RAE Name: Northeast Health Partners (NHP) **Region:** Region 2 **Date Submitted:** July 28, 2017

ADULT INTERVENTIONS

	INSTRUCTIONS for completing the table below: 1) Identify each Intervention that is part of the Contractor's Population Health Management Plan in the column headers (see example below). 2) Place a checkmark in the cell indicating which interventions will be used for each stratification level.									
Stratification Level	Case Management/ Care Coordination for highest risk Members	Leverage Technology for wellness and prevention	Reduce incidence of smoking through texting program and QuitLine	Suicide prevention – Use Zero Suicide Teams	Reduce ED visits for ambulatory sensitive conditions	Improve well visits rate	Improve prenatal care rates for pregnant women			
Low Physical Health Risk/Complexity Low Behavioral Health Risk/Complexity		✓	✓	✓	✓	✓	✓			
High Physical Health Risk/Complexity Low Behavioral Health Risk/Complexity	✓	✓	✓	✓	✓	✓	✓			
Low Physical Health Risk/Complexity High Behavioral Health Risk/Complexity	✓	✓	✓	✓	✓	✓	✓			
High Physical Health Risk/Complexity High Behavioral Health Risk/Complexity	✓	✓	✓	✓	✓	✓	✓			

Name of Intervention: Case Management/Care Coordination for highest risk Members

Description: Individualized Member and family-centered case management programs with on-site case managers and fully engaged providers have demonstrated a net reduction in total cost of care, Member satisfaction as well as improved provider satisfaction. We will provide Integrated Case Management/Care Coordination for Members with complex and persistent physical and behavioral issues requiring dedicated support from a dedicated resource. Care Coordinators reevaluate clients on a regular basis and also "check-in" with Members with chronic conditions to assess status and determine current needs. Case identification will be based on Business Intelligence and Data Management stratification, real-time/near real-time data such as utilization management (UM), predictive analytics, electronic referrals to adjust risk profile, and other referrals (no wrong door). Our primary goal is for the Member to achieve their greatest functional and health status and improve their ability to live a full and productive life in the community

- Electronic communication will be provided to Care Coordinators and providers to identify Members and provide information on health status, related agency involvement through the integrated information system.
- Program will be staffed by multidisciplinary care team, which comprises RNs, social workers, health coaches, the Member and family members, and to include all providers working with the individual Member. Staffing, co-location, and interoperability facilitate the flow of information to providers that will enable them to address the multidimensional needs of these complex Members.
- Case management caseloads vary by intensity of caseload but approximate 50:1. These are the highest risk Members and we will have increased contacts and frequency of outreach to the Member, family and other agencies to provide support, linkages, and access to health care.
- Over time, as the Member becomes more stable, frequency will be reduced depending on individual needs. Along a continuum, there will be a small cohort with intense, immediate needs; a group of Members who are engaged in education, life training and linkages to community resources; and a more stable group in which the focus is on monitoring and reassessment.
- We will address the needs of Members at highest risk and will use all the Regional resources we have—linking to our extensive provider and community supports including 1915b(3) waiver services.
- We will work with providers and Care Coordinators to identify Members most appropriate for this level of Care Coordination and fully engage the Member and their families in the process.
- Our model is multi-disciplinary, incorporating multiple avenues to improve health literacy, resiliency, engage health neighborhoods, and coordinate care across providers and geographic areas.

Please check one of the following three options:

- ☒ Evidence-Based: (1) Druss BG (2007) Improving medical care for persons with serious mental illness: challenges and solutions. J Clin Psychiat68 (Suppl. 4): 40-44. (2) Druss BG, Rorhbaugh RM, Levinson CM and Rosenheck RA (2001b) Integrated medical care for patients with serious psychiatric illness: a randomized trial. Archs Gen Psychiat58: 861-868. (3) Case Management/Care Coordination for highest risk patients also addresses a RAE RFP requirement, KPI of impacting total cost of care, and Region 2 Health Department Mental Health priorities.
- ☐ Promising Practices:
- ☐ Other:

How the frequency of intervention will be determined: This is a person- and family-centered approach building on the recommended model for complex case Care Coordination (evidence-based reference above). We develop a care plan collaboratively with the full team including the Member, family members, all providers, the Care Coordinator, and any other members of the team. Interventions are developed that are consistent with the care plan to support the Member meet individualized goals. Our model includes explicit goal interventions to stabilize the Member's health, coordinate their care, better understand their medical requirements (e.g., medications), and assist them in obtaining necessary services such as education or housing and nutrition to reach their goals and transition to self-management.

Name of Intervention: Case Management/Care Coordination for highest risk Members

How the method of delivering the intervention will be determined: We develop a care plan collaboratively with the full team including the Member, family members, all providers, the Care Coordinator, and any other members of the team. Interventions are developed that are consistent with the care plan to support the Member to meet individualized goals.

Potential outcomes:

- Reduction in inpatient admissions for those with chronic conditions
- Reduction in Emergency Department (ED) utilization
- Increase in medication compliance/adherence
- Increase in health-related quality of life

Name of Intervention: Leverage Technology for wellness and prevention

Description: We will offer and use text-based population health campaigns and tools to support wellness and prevention campaigns for all Members across the region. We propose using the Text4Health solution to effectively communicate with and educate Members, as well as reach a broader audience. Using technology will supplement our existing efforts in the community, with PCMPs, Care Coordination, public health, and across the spectrum of our close relationships in Region 2.

- Cellular phone adoption and the use of texting are very high with Medicaid Members, especially those in rural and frontier counties.
- Text messaging is a cost effective and widely accepted method of communicating with Members.
- Over 90% of text messages are viewed within 3 seconds of receipt.
- Text messaging for health has been widely researched and is a well-established population health solution that has proven effective.
- Because of the flexibility of Text4Health, we will be able to add additional wellness and prevention campaigns that reach all Members with minimal cost or planning time. PCMPs and Care Coordinators will be engaged in these campaigns so that they can share consistent messages and reinforce the texting information that Members will receive.
- We will coordinate Text messaging campaigns with PCMPs, Care Coordinators, other members of our PCMP teams and health departments to further engage Members, maintain linkages with the Health Neighborhood and reinforce wellness and prevention messaging. A well-documented evidence based approach to impacting health behavior in individuals (Massachusetts Tobacco Control Program) has incorporated clinical and community strategies, combining and connecting activities of across providers, marketing and information resources, clinical settings, community agencies, and local and state policy makers. While leveraging technology, our multi-faceted approach also combines a broad range of options to engage Members in a manner that is most effective for their personal needs.
- Tex4Health addresses general wellness and can be targeted for specific diseases such as diabetes, hypertension and high cholesterol.

Please check one of the following three options:

☒ Evidence-Based: Evidence: (1) Healthcare via Cell Phones: A Systematic Review - Telemedicine and eHealth 2009. (2) Krishna,S., Boren,S.A., & Balas, E.A. (2009). (3) Mobile Text Messaging for Health: A Systematic Review of Reviews. Amanda K. Hall,1 Heather Cole-Lewis,2,3 and Jay M. Bernhardt4 Annu Rev Public Health. 2015 Mar 18; 36: 393–415. (4) Text Message Reminders of Appointments: A Pilot Intervention at Four Community Mental Health Clinics in London. Psychiatric Services 63:161–168, 2012. (5) Integrating Evidence-Based Clinical and Community

Name of Intervention: Leverage Technology for wellness and prevention

Strategies to Improve Health. Judith K Ockene, Ph.D., accessed through uspreventiveservicestaskforce.org. (5) Improving overall health of the community including addressing healthy living, nutrition, activity levels are consistent with the priorities of the Region 2 County Health Departments, Colorado's 10 Winnable Battles, the Colorado Opportunity Project and Community Health Center's 17 Population Health Related Measures.

☐ Promising Practices:
☐ Other:

How the frequency of intervention will be determined: Through Text4Health, we will be able to communicate with all Members in the region on a regular basis, communicating with them as frequently as daily, depending on the campaign. We will begin by engaging all Members concerning general wellness, especially need for well visits for adults. Because of the flexibility of this technology approach, we will expand wellness and prevention messaging to address timely issues such as flu shots in the winter, how to access a PCMP, safe driving, binge drinking, healthy exercise, etc.

How the method of delivering the intervention will be determined: This is a text-based solution. The Chief Clinical Officer and the Regional Performance Improvement Advisory Committee (Regional PIAC) will develop an implementation schedule as part of finalizing the Population Health Management Plan with input from the Member Advisory Council, Care Coordinators, PCMPs and the Department. Text messaging campaigns will be coordinated with PCMPs and health departments" efforts.

Potential outcomes: The goal of this initial campaign will be to improve the number of Members of all ages in populations with at least 90 days of continuous program enrollment that have a well visit within a rolling 12-month period.

Name of Intervention: Reduce incidence of smoking through a text solution and QuitLine

Description: We will provide the necessary supports and interventions for Members to quit smoking so that we can reduce the incidence of smoking in Region 2 (see Social Determinants of Health):

- QuitLine and Medicaid smoking cessation medication benefits are already available for Members and will be encouraged.
- Outcome data demonstrate a need for additional Member support to reduce the incidence of smoking in Region 2.
- Evidence demonstrates that integrating technology support with the commitment of the PCMP improves success rates. PCMPs and care teams are integral members of this solution.
- Support of statewide initiative: Colorado Opportunity Project and Colorado Winnable Battles.
- By purchasing at a multi-region level, we will be an aggregator of this common technology. Members moving from one region to another will be able to keep the tools that are working for them.
- Text2quit is a program to help people quit smoking permanently. It includes text messages, emails, and access to a personal web portal. Members have to enroll and then the text messages can be used on their own.

Name of Intervention: Reduce incidence of smoking through a text solution and QuitLine

- Message frequency varies by account settings. Messages are sent according to quit date. For the 4 weeks before and 4 weeks after the Member's quit date, they receive about 2-5 messages per day. For the remainder of the program, they are sent 1-5 messages per week. The messages are personalized to the quit date and other items in the Member's smoking profile (e.g., smoking triggers, medications used).
- Interventions will be coordinated with PCMPs and Care Coordinators to reinforce provider communications and efforts to reduce smoking for individual Members.

Please check one of the following three options:

☒ Evidence-Based: Evidence: (1) In a randomized controlled trial 11 percent of Text2quit users were abstinent compared to 5 percent of the control group ($p<0.05$). At 6 months, 32 percent of the Text2quit group reported not smoking in the past 7 days compared to 21 percent of the control group (p,0.01). Non-respondents were assumed to have smoked. (2) https://www.cdc.gov/tobacco/stateandcommunity/best-practices-health-equity/pdfs/bp-health-equity.pdf. (3) Am J Prev Med. 2014 Sep;47(3):242-50. A randomized trial of Text2quit: a text-messaging program for smoking cessation.. Abroms LC1, Boal AL2, Simmens SJ2, Mendel JA2, Windsor RA2. (3) Smoking cessation and reduced use of tobacco products is a Region 2 priority for County Health Departments as well as one of Colorado's 10 Winnable Battles.

☐ Promising Practices:

☐ Other:

How the frequency of intervention will be determined: Frequency varies by user participation. Minimum 1 message/week.

How the method of delivering the intervention will be determined: This is a text-based solution. The Chief Clinical Officer and the Regional PIAC will develop an implementation schedule as part of finalizing the PHMP.

Potential outcomes: The goal of this initial campaign will be to reduce the incidence of smoking in the population as measured over time.

Name of Intervention: Suicide prevention—provider education and targeted programs for providers to aide suicide prevention

Description: Expand existing suicide prevention programs to provide PCMP training, education, toolkits, referral and follow-up referral mechanisms to aide suicide prevention. Provide educational outreach to PCMPs regarding depression and suicide prevention. We will leverage existing programs in the Region, publicize them and educate PCMPs on their availability. In addition, we will work with the County Public Health Departments and other local community agencies to expand access to programs such as the following across the region:

- Applied Suicide Intervention Skills Training (ASIST) teaches skills to confidently intervene with someone at risk of suicide. ASIST is a standardized suicide intervention program developed by Living-Works Education, Inc.
- Mental Health First Aid (MHFA) has proven to help participants gain confidence in approaching and offering assistance to individuals experiencing a mental health concern such as depression, anxiety, impulse control and misuse of alcohol and other drugs.

Name of Intervention: Suicide prevention—provider education and targeted programs for providers to aide suicide prevention

- Question Persuade Refer (QPR) Gatekeeper Training is an effective training for adults.
- Sources of Strength is used to prevent suicide by increasing help seeking behaviors and promoting connections between peers and caring adults. This upstream model strengthens multiple sources of support (protective factors) around young individuals so that when times get hard they have strengths to rely on.
- Zero Suicide is a commitment to suicide prevention in health and behavioral health systems, and also a specific set of tools and strategies. It is both a concept and a practice. We will collaborate with the Zero Suicide teams from UC Health Sterling, Salud and East Morgan County Hospital and additional resources as they are developed.

Please check one of the following three options:

☒ Evidence-Based: Evidence: (1) http://zerosuicide.sprc.org/about. Zero Suicide is an evidence-based program endorsed by the Colorado Legislature through legislation and embedded in statewide programs through Colorado Department of Public Health and Environment. (2) These approaches are included on SAMHSA's National Registry of Evidence-Based Programs and Practices

☐ Promising Practices:

☐ Other:

How the frequency of intervention will be determined: Interventions occur annually for PCMPs and at regular Care Coordinator trainings. Materials and practice support tools will be developed and made available on a continual basis and by request.

How the method of delivering the intervention will be determined:

- Provider Relations will educate Region 2 providers about the availability of these programs annually.
- Care Coordinator and Case Manager trainings will include components on suicide prevention including availability of local resources and programs.
- Our intervention will target PCMPs and Provider groups in areas of the region with the greatest levels of suicide amongst their panel of patients.
- We will develop and deploy practice support tools including Member, family, and provider tip sheets, screening tools, and assistance with billing for screening.
- We will connect PCMPs to Psychiatric Consultation and work with PCMPs to ensure they have connection to referral resources and a way to follow up on referrals.
- We will conduct annual quality review of program including performance, provider feedback, and reduction in suicide.
- We will participate at the State level in suicide prevention and depression screening initiatives and policy programs.

Potential outcomes: During Year 1, we will measure the number of PCMPs that have received training and materials, the number of PCMPs that utilize Psychiatric Consultation, and evaluate effectiveness of Care Coordinator and Care Management trainings by assessing their knowledge base on covered materials. We will also work with the Regional PIAC and behavioral health specialists to build additional outcome measures for subsequent years.

Name of Intervention: Reduce ED Visits for Ambulatory Sensitive Conditions

Description: We will actively promote the Department's Nurse Advice Line and after-hours call services at all local providers through Member education, Member Portal access and wellness materials, Text4Health, and PCMP engagement to educate Members on alternatives to using Emergency Departments (ED). Region 2 has been able to impact ED utilization for ambulatory sensitive conditions. However, this is an area we believe can continue to be enhanced. Members who have a history of over-utilizing EDs or who have multiple ED visits will be identified for Care Coordination assessment and appropriate follow-up.

Please check one of the following three options:

- ☒ Evidence-Based: (1) Association between primary care practice characteristics and ED use in a Medicaid managed care organization. Lowe RA, Localio AR, Schwarz DF, Williams S, Tuton LW, Maroney S, Nicklin D, Goldfarb N, Vojta DD, Feldman HI. Med Care. 2005;43(8):792–800. (2) Bogdan GM, Green JL, Swanson D, Gabow P, Dart RC. Evaluating patient compliance with Nurse Advice Line recommendations and the impact on healthcare costs. Am J Manag Care. 2004;10(8):534–542. (3) Margolius D, Bodenheimer T. Redesigning after-hours care. Ann Intern Med. 2011;155:131–132.
- ☐ Promising Practices:
- ☐ Other:

How the frequency of intervention will be determined: Education on using after-hours call centers, accessing the Member Portal and communicating proactively with PCMPs and Care Coordinators is an ongoing effort that needs continuous messaging. Targeted messaging and communications will be made available on the NHP website, available for providers to include on their websites, along with materials and messages for PCMP offices, Care Coordinators, case managers and peer specialist as well as on the Member Portal. There will be regular text messages from Text4Health that are distributed to targeted populations. The Chief Clinical Officer and his/her staff will manage materials development and determine the frequency of distribution. Care Coordination is one component of this solution for Members with chronic conditions and/or who have a history of over-utilization of Emergency Departments.

How the method of delivering the intervention will be determined: Messaging on appropriate use of EDs for ambulatory sensitive conditions and use of alternatives such as the Department's Nurse Advice Line is an ongoing, multifaceted intervention. We will regularly assess changes in ED utilization by reason, community, age of the population, etc., and revise the intervention to target areas of need. We will engage PCMPs in this process, sharing data on utilization by their Members as well as community-wide data. Through the Regional PIAC, NHP will also explore other options to further improving appropriate use of EDs for ambulatory sensitive conditions.

Multiple emergency department visits matches the criteria for Care Coordination case identification. These cases will be referred to Care Coordinators for assessment and appropriate follow up. This is a second group of Members that will be targeted by this intervention.

Potential outcomes: Reduced ED visits for ambulatory sensitive conditions.

Name of Intervention: Improve Well Visits Rate (Number of Members that have had a well visit within a rolling 12-month period)

Description: NHP will use three primary methods to further engage Members in their health care to improve the number of Members who obtain well visits:

- PCMPs and Care Coordinators will receive regular alerts identifying attributed Members that have not had a well visit six months into their membership. This is in addition to any Members who, through stratification or other risk categories, have been identified for Care Coordination including access to more immediate health services.
- Text4Health will include regular messages to all Members stressing the benefits of a well visit.
- Member services representatives will include a brief statement on the availability of well visits in their contacts with Members.
- Information on the importance of well visits, how to access a PCMP, and how to get assistance in making appointments will be included on the NHP website and will be provided to all PCMPs, Federally Qualified Health Centers, and Community Mental Health Centers to add to their Member Portals and websites.

Please check one of the following three options:

- ☒ Evidence-Based: (1) Colorado Opportunity Project – addressing full life cycle of population. Also, building Health Neighborhood. (2) Text message-based program boosts adherence to appointments, Montifiore Medical Center Randomized Control Trial.
- ☐ Promising Practices:
- ☐ Other:

How the frequency of intervention will be determined: Education on the need for a well visit, the benefit of well visits and how to access a PCMP or receive assistance is an ongoing effort that needs continuous messaging both for reinforcement and as new Members are enrolled in Medicaid. Targeted messaging and communications will be made available on the NHP website, available for providers to include on their websites, along with materials and messages for PCMP offices, Care Coordinators, Case Managers and peer counselors, as well as on the Member Portal. There will be regular text messages from Text4Health that are distributed to targeted populations. These materials will be developed and the frequency of their distribution will be managed by the Chief Clinical Officer and his/her staff.

How the method of delivering the intervention will be determined: Our staffs have already developed effective strategies for educating Members on the importance of having a PCMP and obtaining necessary medical care.

We will focus efforts to stress the importance of well visits for adults, how to access care in our area and potential benefits through this intervention. We will seek input from Members through the Member Advisory Council to develop messaging that resonates with our different audiences, e.g., various ages, cultural backgrounds, and communities that make up Medicaid Members. We will regularly assess gaps and revise the intervention to target areas of need.

Potential outcomes: Increase percentage of Members who have a PCMP visit in rolling 12-month period.

Name of Intervention: Improve prenatal care rates for pregnant women

Description: Text4baby is a well-established technology solution to improve pregnant care rates for pregnant women. Text4baby is a collaborative program that is implemented with the PCMP or obstetrician. The provider and the Member will voluntary enroll and work together to improve prenatal care for pregnant women. This approach was designed with major national organizations dedicated to improving care for pregnant women and newborns.

Text4baby sends personalized messages directly to the Member with information developed by experts from all over the country. There is also an app that provides additional information about baby's development, pregnancy, childcare tips, and more.

Text4baby topics include:

- Nutrition for mother and baby
- Baby's milestones
- Doctor visit and personalized appointment reminders for mother and baby
- Car seat safety
- Urgent health alerts
- Safe sleep tips
- Signs and symptoms of labor
- Breastfeeding advice
- Information on health insurance
- Resource hotlines and websites

Text4baby is a free service provided in partnership by the nonprofit organization, ZERO TO THREE, and Wellpass. The text messages are sent for free. Beacon will be purchasing access to Text4baby on behalf of NHP.

Please check one of the following three options:

- ☒ Evidence-Based: (1) https://www.text4baby.org/about/data-and-evaluation. (2) Improving Adolescent Preventive Care in Community Health Centers. Jonathan D. Klein, Marjorie J. Allan, Arthur B. Elster, David Stevens, Christopher Cox, Viking A. Hedberg, Rita A. Goodman. Pediatrics, February 2001, VOLUME 107 / ISSUE 2.
- ☐ Promising Practices:
- ☐ Other:

How the frequency of intervention will be determined: Daily/weekly during pregnancy and intermittently for female Members based on age to educate people on the need for prenatal care early in the pregnancy. We will also implement personalized messages and doctor appointment reminders.

How the method of delivering the intervention will be determined: Multimodal approach that emphasizes Member-centric, team-based care. We will work collaboratively with community partners, providers, Care Coordinators, and all components of the Member's team to improve prenatal care. This includes:

- Care Coordination for women identified as high risk
- Interface with Public Health Departments, WIC programs, etc.

- Technology solutions:

Name of Intervention: Improve prenatal care rates for pregnant women

- CONNECTS
- Electronic medical records systems
- Text4baby
- Social media campaigns

Potential outcomes: Increase number of women who are identified during the first term of pregnancy, increase number of women who seek care throughout their pregnancies.