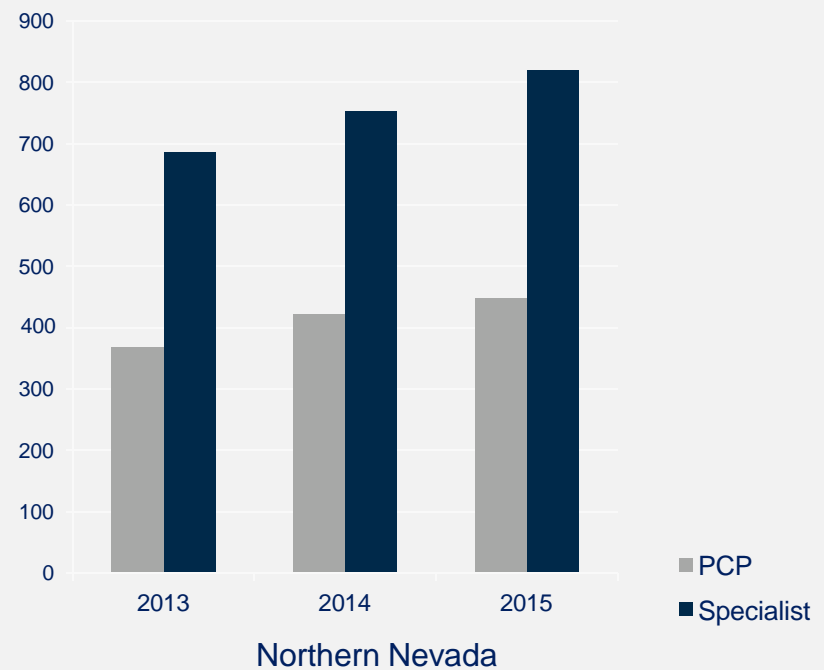
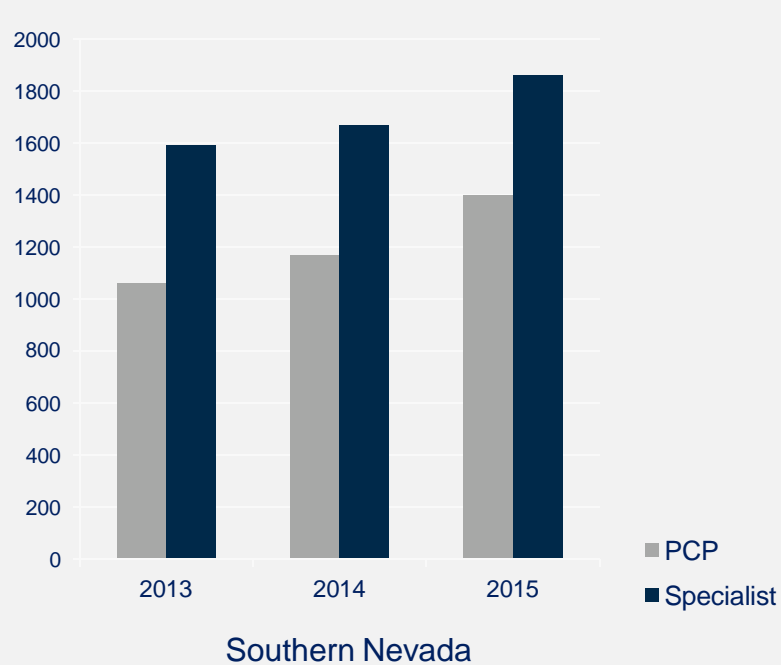
Medical Care Advisory Committee
July 19, 2016

Overview

- **Strengthening Access in Our Community**
- **Innovative Health Care Delivery Tools to Bring Care to the Patient**
- **Investment Now to Build Access for the Future**
- **Additional Examples of Innovative Programs Being Deployed**
- **Ensuring Quality is at the forefront**

Access to Care

Expanding our provider network to meet the growing and evolving needs of Medicaid members.



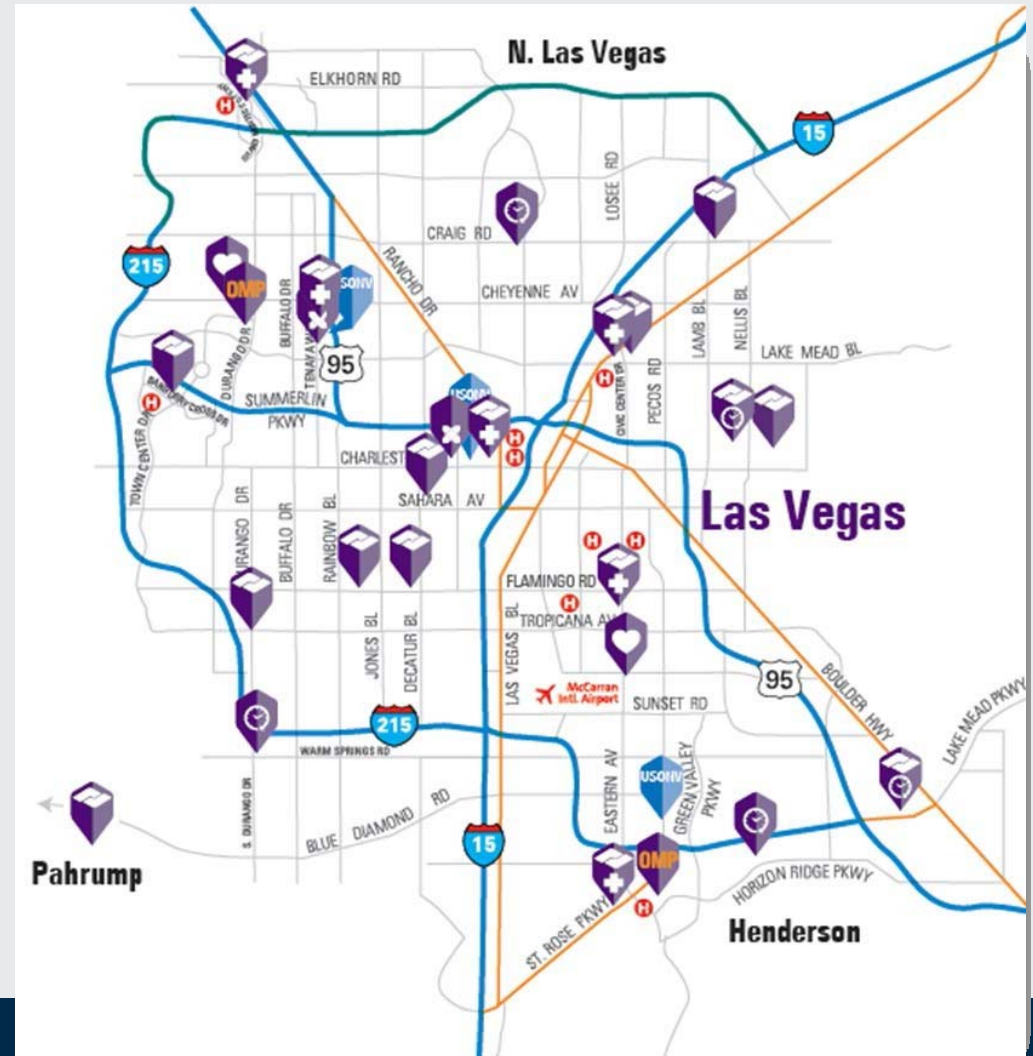
**We are working to address the healthcare needs of today,
while making significant investments for the future.**

Increasing Access in our Community



Health Plan of Nevada's partnership with Southwest Medical is one example of building access to address the delivery needs of our community.

- | | |
|--|-------------------------------|
| | SMA HEALTH CARE CENTERS |
| | SMA URGENT CARE |
| | SMA LIFESTYLE CENTERS |
| | CONVENIENT CARES |
| | OUTPATIENT SURGERY CENTER |
| | OPTUM MEDICAL PARTNERS |
| | UROLOGY SPECIALISTS OF NEVADA |
| | HOSPITAL |



Increasing Access to Meet Nevadans Delivery Needs

- SMA added **new medical clinics** in geographically Medicaid dominant locations
- **Increased** the number of physicians, nurse practitioners and physician assistants
 - **350** SMA providers that are exclusive to HPN Medicaid members
 - **260** Healthcare Partners providers that are exclusive to HPN Medicaid members
- SMA **extended office hours** including weekends and evenings at multiple clinics
- **Increased** the number of Urgent Care locations, including one open 24-hours with a 23-hour observation unit
- Introduced **Now Clinic telemedicine**
- Launched **Medicine on the Move** a mobile medical clinic



Increasing Access in our Community



The **Medicine on the Move** mobile medical center is designed to lower barriers to health care – such as transportation, child care, work obligations and the low number of primary care physicians in Nevada – that often put even routine checkups out of reach.

Medicine on the Move: Mobile Clinic



The Medicine on the Move 45 foot vehicle includes:

- Waiting area
- Two Private Medical Exam Rooms
- Lab/Blood Draw Station
- Private X-ray Suite
- A Mammography Imaging Suite
- Ultrasound
- A Records Intake Area
- Immunization/shots
- Electronic medical records
- Restroom
- Wheelchair lift



*layout above similar, but not identical, to final mobile clinic layout.

“Access to quality primary and preventive care is essential for people to maintain good health and quality of life, especially in Nevada, where the number of primary care physicians has not kept pace with the state’s growing population. Bringing quality health care to the people in our communities is what Medicine on the Move is all about.”

-Don Giancursio, CEO of UnitedHealthcare in Nevada

Medicine on the Move: Mobile Clinic

The onboard staff will consist of:

- two medical assistants
- two licensed nurse practitioners,
- one or two providers/doctors, as needed, and
- a radiology technician, as determined per stop.

www.medicineonthemove.nv.com



“Many patients struggle to get to a health care provider, so we will take the health care provider to them. Reliable transportation, child care or the many other daily life challenges should not be a barrier to quality health care. Medicine on the Move will be a convenient option for Nevadans who want easier access to primary and preventive care closer to where they live and work.”

- Dr. Robert McBeath, president and CEO of Southwest Medical

Investing in Partnerships

Investing in Partnerships *today*, for Nevada's *future*

UNITED HEALTH FOUNDATION®

UNLV | School of
MEDICINE

United Health Foundation awarded a **five-year \$3 million grant** to the UNLV School of Medicine.

The grant will help the new medical school develop new innovative educational programs and underscores our mutual commitment to advance health care innovation and access to care in Nevada, especially for **Medicaid patients** and the medically underserved

LAS VEGAS
REVIEW-JOURNAL

"United Health Foundation's grant will strengthen and support UNLV's commitment to build a cutting-edge medical school that ensures quality health care in the community for generations to come."

-- UNLV President Len Jessup, 4/5/2016

April 5, 2016

\$ **3,000,000.00**

DOLLARS

Nevada faces an extreme shortage of physicians and ranks in the **bottom - five states (47th)** in the number of doctors per 100,000 people, within nearly every medical specialty, according to United Health Foundation's America's Health Rankings

"I applaud UnitedHealth Group for its innovative approaches like the UnitedHealthcare/Southwest Medical mobile clinic and the local partnership between United Health Foundation and UNLV that will create providers for the future who will help increase Nevadans' access to care." - Governor Brian Sandoval

Access Center / The Telephone Advice Nurse (TAN)

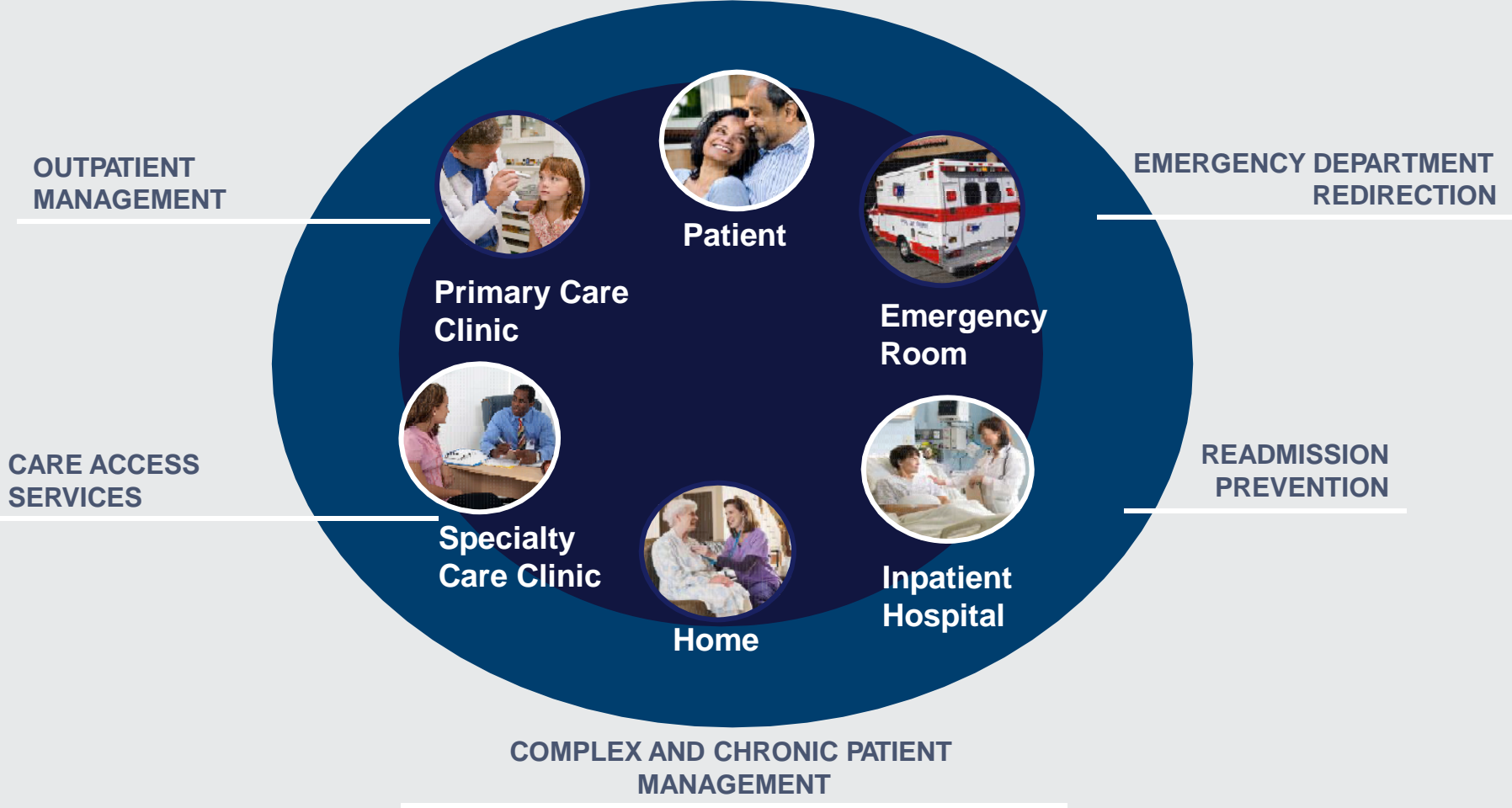
- **24-hour-a-day** Clinical Access Center that continues transitions of care after traditional business hours, weekends and holidays so the member gets the best possible care and services at all times.
- **Triaging to the appropriate care** setting and making certain that the care setting is in-line with the level of severity.
- Eliminating waste and redundancy by identifying members with chronic conditions at the point of contact and **ensuring that they receive the right care at the right time.**

Calls Per Month

~10,000 Inbound Calls
~7,100 Outbound Calls

*Total based on December 2014 –
November 2015 data.*

The Access Center in Health Management



Care For Me Program (CFMP)

The Care For Me Program (CFMP) provides high-touch case management services and care coordination with **a single point of contact for hospital discharges and outpatient members** in all clinics. The case manager works in collaboration with members, providers and key stakeholders in coordinating healthcare services and referrals. This program focuses on the Health Plan's complete member population.

The impact of the CFMP includes the following:

- Decrease admissions and readmissions for all lines of business
- Increase customer satisfaction to support STAR Ratings
- Increase engagement with PCP's and members
- Encourage self-management of care

CFMP serves as a single point of contact for complex patients

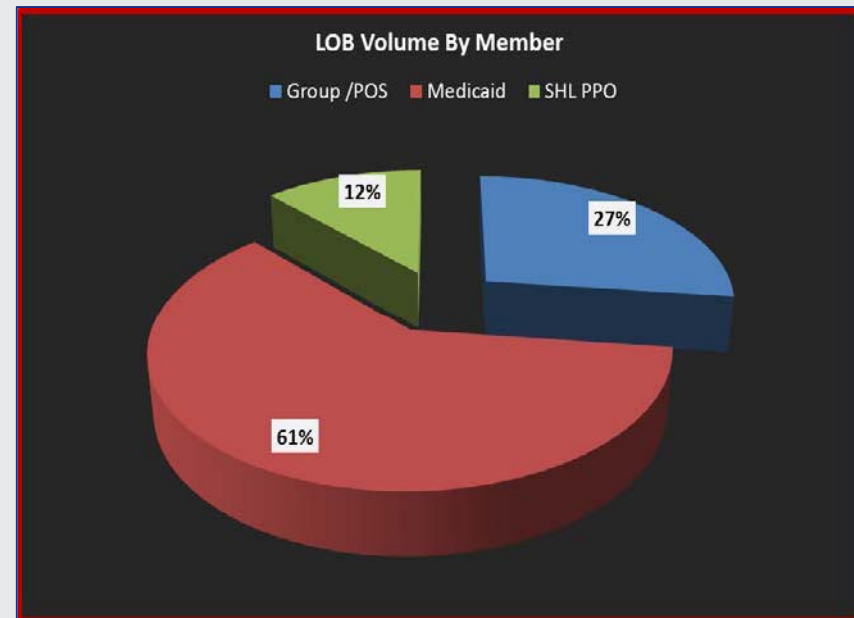
Care For Me Program Results

1 st Quarter	Difference (Before CFMP and After)
ER Visits	-47%
Readmits	-72%
SNF Utilization	-66%

2 nd Quarter	Difference (Before CFMP and After)
ER Visits	-40%
Readmits	-68%
SNF Utilization	-45%

3 rd Quarter	Difference (Before CFMP and After)
ER Visits	-34%
Readmits	-69%
SNF Utilization	-13%

4 th Quarter	Difference (Before CFMP and After)
ER Visits	-38%
Readmits	-66%
SNF Utilization	-60%



Willing Hands Program

Includes the following goals:

- **Support and complete** the homeless members post-discharge care prior to them returning to the street
- **Decrease** admissions and readmissions
- **Decrease** ER Utilization
- **Secure permanent housing** when applicable

Benefits

- Basic skills training
- Short and long-term goal development
- Housing manager onsite – 24/7
- 3-meals/day and snacks
- Home Health, Social Worker, Case Manager and other stakeholders to meet member at the facility
- 11-beds available

Admission Criteria

- Independent for Active Daily Living (ADL's)
- Ability to take own medications
- No violent past
- No sex offenses

Willing Hands



Success Story

A member had seven admissions from 2014-2015, mostly for diabetic ketoacidosis (DKA). She was referred to the CFMP. After talking to the member, the CFMP Case Manager learned she was living in a shelter with her daughter.

The member was accepted to Willing Hands, while a family member was contacted and provided a home for the daughter during the member's stay.

While at Willing Hands, the member was connected with various services. Member was accepted to Healthy Living and admitted to Veteran's Village. She is able to plan her meals and snacks to include proteins and complex carbohydrates. She checks her blood sugar, still struggles with diabetes management, but has gained a great deal of knowledge about diabetes.

The Healthy Living Program was able to give her a home and a chance to be with her daughter in a safe environment.

Readmits in 30-day per Member Month

Q2-Q4 2015	Before WH (MEM Month)	After WH (MEM Month)	% Change
ER Visits (no admit)	102	70	-31%
Readmit	97	41	-58%

Community Health Workers (CHW)

Community Health Workers (CHW) builds trust and relationships and engage members facing difficult issues. This team serves as the primary connection as well as a bridge for the highest risk members to support a broad array of health care and social issues.

CHW Services Include:

- Make home visits to assess members' needs
- Encourage continuity of care with primary care providers
- Facilitate appointment-keeping
- Educate members on how to navigate through the healthcare system
- Provide support and advocacy during medical visits
- Work with children and their parents to reduce preventable ER visits
- Provide information on available community resources
- Educate members on available transportation options

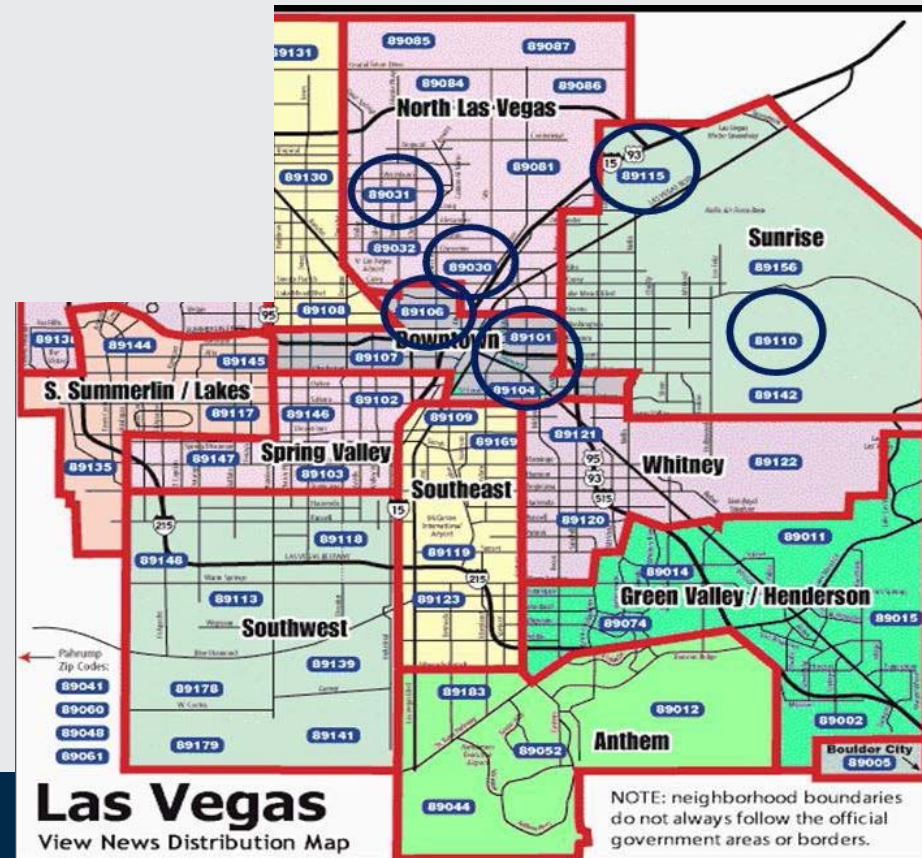
Community Health Workers

Member Outcomes (from December 2015 to YTD 3/25/16) 525

Initial Assessment Through Contact With Member
Home Visits (resulting from initial assessment) 151

Although the CHW team members service members throughout the Las Vegas Area, neighborhoods such as Sunrise, Downtown and North Las Vegas are burdened by economic costs and benefit from CHW services. These areas are included in the following zip codes:

- 89115
- 89030
- 89104
- 89110
- 89101
- 89106



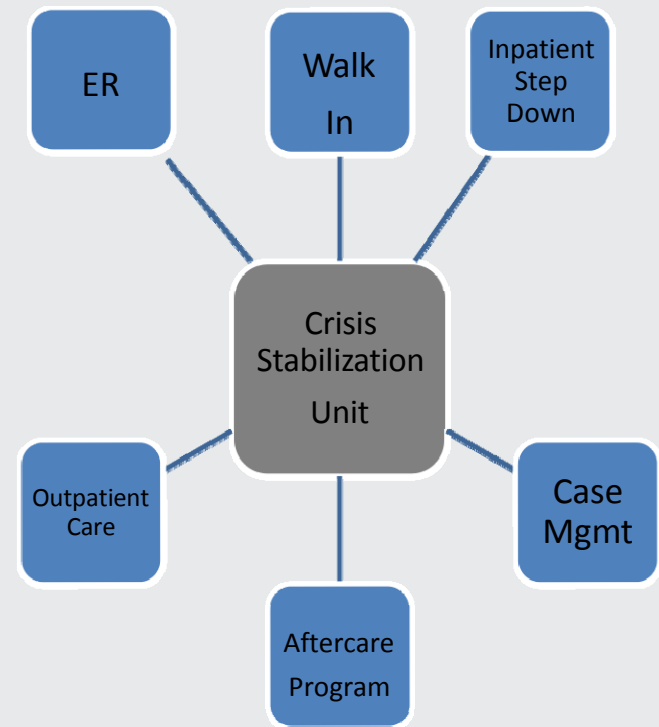
Crisis Stabilization Unit

- Emphasis on stabilizing and increasing psychiatric treatment compliance
- Designed for members that are in need of a higher level of care than traditional outpatient services
- Staffed by psychiatrists, prescribers, mental health and substance abuse counselors, social workers, case managers and nurses
- Available to members seen in the emergency room, walk in and members discharged from inpatient psychiatric hospital in need of additional support and services
- Follow up care includes outpatient treatment, aftercare program with transitional support and case management

The program is focused on engaging Nevada's Emergency Departments to promote utilization of the CSU to increase treatment, compliance and stabilization. In turn, this will decrease the utilization of the emergency room as a mental health crisis center.

April 2015-March 2016	CSU*	Remained in Aftercare*
Adolescent	312	284
Adult	1,128	756

High Utilizers of ER Services*	Average # ER Visits Prior to CSU	Average # ER Visits After CSU
11	8	2.27



Quality of Care

- Health Plan of Nevada is driving quality improvement through innovative programs that help engage and empower people to become more active participants in their own health and by collaborating with physicians and other health care professionals to close gaps in care.
- Health Plan of Nevada participates in all HEDIS, PIP and QI Program audits including the annual External Quality Review (EQR) conducted by Health Services Advisory Group, Inc. (HSAG).
- HPN has demonstrated high levels of compliance in each and every EQRO audit conducted by the State of Nevada with a score of 97% or higher since 2000.
 - HPN received a score of 98.6% for SFY 2014-15.

Successes

- During 2015 HSAG noted the following Medicaid performance measures as strengths based on rate improvements of more than five percentage points over time:
 - Childhood Immunizations Status – Combinations 4, 6, 7, 8, 9 and 10
 - Lead Screening in Children
 - Adolescent Well-child Visits
 - Comprehensive Diabetes Care - Monitoring for Nephropathy
 - Use of Appropriate Medications for People with Asthma – 12-18 Years and 19-50 Years
 - Follow-up after Hospitalization for Mental Illness - 30 days
- The following Nevada Check Up measures were noted as strengths based on rate improvements of more than five percentage points over time:
 - Childhood Immunizations Status – Combinations 4, 6, 7, 8, 9 and 10

Opportunities

- During 2015 HSAG noted the following Medicaid measures as opportunities for improvement based on rate declines of at least five percentage points over time:
 - Annual Dental Visit – Combined Rate
 - Prenatal and Postpartum Care - Timeliness of Prenatal Care and Postpartum Care
 - Frequency of Ongoing Prenatal Care - <21% Visits and ≥81% Visits
- The following Nevada Check Up measures were identified as opportunities for improvement based on rate declines of at least five percentage points over time:
 - Childhood Immunizations Status – Combo 3
 - Lead Screening in Children (expired measure)
 - Annual Dental Visits – Combined Rate
 - Children’s and Adolescents’ Access to PCPs - 25 Months-6 Years
 - Use of Appropriate Medications for People with Asthma – 12-18 Years (expired measure)

Initiatives to Address Annual Dental Visits

Annual Dental Visit – Combined Rate

- Reminder postcards were sent to those members that had not completed an annual dental visit
- Article regarding the importance of dental care and the annual dental visit was included in a member newsletter
- HEDIS 2016 ADV rate did **increase**
- Evaluating **future initiatives** to include live member outreach calls to assist with scheduling and ensuring appointment was kept as well as including this measure in our top providers value based contracts

Initiatives to Address Children's and Adolescents' Access to PCPs

Children's and Adolescents' Access to PCPs - 25 Months-6 Years

- The Citibank Initiative provides members that complete their annual visit with a PCP a \$10 gift card
- HEDIS 2016 CAP (25 months-6 years) rate did **increase**
- Continuing Citibank Initiative and evaluating **future initiatives** to include live member outreach calls to assist with scheduling and ensuring appointment was kept as well as including this measure in our top providers value based contracts

Initiatives to Address Annual Childhood Immunizations

Childhood Immunizations Status – Combo 3

- Reminder postcards were sent to those members that had not completed their well-child visit and immunizations
- Ensured data from WEBIZ was included in HEDIS
- HEDIS 2016 CIS-Combo 3 rate did **increase**
- Including immunizations in Citibank Initiative and evaluating **future initiatives** to include live member outreach calls to assist with scheduling and ensuring appointment was kept as well as including this measure in our top providers value based contracts

Initiatives to Address Pregnancy Measures

- Prenatal and Postpartum Care - Timeliness of Prenatal Care and Postpartum Care
- Frequency of Ongoing Prenatal Care - <21% Visits and ≥81% Visits
 - Implementation of calling all members on the Medicaid EDC list to make referrals to high risk case management and enroll in the Cribs for Kids programs
 - In the Cribs for Kids program, members can receive a free Graco Pack 'n Play® when they complete 81% or more of their required prenatal visits
 - Provider Postpartum Incentive program rewards OB/GYN with \$25 when a member completes their postpartum visit within 21-56 days after the delivery date
 - HEDIS 2016 Postpartum Care and Frequency of Ongoing Care rates did **increase**
 - Evaluating **future initiatives** to include provider education and opportunities to increase the timeliness of the initial member outreach call



THANK YOU