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I. Overview of UnitedHealthcare Community Plan

UnitedHealthcare Community Plan is a business unit of UnitedHealth Group. UnitedHealthcare Community Plan is one of seven health plans participating in the HealthChoice program. We are recognized by the Department of Health and Mental Hygiene as a statewide managed care organization (MCO) providing health care services to Medicaid recipients in Maryland.

The mission of UnitedHealthcare Community Plan is to help people lead healthier lives. One way the organization demonstrates that commitment is by utilizing the outreach and data resources to identify and reduce gaps in care.

UnitedHealthcare Community Plan makes every effort to inform its practitioners and members of the availability of outreach, health education, and case management services. Claims and encounter data is monitored on an ongoing basis to identify members in need of services and to provide feedback to providers on individual performance as well as plan performance.

Outreach activities include both written and verbal mechanisms for the purpose of providing education about the benefit of preventive and clinical exams for members. Routine mailings and automated calls are generated and direct-member calls are placed by health plan staff. In addition to providing education, outreach staff members are available to provide assistance with gaining access to services when needed. When an assessment screening indicates the need for follow-up and/or further evaluation, outreach staff is available to assist with care coordination. Educational information related to preventive care is also made available to members on the website. Communication with internal departments, including case management, member services, and provider services, is ongoing to promote the Preventive Care Program and to work collaboratively on individual cases when indicated.

UnitedHealthcare Community Plan conducts outreach to practitioners as an integral component of the Outreach program. This outreach is provided through multiple mechanisms including written education related to the components of a comprehensive screening exam, the periodicity schedule, and feedback to practitioners relative to assigned members in need of services. On-site visits with practitioners are conducted to provide focused outreach. There is also collaboration between the health plan and practitioners to help ensure the availability and timely receipt of services to members.

Practitioner outreach is conducted to inform clinicians of panel members who need services. Practitioner performance is monitored to identify those in need of assistance such as education, care coordination, or claim research, to improve compliance with preventive health services.

The health plan contracts with a network of providers to render health care members. The Plan encourages network practitioners to employ a diverse work force that possess extensive practical experience. These characteristics in the workforce are critical assets in helping meet the needs of members.

UnitedHealthcare Community Plan's Outreach Program includes collaboration with community and state organizations. Through these partnerships, multiple resources are linked to enhance member and practitioner educational efforts. These resources may also be used to coordinate services and/or to identify alternate mechanisms of contact for hard-to-reach members.

Using state and/or national guidelines, quality indicators for preventive care services are monitored and evaluated on a continual basis and interventions are implemented as indicated for continued quality improvement.

Outreach is conducted to help ensure that members have the appropriate information to make decisions about their health care. Member outreach is conducted through multiple mechanisms such as mailings, automated calls, and direct-
member calls. Each of these efforts is designed to provide educational information to members about needed services as well as assistance with obtaining those services as indicated.

Furthermore, outreach staff provides preventive health and screening services consistent with the HealthChoice Program Benefits. Because of the demographics of the enrolled population, targeting these groups for preventive services has the potential to yield improvements for a large number of members.

UnitedHealthcare Community Plan selects preventive service indicators that reflect important aspects of care for our members; indicators that are relevant to the enrolled population, reflective of high volume services, encompass preventive and chronic care, and span a variety of delivery settings.

Preventive services are both population and condition based. Using multiple data sources, including but not limited to The Healthcare Effectiveness Data and Information Set (HEDIS) or State provided data; members are identified for outreach. Claims and encounter data is consistently monitored to identify members in need of services and to provide feedback to practitioners on individual performance as well as overall plan performance relative to performance indicators such as HEDIS.

Outreach is provided to members in both written and verbal form. On a routine basis, mailings are sent to members to provide education related to preventive care and/or screenings due. Verbal outreach is provided through both automated telephone calls and direct-member outreach. On an annual basis, written information is mailed to members to encourage receiving physical exams and recommended screenings. Educational information related to preventive care is also made available to members on the UnitedHealthcare Community Plan website. Communication with internal departments including case management, member services and provider services is ongoing to promote the Preventive Care Program and to work collaboratively on individual cases when indicated.

Educational and member-specific information is submitted to practitioners on a routine basis to provide up-to-date screening guidelines and notification of members among the panel who are due for screening. On-site visits to practitioners may also be conducted for focused education and/or medical record review.

UnitedHealthcare staff develops partnerships with community and state agencies for community-wide health promotion. Through these partnerships, multiple resources are linked to enhance member and practitioner educational efforts. These resources may also be used to coordinate services and/or to identify additional means of contact for hard-to-reach members.

Using state and/or national guidelines, as well as HEDIS data, quality indicators for preventive care services are monitored and evaluated on a continual basis and interventions are implemented as indicated for continued quality improvement.

UnitedHealthcare Community Plan emphasizes preventive health education and regularly encourages members to get annual physicals and routine screenings. Staff works with community organizations, such as the Healthy Kids program, School Based Health Centers, and Local Health Departments, to ensure that there are no access barriers to members for getting the care they need.

This plan summarizes UnitedHealthcare Community Plan’s current multifaceted outreach efforts, tracking databases as well as proposed strategies for calendar year 2011. Our objective is to exceed performance expectations of our customers and partners (members, government, and providers) by educating and notifying members and providers about health plan activities, benefits, and community events while consistently identifying strategies to improve our member, provider, and community partnerships.
II. Membership Profile

A. Population Assessment

UnitedHealthcare Community Plan provides outreach and care management to the following HealthChoice populations:

<table>
<thead>
<tr>
<th>Special Needs Population</th>
<th>Count*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children with special health care needs</td>
<td>3331</td>
</tr>
<tr>
<td>Individuals with a physical disability</td>
<td>2050</td>
</tr>
<tr>
<td>Individuals with a developmental disability</td>
<td>805</td>
</tr>
<tr>
<td>Pregnant and postpartum women</td>
<td>5672</td>
</tr>
<tr>
<td>Individuals who are homeless</td>
<td>6</td>
</tr>
<tr>
<td>Individuals with HIV/AIDS</td>
<td>614</td>
</tr>
<tr>
<td>Individuals with a need for substance abuse treatment</td>
<td>4952</td>
</tr>
<tr>
<td>Children in State-supervised care (E03 &amp; E02)**</td>
<td>2901</td>
</tr>
</tbody>
</table>

Note: *The count for UnitedHealthcare Community Plan’s Special Needs Population details our monthly new additions for October 2010. ** State funded foster care based on medical care program coverage groups and HealthChoice eligibility

UnitedHealthcare Community Plan is comprised of the following groups (1) families receiving Temporary Assistance for Needy Families (TANF), (2) individuals receiving Supplemental Security Income (SSI) benefit, and (3) Primary Adult Care (PAC). HealthChoice membership is currently 125,249 and Primary Adult Care membership is currently 9,983. UnitedHealthcare Community Plan has a total membership of 135,232 members as of October 2010.
UnitedHealthcare Community Plan's membership and market share is illustrated in the (Figure 1) graph below:

Figure 1
UnitedHealthcare Community Plan’s HealthChoice membership ethnicity and population by county (Figure 2) is illustrated in the graphs below:

Figure 2

UHC Membership By Ethnicity

UHC Population By County
B. Common Health Diagnoses

The most common health conditions within our membership are those typically associated with children and women of childbearing age. Below is an analysis of UnitedHealthcare Community Plan's most common inpatient and outpatient utilization by diagnosis. Figure 3 and Figure 4 illustrate the major diagnoses for Inpatient and Outpatient utilization data. Pregnancy-related conditions were the most frequent inpatient service provided to UnitedHealthcare Community Plan members, while chronic respiratory diseases were the most frequent in the outpatient Setting. The results of the inpatient and outpatient data are not unanticipated as the majority of UnitedHealthcare Community Plan's members are children, women of childbearing age, and adults with disabilities.

**Figure 3**

**Top Inpatient Diagnoses**

<table>
<thead>
<tr>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Live birth</td>
</tr>
<tr>
<td>Heart Failure</td>
</tr>
<tr>
<td>Septicemia</td>
</tr>
<tr>
<td>Hereditary Hemolytic anemias</td>
</tr>
<tr>
<td>Abnormality of Organs and Soft Tissues of Pelvis</td>
</tr>
<tr>
<td>Respiratory distress syndrome</td>
</tr>
<tr>
<td>Asthma</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>Pneumonia</td>
</tr>
<tr>
<td>Hypertension complicating pregnancy</td>
</tr>
<tr>
<td>Trauma to perineum and vulva</td>
</tr>
<tr>
<td>Prolonged pregnancy</td>
</tr>
</tbody>
</table>

**Top Outpatient Diagnoses**

<table>
<thead>
<tr>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms Involving Respiratory System and Other Chest Symptoms</td>
</tr>
<tr>
<td>Other Symptoms involving abdomen</td>
</tr>
<tr>
<td>General Symptoms</td>
</tr>
<tr>
<td>Diseases of hard tissues of teeth</td>
</tr>
<tr>
<td>Pther conditions in unspecified aftercare</td>
</tr>
<tr>
<td>Asthma</td>
</tr>
<tr>
<td>Chronic renal failure</td>
</tr>
<tr>
<td>Drug dependence</td>
</tr>
<tr>
<td>Normal Pregnancy</td>
</tr>
<tr>
<td>Chronic Disease of Tonsils and Adenoids</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
</tr>
<tr>
<td>Other disorders of the urethra</td>
</tr>
</tbody>
</table>

When compared to inpatient and outpatient common diagnosis, the analysis for UnitedHealthcare Community Plan's Emergency Department (ED) for the same period shows a similar profile of common conditions, especially abdominal pain and respiratory symptoms. Although the inpatient, outpatient, and ED member profiles are similar in all three populations (children, women, and adults with disabilities) they require different outreach and care management strategies. With UnitedHealthcare Community Plan's cross-departmental, provider, and community outreach approach, all three populations are managed differently but appropriately.
UnitedHealthcare's Top five ED Diagnoses are illustrated in Figure 5.

### Figure 5

**Top 5 Emergency Department Diagnoses**

<table>
<thead>
<tr>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Pain</td>
</tr>
<tr>
<td>Respiratory and other chest symptoms</td>
</tr>
<tr>
<td>General Symptoms (Trauma)</td>
</tr>
<tr>
<td>Asthma</td>
</tr>
<tr>
<td>Other disorders of urethra</td>
</tr>
</tbody>
</table>

DHMH measures UnitedHealthcare’s performance individually and all Managed Care Organizations (MCOs) collectively through several initiatives, including the audit and analysis of the Medicaid HEDIS and Value Based Purchasing (VBP) encounter reports. In addition to the clinical inpatient, outpatient, and ED outreach opportunities identified in Figures 3-5; the following HEDIS and encounter-based VBP measures are tracked to ensure initiatives are implemented to close gaps in care. UnitedHealthcare Community Plan's CY 2010 quality performance scores are illustrated in the grid below.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Care</td>
<td>% of children ages 4-20 enrolled 320 or more days receiving at least one dental service during year</td>
<td>52.0%</td>
<td>54%</td>
<td>Retired</td>
</tr>
<tr>
<td>Access to Care</td>
<td>% of SSI adults enrolled 320 or more days with at least one ambulatory service during year</td>
<td>77.7%</td>
<td>79%</td>
<td>79%</td>
</tr>
<tr>
<td>Access to Care</td>
<td>% of SSI children enrolled 320 or more days with at least one ambulatory service during year</td>
<td>68.1%</td>
<td>69%</td>
<td>50%</td>
</tr>
<tr>
<td>Access to Care</td>
<td>% of pregnant women who receive a prenatal visit during the 1st trimester or within 42 days of enrollment</td>
<td>92 %</td>
<td>90%</td>
<td>Retired</td>
</tr>
<tr>
<td>Access to Care</td>
<td>% of deliveries by a pregnant women who had a postpartum visit on or between the 21 and 56 days after delivery</td>
<td>NA</td>
<td>NA</td>
<td>63.39%</td>
</tr>
<tr>
<td>Use of Services</td>
<td>% of children ages 3-6 receiving at least one well child visit during the year</td>
<td>76 %</td>
<td>75%</td>
<td>82.43%</td>
</tr>
</tbody>
</table>

(continued on next page)
Activities implemented to achieve UnitedHealthcare’s outreach goals are carefully customized by age group and disease state.

After reviewing UnitedHealthcare’s HEDIS and Healthy Kids scores and evaluating current outreach activities, we have identified successful outreach strategies to continue and others to eliminate, enhance or implement.

Outreach initiatives in 2011 will continue to target HealthChoice, SSI and Primary Adult Care (PAC) subgroups. The grid below details the outreach initiatives for the following HealthChoice and PAC measures:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness of Care</td>
<td>% of children who turned two and who received combo 2 (all childhood immunizations) by their 2nd birthday</td>
<td>78 %</td>
<td>85%</td>
<td>Retired</td>
</tr>
<tr>
<td>Effectiveness of Care</td>
<td>% of children who turned two and who received combo 3 (all childhood immunizations) by their 2nd birthday</td>
<td>NA</td>
<td>NA</td>
<td>78.72%</td>
</tr>
<tr>
<td>Effectiveness of Care</td>
<td>% of children ages 12 through 23 months enrolled 90 or more days who receive lead test during year</td>
<td>47.6%</td>
<td>52%</td>
<td>Specification Retired</td>
</tr>
<tr>
<td>Effectiveness of Care</td>
<td>% of women ages 21-64 receiving at least one PAP test during the last 3 years</td>
<td>65 %</td>
<td>66%</td>
<td>64.0%</td>
</tr>
<tr>
<td>Effectiveness of Care</td>
<td>% of diabetics that received a dilated fundoscopic eye exam during the year</td>
<td>58 %</td>
<td>66%</td>
<td>71.29%</td>
</tr>
</tbody>
</table>

HealthChoice measures | PAC measures  
Well Child services | Adult Access  
Immunizations | Well Women  
Comprehensive Diabetes | Comprehensive Diabetes  
Pregnancy related services |  
Well Women services |  
Asthma |  
Lead |  
SSI adult and child |  

8
C. Identified Barriers to Care

Based on member and provider reports, UnitedHealthcare Community Plan develops targeted outreach and care management strategies to reduce barriers to care. We employ a number of strategies to contact these members as soon as possible after enrollment, including the use of external vendors to search for updated member information, contacting the PCP/specialist office, and reviewing claims information. UnitedHealthcare Community Plan staff makes every attempt to schedule members for appointments and provide educational materials that ultimately impact the overall success of members managing their health care. We require all contact attempts be documented to ensure that all options have been exhausted prior to reporting failure to contact. Letters are sent to members who are identified as “unable to reach” as a final attempt to make contact.

Members who are not able to be contacted due to lack of a telephone or who do not have a reliable address are sent to their local health department.

The strategies include extensive member health education, provider network recruitment and retention in underserved communities, and increased collaboration with local health departments and participating providers. Despite extensive outreach methods, the following barriers and challenges still exist:

Unreachable Members

UnitedHealthcare Community Plan Outreach staff work diligently to collaborate with providers and the local health departments to obtain accurate demographic information for our unreachable members. The nature of the population tends to be transient. As a result addresses and telephone numbers change frequently.

Non-Adherence

Non-adherence to treatment and care plans continues to be an ongoing barrier to members getting appropriate quality health care. Reasons for member non-adherence include difficulty with lifestyle changes, behavioral challenges, substance abuse, homelessness, and lack of transportation. UnitedHealthcare Community Plan’s Outreach, HEDIS, and Case management units utilize internal and community resources to improve member adherence.

Transportation

Some members are noncompliant to needed healthcare services because they cannot access transportation. Local Health Departments are responsible for coordinating transportation for Medicaid members in their county; these transports are often limited to that particular county. Many Local Health Departments will not transport members across county lines.

Child Supervision

Lack of child supervision can be a barrier to their care. Many mothers are unable to find someone to watch their children while they go for health appointments.
**Foster Care**
Challenges in communicating with social workers at DSS and the Maryland Department of Human Resources are related to a lack of timely response. Another challenging is identifying the physical location of UnitedHealthcare Community Plan member while being placed in foster care.

**Provider Network**
Recruitment and maintenance of UnitedHealthcare Community Plan provider network for Medicaid is a continuous challenge. With subspecialty shortages in Maryland and geographic limitations, members and providers experience difficulty in obtaining resources to coordinate care and require assistance.

**Challenging Regions**
Rural regions present the greatest challenges to successful outreach efforts. For UnitedHealthcare Community Plan, those areas are Western Maryland and the Eastern Shore. Specialty providers in these areas are fewer than those available in the State’s suburban and urban locations.
III. Organizational Resources and Outreach Activities

UnitedHealthcare Community Plan uses a combination of direct staffing and network contracting activities for delivering outreach and care management services to our members. Outreach is based upon the premise that collaboration between the member, support systems, and health care professionals result in the development of partnerships that promote targeted interventions and health care goals and that contribute to improving health care outcomes. This coordination of care provides an opportunity for an improvement in the quality of care continuum. UnitedHealthcare Community Plan’s Outreach Program offers services that address the entire continuum of clinical and preventive needs utilizing data analytical capabilities to assist in providing evidence on the improvement of care and services.

We have multiple departments conducting member and provider outreach services both independently and interdependently. Areas that perform outreach include the Quality Department (QM, Outreach and HEDIS unit), Marketing Department, Operations Department, Customer Service Department, Customer Service Department, Hospitality, Assessment, and Reminder Center (HARC), and United Behavioral Health.

The following section outlines specific UnitedHealthcare Community Plan personnel who participate in our outreach efforts:

Quality Management Department

Chief Medical Officer

The Chief Medical Officer (CMO) is a Maryland licensed physician who is responsible for implementation of the QI Program. Chief Medical Officer and Medical Directors: Physicians with current Maryland licenses and extensive experience in quality management. Medical team meets with network providers to discuss their individual or practice profiles which emphasize practice utilization and quality performance.

Associate Director Quality Management

The Associate Director Quality Management is responsible for oversight of the implementation of the Quality Improvement (QI) Program, including monitoring the quality of care and service UnitedHealthcare Community Plan provides (Quality Evaluation) and the evaluation of quality improvement initiatives involving member and provider outreach (Quality Improvement). The Associate Director Quality Management maintains oversight of activities designed to increase performance on HEDIS, measures, prepares annual QI program documents, submits quality regulatory reports has day-to-day responsibility for implementation of quality improvement studies and patient safety initiatives, and manages the health plan Quality Improvement infrastructure.

The Associate Director Quality Management is the secondary point of contact for regulatory inquiries and works with the Compliance Officer to assure compliance with regulatory and accreditation standards. The Associate Director Quality Management reports to the Chief Medical Officer to ensure that fiscal and administrative management decisions do not compromise the quality of care and service UnitedHealthcare Community Plan provides to members. One full time Associate Director Quality Director who is a Registered Nurse with current Maryland License. The Associate Director Quality Management is responsible for oversight of the implementation of the QI Program, including monitoring the quality of care and service UnitedHealthcare provides (Quality Evaluation) and the evaluation of quality improvement initiatives involving member and provider outreach (Quality Improvement). The Associate Director Quality Management manages the health plan Quality Improvement infrastructure. The Associate Director Quality
Management reports to the Chief Medical Officer to ensure that fiscal and administrative management decisions do not compromise the quality of care and service UnitedHealthcare provides to members.

**Quality Management Staff**

One full-time Senior HEDIS Manager, Masters in Healthcare Administration, with extensive experience in implementing quality among Medicaid population; responsible for developing and implementing CQI initiatives designed to ensure members receive timely preventive health services. HEDIS manager reports to the Associate Director Quality Management and also works with other Quality Management, provider relations staff and operations staff to resolve provider issues which impact quality.

HEDIS staff includes a Health Educator, Bachelors in health related field and a Certified Health Education Specialist (CHES); Clinical Quality Analyst; Information Technology experience and Outreach.

HEDIS staff educates internal and external partners about quality projects such as HEDIS, Health Education, and Healthy Kids regulatory requirements. HEDIS staff coordinates medical and preventive healthcare events, perform health education presentations to people during our community HUB forums, and create outreach database management systems to ensure special populations are being tracked and monitored.

The Outreach Unit is supported by one full-time supervisor with extensive outreach experience and six full-time Clinical Administrative Specialists. The primary goal of the Outreach staff is to improve UnitedHealthcare Community Plan’s member compliance with preventive and chronic health services.

To fulfill the goals of the outreach unit, the Clinical Administrative Specialists are dedicated to providing multifaceted outreach services such as performing Initial Health Appointment (IHA) for EPSDT members and linking members identified on Health Risk Assessments with a specialty provider and assigning a physician. Appointment setting includes, but not limited to the following services:

- EPSDT and immunization appointments
- Lead screenings
- Well Child Visits
- Comprehensive Diabetic services
- Well women services
- Adults and Children with physical or developmental disabilities
- Homeless

UnitedHealthcare Community Plan’s Outreach unit tracks and manages member appointments using the following multifaceted, multifunctional methodologies:

- Telephonic outreach including direct member and provider calls
- Direct and personalized mailings to members
• Messaging services and reminder cards
• Participation on UnitedHealthcare Community Plan’s Member Consumer Advisory Board
• Collaboration with Local Health Departments, FQHCs, School Based Health Centers and State Agencies
• Community events and health fairs
• Bulk appointments with provider collaboration
• Member clinic day events
• Collection of patient data
• Encounter Corrections

**Quality Management Specialist**
The Quality Management Specialist supports QI activities at the health plan level. The Quality Management Specialist reports to the Associate Director of Quality Management and also communicates routinely with the Chief Medical Officer regarding quality of care issues. The Quality Management Specialist manages the health plan Quality of Care and Credentialing functions, prepares quarterly regulatory reports, manages investigation of peer review and quality of care issues and interfaces with the CMO, Health Services, and Medicaid Operations, and Administrative management to ensure appropriate resolution of quality of care issues throughout the health plan. Oversight of these activities is reviewed at the Physician Advisory Committee (PAC) meeting and by the Quality Management Committee (QMC).

**Quality Management Health Educator**
Within the Quality Improvement unit, the Quality Management Health Educator is responsible for developing and implementing CQI initiatives designed to ensure members receive timely preventive health services. The Health Educator reports to the Associate Director of Quality Management and works with national and UnitedHealthcare Community Plan HEDIS, staff, CQI teams in Health Services, Operations, and others throughout the health plan to effectively coordinate performance improvement initiatives. The Health Educator is responsible for leading the EPSDT program, and all other prevention and wellness activities implemented as well as coordinate collaborative initiatives with community organizations. Oversight of these activities is reviewed at the Healthcare Quality and Utilization Management Committee (HQUM) meetings and by the QMC.

**HEDIS RN**
Within the Quality Management unit, the HEDIS RN is responsible for developing and implementing CQI initiatives designed to assist providers in delivering timely and effective health services. The HEDIS RN reports to the Associate Director of Quality Management and also works with other external departments such as case management provider relations staff and operations staff to resolve provider issues which impact quality. The HEDIS RN is responsible for analysis and review of quality outcomes at the provider level, provider education on quality programs, monitoring and reporting on key measures to ensure providers meet quality standards. Oversight of these activities is reviewed at the HQUM meetings and by the QMC.
Utilization Management Department:
The Utilization Management (UM) department functions as a multi-disciplinary team that places the member in the center of all activities. All UM decisions are based on appropriateness of care and service and the existence of coverage. UM decision makers are not rewarded for issuing denials of coverage or care nor do they receive financial incentives that encourage decisions that result in underutilization.

Physician Reviewer Qualifications and Responsibilities:
• Maintain a current non-restricted license to practice medicine in the State
• Demonstrate adequate education, training and clinical experience in a medical or clinical practice setting to utilize medical appropriateness criteria and other applicable review standards or medical policy
• Ability and credentials (e.g., Board Certification) to review cases for which a clinical decision cannot be made by the first level reviewer
• Ensure reasonable availability, within one business day, to discuss clinical determinations with the attending or ordering physician
• Obtain consultations from specialist physicians if indicated
• Become and maintain credentialed status with AmeriChoice

UM Medical Director Qualifications and Responsibilities
• Maintain a current non-restricted license to practice medicine in the State
• Demonstrate adequate education, training and clinical experience in a medical or clinical practice setting to utilize medical appropriateness criteria and other applicable review standards or medical policy
• Develop and implement clinical (medical and/or behavioral health) components of UM Program.
• Develop clinical strategies to improve UM policies, procedures, processes and outcomes.
• Oversee clinical decision making activities of UM staff.
• Develop clinical policies, procedures and programs.
• Oversee clinical appeals process/decision making.
• Facilitate grand rounds and case conferences.
• Become and maintain credentialed status with AmeriChoice

Manager of Clinical Resource Management Responsibilities
• Develop and implement UM Program.
• Develop operational strategies to improve UM, procedures, processes and outcomes.
• Maintains registered nurse license in the State
• Monitor key performance and outcomes indicators indicative of program success.

• Collaborate with other department heads and external customers (e.g. PHOs, hospitals, home health agencies, community agencies) to facilitate coordination of activities to achieve goals

**Case Management Department:**

UnitedHealthcare Case Management (CM) Programs serve to optimize the health and wellbeing of members with chronic illness or at high risk for adverse medical outcomes. To accomplish this, AmeriChoice has developed comprehensive CM Programs that are member-centric and facilitate collaboration between members and their health care teams. Case managers promote member self-management, active decision-making, and participation in health care interventions and outcomes.

Case Management is based upon the premise that collaboration among the member, support systems, and health care professionals result in the development of partnerships that promote targeted interventions and health care goals which contribute to improving health care outcomes. This coordination of care provides an opportunity for an improvement in the quality of care continuum. This integrated CM Program offers services that address the entire continuum of clinical and psychosocial needs utilizing data analytical processes to assist in providing evidence on the improvement of care and services. We strive to empower the individual member to become successful in managing their chronic disease or condition.

CM staff is available through a toll free number from 8 a.m. to 5 p.m., Monday through Friday. All callers have the option to speak with an organizational representative at any time during business hours. Callers with rotary phones are given the option to speak with an organizational representative. The member service line is available 24 hours per day and seven days per week.

In our effort to make CM services accessible and user-friendly, the Plan employs registered nurses with diverse foreign language capabilities, including Spanish. This effort will be a part of our strategy to employ individuals whose language skills and cultural backgrounds mirror that of the enrolled population. To the extent possible, we will hire nurses that can accommodate these prevalent languages and communicate with our members.

To supplement our staff’s capabilities, we will also contract with a Language Line provider and call center translation services. The Language Line service offers a breadth and quality of services sufficient to meet member and provider needs. Specifically, Language Line services can provide staff with specific experience in clinical translation and provide support for provider-member interactions.

To address the needs of our hearing impaired members, UnitedHealthcare Community Plan relies on the capabilities of the National Relay System. By using the Relay system, calls from hearing impaired members are routed through the same system as all other calls, resulting in the same high quality service and efficiency of the call center.

In accordance with program performance standards and expectations, the UnitedHealthcare Community Plan CM Program services routine after-hour calls through a voice mailbox. A member of the CM staff returns all messages that are left in this mailbox the next business day. To promote member safety, callers will receive clear instructions regarding circumstances under which they should call “9-1-1” to address after-hours emergencies.
**Associate Director Medical and Clinical Management**

- Execution of Medical Cost Management Programs
- Contractual Compliance with Requirements of Medical Management Programs
- Medical Cost Management Reduction in IP, OP and Physician Costs
- Implement HCAIs
- Multidisciplinary ICCT Performance
- Staffing and Development
- OFR and Regulatory compliance
- Provide scorecard reporting weekly, monthly and quarterly at the individual, team and health plan levels
- Develops, translates and executes strategies or functional/operational objectives for an ICCT team including medical management, financial accountability, customer and Provider satisfaction, quality improvement
- Directs others to resolve highly complex or unusual business problems that affect major functions or disciplines
- Drives programs that impact markets of customers and consumers.
- Ability to work autonomously to identify issues, craft action plans, and implement changes to positively impact business function
- Ability to promote cross-functional teamwork and fact based decision making
- Ability to lead, develop and coach an ICCT a team
- Ability to understand financial modeling and analysis used in making decisions
- Ability to track and trend data, identify opportunities for improvement and communicate out effectiveness
- Ability to identify training opportunities and deficiencies and work closely with training team
- Experience with identification of operational efficiencies to enhance operations, reduce operating costs, and standardize best practices across the organization
- Problem solving skills; the ability to systematically analyze problems, draw relevant conclusions and devise appropriate courses of action
- Ensures team compliance with all regulatory requirements.

**Specific Education Background:**

- Clinical Registered Nurse with current licensure required
• Bachelors degree in Science or Business required; Masters degree preferred

• 8+ years clinical practice experience

• 5+ years experience in Medicaid and/or Medicare health care and insurance industry, including regulatory and compliance requirements

• 4+ years demonstrated leadership and team development skills

• Proficiency in software applications that include, but are not limited to, Microsoft Word, Microsoft Excel, Microsoft PowerPoint

• Demonstrated ability to assist with focusing activities toward a strategic direction as well as develop tactical plans, drive performance and achieve targets

• Problem solving skills; the ability to systematically analyze problems, draw relevant conclusions and devise appropriate courses of action

• Excellent verbal and written communication skills; ability to speak clearly and concisely, conveying complex or technical information in a manner that others can understand, as well as ability to understand and interpret complex information from others.

**Inpatient Case Management (ICM):** Registered and Licensed Practical Nurses with current Maryland licenses provide inpatient continued stay review for members in an acute or sub-acute setting. Nurses performing concurrent review are responsible for applying Milliman Care Guidelines to determine appropriateness of inpatient stay. They work with hospitals and doctors to ensure that services are provided at the appropriate level of care. They facilitate discharge planning and refer members that would benefit from ongoing Care Management services.

**NICU Case Manager:** Registered Nurses with current Maryland licenses, provides Case Management services for all babies who remain hospitalized after birth and coordinates post-discharge services. Success of this program depends on early identification of pregnant members and frequent prenatal Case.

**Special Needs Case Management:** Special Needs /HIV Coordinator reviews HRA’s, HIV/AIDS lab data, assists with UnitedHealthcare Community Plan’s enrollee action line, reviews specialty referrals issued by physicians, uses diagnostic and procedure code information to identify members with special needs, participates in external and internal provider/member advocate committees, and routinely attend State and community meetings.

**Case Management (CM)** includes a team of two Licensed Social Workers, eight Registered Nurses with current Maryland licenses and three non clinical staff. The Case Management Department provides ongoing service to members with a wide variety of needs. These services include, but are not limited to:

• Discharge planning

• Coordination of treatment plans with physicians

• Member education regarding treatment plans and/or chronic conditions

• Monitoring compliance with treatment plans and physician visits
• Identification of and contact with members who might benefit from Care Management services

• Assisting members with the resolution of social issues which impact compliance with treatment plans, e.g. arranging delivery of prescriptions for members with transportation issues

• Coordinating services between mental health, substance abuse, and somatic health

Chronic and Complex Case Management: The objective of the Complex/Chronic Case Management program is to provide ongoing education to members regarding their disease process and to help members achieve an optimal level of independence through a variety of Case management interventions. The Care Management Department provides ongoing service to members with a wide variety of needs. These services include, but are not limited to:

• Discharge planning

• Coordination of treatment plans with physicians

• Member education regarding treatment plans and/or chronic conditions

• Monitoring compliance with treatment plans and physician visits

• Identification of and contact with members who might benefit from Care Management services

• Assisting members with the resolution of social issues which impact compliance with treatment plans, e.g. arranging delivery of prescriptions for members with transportation issues

• Coordinating services between mental health, substance abuse, and somatic health

These services are provided telephonically or face to face depending on the members’ needs.

**Discharge Follow-up Calls**

Care Coordinators identifies members discharged from an inpatient stay with a complex or serious medical condition from the daily MD Census. “Welcome Home Calls” will be directed at assuring timely assessment of those conditions, including medical procedures to diagnose and monitor them on an ongoing basis. The HARC will provide timely discharge calls to all identified members provided from the daily MD census. Care Management will assure the establishment and implementation of plans of care, address medication issues, provide follow up on discharge instructions and address appropriate home health care. Care managers will assure access to specialists to accommodate the plan of care. These efforts will be coordinated by the designated care manager.

Care Management will coordinate programs and assure timely access and cost-effective quality health care service delivery to members with complex, serious, and sometimes fatal chronic conditions, such as end-stage renal disease, cancer, and medical device technology dependent children or complex conditions such as Asthma, Chronic Obstructive Pulmonary Disease (COPD), Cardiovascular Disease (CVD), and Diabetes Mellitus (DM).
**Transitional Coaching Model**

The transition coach (Nurse/Nurse Practitioner) works with patients and their families to improve care in four areas, referred to as “pillars”: medication self-management, the creation of a personal health record (PHR) maintained by the patient, obtaining timely follow up care and developing a plan to best seek care if particular target symptoms arise. Each of these goals allows the patient to actively enhance the quality of care received.

**Healthy First Steps**

The Healthy First Steps (HFS) Program ensures a proactive integrated delivery of a member’s care throughout her pregnancy. The obstetrical (OB) team is responsible for coordinating a member’s care from the onset of pregnancy, through delivery, and their postpartum checkup. This integrated system is efficient and comprehensive for both members and providers. From the onset of pregnancy, providers contact one individual who can assist with all their needs. This approach enables the team to capture high-risk pregnancies early on and immediately refer to the OB case manager. Further, members who are hospitalized during their pregnancy will work with their OB case manager, therefore ensuring a continuity of care after discharge. The OB case manager is involved with concurrent review as well as case management activities. Additionally, the case manager follows NICU cases after delivery, ensuring continuity of care, discharge planning, and referrals as needed to the pediatric case manager.

The ultimate goal is to ensure the highest quality of care for pregnant members and facilitate a proactive approach toward promoting healthy pregnancies:

UnitedHealthcare Community Plan implemented a high risk prenatal program to proactively identify all pregnant members with risk factors and provide case management in order to achieve optimal birth outcomes.

Several mechanisms are used to identify members at risk through us of such tools as Health Risk Assessments (HRA), Emergency room reports, utilization management and the daily census.

A dedicated OB case manager with extensive experience in obstetrics attempts to contact all identified high risk pregnant members to confirm the level of risk and target contact frequency. A pregnancy is considered high risk when a risk factor is identified for a preterm delivery or a poor pregnancy outcome due to medical, nutritional, psychosocial or compliance issues. Members are contacted as often as necessary, but minimally case managers make monthly telephone contacts with these members. Member education and outreach is an important part of the prenatal program. Members are educated regarding the importance of timely prenatal care during the initial assessment and when follow-up contact is made. Members are educated on the avoidance of drugs, alcohol, smoking, and also preterm labor signs and symptoms. The prenatal case manager makes referrals to educational or community resources for those members identified with needs. Members receive a prenatal educational packet and a congratulatory letter which includes the prenatal case manager’s name and phone number. Members receive free transportation to all medical appointments and to the pharmacy.

UnitedHealthcare Community Plan partners with Alere Health Care to provide services for members in the home setting when appropriate.

The OB case manager makes every effort to work closely with the member’s obstetrician to support the treatment plan and coordinate any necessary care. The prenatal case manager educates providers about the services offered to their patients.
Providers are encouraged to refer high risk pregnant members to the program as well as those members who exhibit non-compliant behavior.

Postpartum contacts are attempted for all members who were in case management and for those members who had a complicated pregnancy. Members receive a postpartum letter encouraging follow-up visits for mom and for the newborn. The letter also encourages immediate contact with the OB provider for any physical or emotional concerns. The phone assessment attempts to educate the member on the importance of the six weeks postpartum visit, the newborn visit with the pediatrician, and possible referral to Member Service if pediatrician assignment wasn’t done prior to delivery. Members receive a postpartum packet that includes an immunization schedule and information about lead level testing. A referral to the pediatric case manager is made if the infant needs additional services or coordination of care.

The objective of the HFS Case Management program is to create a structure that consistently:

- Increases early identification and enrollment of expectant mothers
- Assesses the risk level of each member and directs them to proper care
- Increases the member’s understanding of the importance of early prenatal care
- Encourages self-management of the pregnancy
- Ensures appropriate postpartum and newborn care and
- Fosters a solid physician-member partnership throughout the process.

HFS goals are to:

- Ensure healthy outcomes for mothers and their infants through OB care management
- Increase program participation
- Decrease inpatient NICU lengths of stay and readmissions
- Decrease low birth weight and premature births
- Improve prenatal and postpartum HEDIS measures

HFS outreach is performed telephonically. Mothers are contacted telephonically and reminded to get their post partum check up and take their new infant for their 2 week checkup.

**United Behavioral Health:**

United Behavioral Health (UBH) assists UnitedHealthcare Community Plan in the delivery of its substance abuse benefit to members. There are three Complex Care Coordinators working at UBH that integrate outreach functions into their jobs. Complex Case Management staff provides ongoing education to members regarding their disease process and substance abuse benefits.
There is a high risk protocol in place for Medicaid members who are determined to be high risk either through recent or recurrent inpatient admissions, or through other indicators (e.g. unstable social environment, housing problems, and treatment failure). The high risk workflow is as follows: When a member is ready for discharge from an inpatient unit, the inpatient Care Manager assists with the discharge planning to ensure that there are aftercare plans in place.

Once a member is formally discharged from an inpatient unit, the inpatient Care Manager is responsible for making a Welcome Home call to the member to verify that the member understands the aftercare plans, and to provide any other assistance needed. Once this has been completed, the care is transitioned to a Care Manager who will monitor the member for compliance with treatment through regular contacts with the member, the treatment program, and any other sources of support for the member. Members are transitioned from the high risk program only after the care has been established by the UBH treatment team. They also outreach members based on Health Risk Assessments (HRA).

UnitedHealthcare provides substance abuse services to members. Participating specialists and UnitedHealthcare collaborate on an ongoing basis to improve quality of care and service to the Plan's members. The Associate Quality Director is involved in implementation of the behavioral health aspects of their QI Program. These activities include, but are not limited to, access and availability, practice guideline development, continuity and coordination of care between medical and behavioral health care, over and under utilization, complaints, grievances, and appeals, and triage and referral.

Customer Service Department:
UnitedHealthcare Community Plan Customer Service Representatives educate members when they call in with questions about benefits, procedures and services.

UnitedHealthcare Community Plan Customer Service ensures that hearing impaired or foreign language speaking members have equal access to Customer Services through the use of AT&T's Language Line (this Line offers translation services to members of most foreign speaking language) and TDY (this program offers translation services to those with hearing impairments). UnitedHealthcare Community Plan obtain support from the AT&T language line when considering how best to serve its non-English speaking members.

Additionally, if a member has to hold while waiting for a Customer Service Representative, they are able to hear educational promotions on UnitedHealthcare Community Plan's phone lines. These pre-recorded promotions educate members about such seasonal topics as: diet, heart disease prevention, asthma, outdoor safety, sun protection, immunizations, breast awareness, nutrition, flu prevention, diabetes management, dental, and holiday stress.

General Outreach Information:
It is the expectation of UnitedHealthcare Community Plan that network providers perform outreach to their panel members. It is critical that members receive outreach to remind them of need to receive routine health services, such as immunizations, mammography, lead screening to name just a few. UnitedHealthcare Community Plan notifies contracted providers about outreach requirements through the Provider Manual which is updated periodically. Information about outreach requirements is also issued to practitioners through visits by Provider Client Managers, newsletter articles and/or website postings. UnitedHealthcare Community Plan’s newsletters, postcards, and other health plan communications are printed in English and Spanish.
**Welcome Calls**

UnitedHealthcare Community Plan utilizes outreach staff managed under Hospitality, Assessment, and Reminder Center (HARC) to perform welcome calls. HARC is an outbound calling unit to perform new member welcome calls in an effort to educate members regarding their health care benefits. It reflects UnitedHealthcare Community Plan’s commitment to ensuring members are graciously welcomed into our health plans and that we quickly and accurately identify each individual’s health care needs.

HARC functions include:

- Welcome calls and health risk assessments for all new members
- Timely referrals to care management for members with significant health care needs
- Reminder calls about preventive care according to recommended schedules
- Reminder calls for members to renew their Medicaid eligibility
- Outreach calls during open enrollment periods

New members are identified from the new member report and outbound calls are made. The purpose of the call is to welcome members to UnitedHealthcare Community Plan, educate them about their benefits, conduct a Health Survey for those members without one, and assist with any service issues.

UnitedHealthcare Community Plan notifies enrollees about the importance of scheduling an initial appointment in order to establish a relationship with their primary care physician through UnitedHealthcare Community Plan’s Hospitality, Assessment, and Reminder Center (HARC). HARC representatives use a database to identify services each new member needs and to document their interactions with each member.

Backing up HARC is the vendor, Silverlink. This vendor performs outreach calls targeted to remind members about appointments, needed immunizations and common preventive health screenings. Silverlink also reminds members, on behalf of UnitedHealthcare Community Plan, of the appropriate time to renew their Medicaid eligibility. This activity helps improve member retention.

All combined, the functionalities offered by HARC and Silverlink represent a solid compilation of tools that leverage current technologies in ways that deliver a stronger experience of personalized care coordination for members.

**Member Newsletters**

UnitedHealthcare Community Plan’s corporate office distributes a newsletter, HEALTH TALK, to all enrollees on a quarterly basis. It reports on various health care issues, benefits and customer concerns, with an emphasis on health education. The Newsletter is printed in both English and Spanish (Attachment A).

**Website**

Members can access articles, discussions and links regarding specific topics or health care interest on-line through www.americhoice.com, our member internet site.
IV. Tracking and Monitoring Outreach Activities:

**Data Base and Software Applications**

After eligibility is determined, a welcome letter and new member handbook is mailed to the member. This packet informs the member how to use Outreach services, member handbook, and member rights. Once the member is engaged and when requested the staff sends program and health education materials to the member.

UnitedHealthcare Community Plan uses several data systems to manage and perform outreach services to members. These data systems include Diamond, CarePlanner, Appointment setting software, Microsoft’s suite of applications (Word, Excel, and Power Point), Outreach database, Med measures, and the Internet. A Health Risk Assessment reporting program is utilized to tailor the enrollment data received from DHMH to conduct outreach within required timelines, and to report to local health departments and the Department of Social Services, when appropriate.

The desktop working system employed by UnitedHealthcare Community Plan Quality, Outreach, and HEDIS staff is a Windows based system that allows easy access to all functional areas including claims, customer service, health services, provider, enrollment, and eligibility.

The Health Services Department utilizes CarePlanner. In addition to serving as a tool for documentation for authorization of services, it contains screens for documentation of clinical notes, including outreach activities. Cases are accessed by a Care identification number and can be viewed and updated by any staff member with access privileges.

The Outreach staff utilizes a customized Microsoft Access Database. The Database uses member population data, based on HEDIS specifications, from Med Measures software for specific HEDIS measures. The application identifies members who are missing specific clinical services, such as childhood immunizations. In addition to facilitating outreach by telephonic means, the database can produce reminder/appointment letters to members, production reports, and listings to physicians of all members enrolled in their practice that are in need of outreach. The database system is supplemented through the SMART Data Warehouse for claims research, member demographics and provider information (such as OBGYN and vision provider lists) to enhance appointment scheduling.
V. Community Partnerships

UnitedHealthcare Community Plan has continued to develop and maintain various partnerships within the community it serves. These relationships were developed in an effort to reach out to our current and potential members with the goal of responding to individual and community concerns.

In 2010, our focus was to strengthen our relationships in the community with our advocates and members as well as member retention. As a result, we teamed up to make our presence known and spread awareness about our products, services, and social responsibility. We wanted the community and membership to understand that UnitedHealthcare Community Plan is more than an insurance company. We accomplished this by continuing to provide hands-on assistance to our members with the goal of empowering them to take control of their health. This was accomplished through benefit education, navigation of the health plan, and question to ask the doctor. UnitedHealthcare Community Plan continued to bridge the gap between the member and access to social needs through our partnerships in the community.

We hosted the following:
• Community hub sites,
• Faith Based Initiative àGet Fit Weight Loss Challenge (started 6/12- 300lbs),
• Focus with Quality on back to school drive August 19 utilizing Connected Care mobile)
• Community Grants with nutrition focus (Sesame Street, 9/1).
• Sesame Street Campaign (Educational DVDs 4th Quarter, Title 1 schools, daycare centers, and Head Start).
• Held town hall resource meetings in the communities.

The hub sites served as our vehicle to educate members face-to-face and allow them to put a face with the health plan. Here are a few of the locations we partnered to create these hub sites:
• Baltimore County Head Start
• Franciscan Center
• Total Health Care
• Prince George's County Head Start
• Charles County Children's Aid Society
• The Woman's Resource Center
• The Mary Center
• Catholic Charities
• Howard County Salvation Army

This hub initiative has allowed us to interface with several of our members and address their individual health care and social needs. This information learned is analyzed and assists the health plan with our future marketing and outreach efforts.

Another relationship is the partnership between UnitedHealthcare Community Plan and its Consumer Advisory Board. The Board’s purpose is to provide a format for communication between members and UnitedHealthcare Community Plan staff. The Board meets bi-monthly and has about twelve members. The objectives include, but are not limited to, reviewing member concerns, health education, offering community resources, and developing initiatives to add value added services. The Board reviews member educational materials, marketing information, newsletters, and other relevant communication in order to provide valuable input for process improvements.
Topics Discussed at the 2010 Consumer Advisory Board Meeting:

- Member Materials
- UnitedHealthcare’s Provider Network
- Community Events
- CAHPS Survey-Health Plan Report Card
- When You Go To The Doctor
- Outreach Initiatives-Diabetes, Asthma, Maternity, Dental
- Women’s Health
- Healthy Eating & Nutrition
- Maryland Healthy Smiles
- Immunizations
- H1N1 & Flu Virus
- HEDIS and Health Education Overview

UnitedHealthcare Community Plan participated in many community events and health fairs in CY 2010 (Attachment B). We will continue to participate in community events and health fairs statewide.

Additionally in 2010, we continued to improve our health services through our Community Advisory Committee. The board is dedicated to local health departments, providers, community and faith based organizations that serve the Medicaid population. UnitedHealthcare travels this board around the state and meets bi-monthly to discuss opportunities and address challenges that may plague specific counties. Our goal is to improve our services and learn specifically from those utilizing our services. Here is a list of the counties visited this year:

- Montgomery County
- Baltimore City
- Baltimore County
- Frederick County
- Howard County
- Prince George's

Finally in 2010, UnitedHealthcare enhanced their provider marketing program to focus more on servicing our providers. The Provider Advocates insures that providers are equipped with the tools they need to service the members and access the UnitedHealthcare provider portal. UnitedHealthcare Community Plan will continue to collaborate in community events and partnerships with a common goal of educating the community of the importance of receiving quality healthcare.
UnitedHealthcare Community Plan staff works closely with the Local Health Department (LHD) to locate or contact UnitedHealthcare Community Plan members and encourage them to get preventive or chronic health services. UnitedHealthcare Community Plan staff collaborates with the Local Health Department (LHD) to fulfill outreach and transportation referrals as outlined in the current COMAR regulatory requirements.

**Outreach**

If the LHD is successful in finding the member, Outreach updates the demographic information and proceeds with efforts to getting the member into care. If the LHD is not successful in finding the member, the health plan is notified, and the outreach case is closed.

There are relationships that exist between UnitedHealthcare Community Plan and all LHDs. In these partnerships, UnitedHealthcare Community Plan and LHDs work on processes to improve services to members. UnitedHealthcare Community Plan attends meetings held by the local health departments. The LHDs and MCOs address member and provider related topics. UnitedHealthcare Community Plan works with the LHDs to find solutions to problems, determine better methods of access and care coordination, and identify opportunities for greater physician involvement. UnitedHealthcare Community Plan is in talks with several LHDs regarding collaboration for case management services.

UnitedHealthcare Community Plan will continue working with all LHDs in CY2009 on outreach efforts, local events and other activities in order to better serve enrollees.
VII. Role of Provider Network

In order to ensure UnitedHealthcare Community Plan enrollee has every opportunity to access needed health related services, providers must collaborate with Healthy Kids, Healthy Start, Specialty providers, and UnitedHealthcare Community Plan health plan to schedule routine and follow up appointments in accordance with the enrollee’s treatment plan by attempting various notification methods which may include written, telephonic, or face to face contact.

It is the expectations of UnitedHealthcare that providers will perform the above mentioned outreach mechanisms to the members assigned to them. It is critical that members receive outreach to remind them of the following, but not limited to medical, preventive, or routine health services, such as immunizations, mammography, or lead screening.

The following are recommended methods:

• Postcards – as an example; as children are having a birthday to remind parents/guardians to bring the child in for routine care, vaccines etc.

• Reminder calls – placing phone calls to members and their families to ensure they receive necessary services

• Letters to families reminding them of needed health care services

• Referrals to the Health Plan or Local Health Department in the event a member can not be found or has missed several appointments.

• Provider can also see our Provider manual for documents that can assist with the referral of non compliant members.

UnitedHealthcare Community Plan’s Chief Medical Officer, Medical Directors, Provider Advocates and HEDIS staff routinely visit, educate, and produce profile reports which compare providers against their peers in quality and utilization indicators. The HEDIS team provided recommendations for outreach initiatives and take steps to address opportunities for improvement when identified.

The Outreach Plan outlines UnitedHealthcare’s multifaceted outreach activities for CY 2010, we will continue to explore, strategize measure, collaborate, and assess ongoing activities to ensure our member and provider partners receive the most effective healthcare service.

At its core, the Outreach Model is a way for us to deliver better service to members, improve provider and regulator satisfaction, and reduce costs. The model leverages Community, Local, National and Regional services available due to the scale and experience available within Maryland. The result is efficiency and scalability that allows UnitedHealthcare Community Plan to focus on nurturing key constituent relationships and delivering high value services at the local level, where it matters most. We strive to empower the individual member to become successful in managing their medical or preventive health needs.

Evaluation of the Outreach Program

Annually, the staff evaluates the Outreach Program to determine based on National and State quality metrics the success of the member and provider interventions. This information is reported to the appropriate health plan committee(s) and is included in the annual Quality Improvement (QI) Program evaluation.