McLaren Health Plan Pinnacle Awards

2003
PCP Case Management
Business Operational Performance – Medicaid

McLaren Health Plan identifies pregnancy management as an opportunity to promote prenatal and postpartum education. In addition, through these educational contacts an opportunity presents itself to address the preventive health needs of the child as we connect with the mother during the pre and postnatal period. The Early Care Healthy Families program focuses on the pregnant member and the nurse case manager follows concurrently the mom and the infant for 36 months. Many creative tools are utilized to promote appropriate services. Additional support from McLaren Health Plan targets the member not utilizing MSS with home health visits, phone calls and frequent mailings.

2004
Let's Connect
Business Operational Performance – Medicaid

To facilitate appropriate utilization and provide high quality cost effective care, MHP developed, *Let's Connect.* This program targets new ABAD members with the goal of connecting the ABAD member to their primary care physician (PCP) within 60 days of enrollment. The program begins with a member service phone contact scheduling a PCP appointment and includes sending a reminder card with the appointment details and the member's nurse support contact card.

In addition, if the member is not available by phone, a written communication is sent that confirms their PCP and includes the phone number of the doctor, a health-screening tool and the nurse support contact card. MHP anticipates this early contact with the PCP will enhance the quality of care and encourage the appropriate setting of care. Quarterly individual utilization patterns of the ABAD population will be analyzed for PCP access and if not present the member will be referred to case management or back to the *Let's Connect* program.

2005
Application of a Disease Management Approach to a Population of Well Children
Community Outreach – Partnerships – Multiple Plans

Periodic well child health screenings are essential for assessment of normal growth and development. In addition, these screenings allow for early detection of problems that can be treated more efficiently and result in better outcomes because of the timely identification

of an abnormal condition. Medicaid Health Plans have ongoing efforts that are directed at members and practitioner to promote and provide access to these valuable screenings.

During 2002-04, McLaren Health Plan, Midwest Health Plan, and Total Health Plan participated in a unique collaborative project with the Michigan Department of Community Health (MDCH), the Michigan State University Institute for Health Care Studies and The Angel Group. The goal of this project was to apply a disease management approach to a population of well children to:

- Improve rates of preventive care received by children, and
- Assist the plans in understanding, developing, and implementing disease management strategies.

This project was accepted for poster presentation at the Disease Management Association of America's Annual Leadership Forum (October 2004) and the National Initiative for Children's Healthcare Quality (March 2005).

2006
Not in My Back Yard (NIMBY)
Community Outreach – Partnerships – Multiple Plans

Screening for lead poisoning is a health priority for the State of Michigan. The Michigan Department of Community Health (MDCH) released a map of Ingham County, showing areas where children resided who had not been tested. The threat of lead poisoning was right in our back yard! This revelation inspired the Not In My Back Yard (NIMBY) project, with the goal of getting children in these areas tested for lead poisoning.

Physicians Health Plan of Mid-Michigan (PHPMM) initiated a partnership with McLaren Health Plan (MHP), Sparrow Health System, Ingham Regional Medical Center, Lansing Board of Water and Light (BWL), McDonald's restaurants and other partners to educate the community by leaving door hangers at houses about lead poisoning, and to encourage lead testing for children six and under.

As a result, 163 children were tested, and three children had an elevated blood lead level. Children tested received a $10 McDonald's gift certificate in the mail.

2007
Eyes Wide Open
Chronic Disease Care – Medicaid

Depression is common, serious, and costly. It affects one in every ten adults in the United States each year. **Eyes Wide Open** is a depression outreach program that identifies, educates and supports our members with depression.

Outreach targets the practitioner and the member. Practitioner education begins with distribution of the *Management of Adults with Major Depression* guideline, followed by promotion of the importance of screening and providing a suggested screening tool. Through our monthly provider fax program, **PCP Connection,** and our website, www.mclarenhealthplan.org, recommended readings emphasize optimal care for our members.

Member initiatives begin with ongoing newsletter articles for the membership, and then quickly move to targeted outreach for members prescribed an antidepressant.

A long term goal of the program is to monitor over time the participant's utilization patterns to evaluate the impact of depression on their use of services, including preventive and chronic disease care before, during, and after depression treatment

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2008
You've Got a Nurse
Business Operational Performance – Commercial

Recent statistics reveal that over 42% of employers choose not to provide healthcare coverage for a variety of reasons. McLaren Health Plan has the answer. Our operational approach is simple: An affordable health plan that the employee has confidence in.

Our *You've Got a Nurse* program, championed by our Medical Management Department, uniquely couples member outreach with upfront worksite education that supports our members with access to preventive services, promotes the use of cost effective medications, facilitates appropriate medical treatments, and encompasses healthy life style support.

The goals of *You've Got a Nurse* are to:

- Connect with employers and employees and their families and engage them in a long term relationship that pursues a healthy lifestyle
- Provide information to increase knowledge and awareness of the most efficient and cost effective use of healthcare benefits
- Offer ongoing support to improve health outcomes as our members utilize their healthcare benefits

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McLaren HEALTH PLAN

2010
Honorable Mention
Early Care Healthy Family
Clinical Service Improvement – Medicaid

McLaren Health Plan's **Early Care Healthy Family** prenatal program is aimed at producing full term pregnancies. Education begins with provider information regarding evidence based clinical guidelines, continues with ongoing contact with the treating obstetrician, and then remains focused on the member and her needs.

McLaren Health Plan promotes prenatal and postpartum education through aggressive outreach. With these educational contacts, we also address the preventive health needs of children as we connect with the mother during the prenatal and postpartum period. The **Early Care Healthy Family** program focuses on the pregnant woman, and the nurse case manager follows concurrently the mother and the infant for 36 months. Many creative tools are utilized to promote appropriate services. Program support provides nurse contacts, reminder calls and cards, frequent educational mailings, provider coordination contacts, and home health visits if necessary.

2011
Med Check
Business Operational Performance – Commercial

Our ***MedCheck*** program, championed by our Pharmacy Management Administrator, uniquely couples group education at the employer level with individual member outreach. ***MedCheck*** enhances the members' understanding of their pharmacy coverage and provides tools on how to best utilize this benefit with a focus on quality, safety, and cost.

This program supports our members with tools such as:

- Need It Now List
- Newly Available Generics Information
- Individual utilization review of therapeutic classes by clinical pharmacist to target safety issues such as duplication, interactions, and daily consumables
- Individual copay review by clinical pharmacist to encourage cost savings
- Check List of Cost-Effective Medications
- Worksite visits prior to enrollment
- 30 day after enrollment Group Drug Review
- E-prescribing for our providers

MedCheck ensures employees have the knowledge to maximize their pharmacy benefit by utilizing cost savings programs developed by McLaren Health Plan, and at the same time improve health outcomes as our members optimally utilize their pharmacy benefits.

McLaren
HEALTH PLAN

2012
Taking it Off
Business Operational Performance – Commercial

MHP's Weight Management Program, *Taking It Off* is a comprehensive program that begins with early identification of members in need of weight management resulting in improved health outcomes.

The overall goal of MHP's Weight Management Program, *Taking It Off* is to improve the health status, the quality of life, and the clinical outcomes of this population. By educating members with weight management techniques, empowering members through self-management, and encouraging partnerships with primary care physicians, community resources, and other health care providers, we have increased the population of "right weight" persons.

Member interventions are varied from Michigan Steps Up, 5-2-1-0 outreach, walking programs, nutritional tips from a dietician, to just a familiar voice to talk with! Added in 2011 was a partnership with W.O.W., a program developed by a pediatric group of Memorial Healthcare. Members stratified as level 2 are in active case management which includes planned contacts with the member to provide teaching and support in achieving self-care goals based on an agreed care plan.

2013
Maximizing a Regulation!
Business Operational Performance – Medicaid

The Healthcare Effectiveness Data and Information Set (HEDIS)® developed by the National Committee for Quality Assurance (NCQA) is a reporting tool that is considered the industry standard for measurement of the quality of a health plan's performance on important dimensions of care and service. HEDIS submission is a regulatory requirement of MDCH for all health plans.

A business decision was made by McLaren Health Plan (MHP) to not just meet this regulation, but to capitalize on the data collection by training our nurse case managers to abstract the information at the PCP office, rather than an outside review company. This business decision has allowed MHP to meet the HEDIS regulatory requirement, and at the same time has provided provider outreach, care coordination, and increased the nurse case managers' knowledge of their members' healthcare experience.

Through ***Maximizing a Regulation,*** MHP has taken a "requirement" and turned it into a positive action that has produced better outcomes for our members and providers, and at the same time lowered administrative costs!

2015
Two Way Touch!
Business Operational Performance – Medicaid

Many individuals are receiving care for mental and physical conditions. Often these two systems of care remain segregated and isolated from each other resulting in gaps in care, inappropriate management, and poor care coordination. McLaren Health Plan recognized the need for integration within this population and began a collaborative project with Genesee Heath System (GHS) previously known as Genesee County Community Mental Health (GCCMH) Prepaid Inpatient Health Plan (PIHP.)

This Coordination of Care project boasts several interventions based on this collaboration such as:

- A human services agency at GHS that connects patients to provide coordinated evidence based behavioral health treatment.
- McLaren Health Plan providing clinical support for Primary Care through evidence-based guidelines
- Data sharing platform expanded to utilize Care Connect 360
- GHS employed Community Health Workers (CHW) who assist in member outreach
- Care meetings with McLaren Health Plan's care management team promoting CHW referrals, primary care coordination, and support for community needs and transitions of care

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2016
FOOD 4U
Clinical Service Improvement – Medicaid

As a Health Maintenance Organization (HMO) one of the barriers in promoting a healthy lifestyle is engaging members to *value* preventive screenings. At McLaren Health Plan (McLaren), we provide endless educational materials, spend countless hours trying to contact members, and provide monetary rewards to both members and providers. In addition, significant additional resources are necessary to research and identify the "golden initiative," the one that will motivate and result in the member's commitment to seek the service.

Our preventive program for Breast Cancer Screening over the years has allowed for a variety of outreach and reward programs for both members and providers. For **FOOD 4U,** McLaren partnered with the Greater Lansing Food Bank to provide food bundles (15-28 lbs.) to members as they completed a mammogram. McLaren staff members were present at the screening site,

delivering the food and additionally engaging the member in health risk assessments, satisfaction surveys, and other preventive outreach.

2017
One by One
Business Operational Performance – Medicaid

Population management is a new buzz word in the care management arena. A very useful tool that identifies populations that need more of us: more help, more contacts, more care, more referrals to community resources. **"One by One"** has had significant success in helping our at-risk member's access to care, improves our member's quality of life and provides cost savings opportunities. After a population geographic assessment, with a focus on such Social Determinants of Health (SDOH) as transportation, PCP access, income levels, chronic disease and frequent inpatient and emergency room use, we launched **"One by One".**

The goals of the program are:

- Provide real time outreach to high risk members who have been identified by high cost indicators and high utilization of inappropriate care settings
- Utilize Community Health Workers (CHW) to establish a Primary Care Medical Home (PCMH) relationship
- Collaborate with community resources, mental health and other partners in the member's care continuum to ensure communication
- Maintain progress made through ongoing monitoring and outreach

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2018
Better Together
Collaborative Community Health Initiatives

The key to quality population health care lies in the relationship between providers and members. Mutual investment in this partnership is essential for achieving the best member outcomes and is the foundation for optimal care delivery.

Better Together is a community-based collaborative partnership between the Health Department of Northwest Michigan and McLaren Health Plan, designed to help rural members establish a solid relationship with their primary care provider. Focus is on adults who over-

utilize the emergency room, women needing preventive screenings, and children who need primary care. This population can be very difficult for the health plan to reach so the Health Department community health workers (CHWs) initiate face-to-face contact with members. Once contact is made, the CHW assists the member with making appointments and notifies providers of needed preventive screenings.

Program goals include:

- Health care delivery in the right setting
- Access to timely preventive care
- Improving care coordination

2019

Move on Up

Business/Operational Performance: Government Programs

Imagine the challenges of coordinating health care for a child with special health care needs. These children have overwhelming disabilities that affect their entire family. Often, these families are lost in the health care system with no support for their conditions which require specialized care. "***Move on Up"*** helps children move up from their current Medicaid benefits by qualifying for additional benefits through MDHHS' Children's Special Health Care Services (CSHCS). The goal of "***Move on Up"*** is to help these families meet their challenges on a daily basis. A child in "***Move on Up"*** receives:

- Open access to their own McLaren nurse
- Availability to a broad range of medical care facilitated by their primary care physician
- Coordinated collaboration between medical professionals
- Community-based services to help care for the child at home
- Assistance navigating the health care system

2021

McLaren FIRST

2021 Community Outreach: Single Plan

People are struggling to provide food for themselves and their family. Food insecurity is the lack of access to adequate and consistent healthy food for everyone in a household.
McLaren FIRST is a comprehensive program that ensures families get food as soon as a need is identified. **McLaren FIRST** provides:

- Transportation to local food pantries

- Delivery of a two-week food supply directly to the doorstep of a family in need
- Identification of the root cause of the food insecurity such as lack of income, job insecurity, transportation challenges, caregiver relief or mental health issues

Staff reach out to members to assess needs and members may call anytime to request assistance. The program objectives include:

- Reducing hunger
- Addressing causes
- Improving health

McLaren FIRST improves the health of the community by addressing hunger…a thief that robs each passing generation of enormous potential*.

2022
Diabetes P.A.C.E
(Preventive Annual Care Exams Program)
Helping Members Stay a Step Ahead!

McLaren Health Plan's Diabetes P.A.C.E. program (P.A.C.E.) is a comprehensive strategy to improve the health outcomes for members with diabetes and help our members "stay a step ahead" of diabetes complications.
Goals include:

- Early detection of diabetes complications through preventive annual care exams:
  - Hemoglobin A1c – measures average blood sugar levels
  - Dilated eye exam – detection of eye damage
  - Kidney function test
- Improving health care inequities by addressing social barriers

Cost avoidance through reduction in diabetes-related hospital visits

Interventions:

- Member and provider financial incentives to complete annual screening exams
- Financial incentives for McLaren hospitals to coordinate discharge after-care
- Lists of the members who have not completed their annual exams shared with provider's office so outreach and scheduling can occur
- Nurse care coordination including:
  - Connect member to Primary Care Provider
  - Screening and addressing social barriers
  - Diabetic education
  - Use of 3-way calling to help members schedule preventive annual care exams