UnitedHealthcare®
Community Plan

This summary report is being published at the request of the State of Maryland.

Maryland
2017 - 2018 Outreach Program Plan

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I. Overview of UnitedHealthcare Community Plan

A. Mission

UnitedHealthcare is a business unit of UnitedHealth Group. UnitedHealthcare is one of nine health plans participating in the HealthChoice Program. We are recognized by the Maryland Department of Health (MDH) as a Managed Care Organization (MCO) providing health care services to Medicaid members in Maryland.

B. Objective

The objective of the Outreach Program is to employ practical solutions to this culturally and linguistically diverse population with complex medical, behavioral, and social conditions. Our goal is to improve the health status by addressing care opportunities for approximately 155,000 members. The Outreach Program is a member and provider centric model designed to use several data sources to identify members in need of medical services. Once identified, several approaches are used to assist with scheduling medical appointments including telephonic outreach (live and interactive voice recording); providing health information via the member newsletter and member website; sending reminder letters; and using a contracted vendor to promote and support closure in gaps of care by completing in-home assessments. The Outreach staff educates members about the importance of maintaining good health by keeping scheduled appointment(s) for preventative care and consistent management of their chronic condition(s) as well as reducing identified barriers to care.

C. Member and Provider Outreach Programs

In-Office Appointment Scheduling Outreach Program:

Outreach begins with a 'Welcome Call" to all new enrollees informing them of the necessity of scheduling and completing an Initial Health Appointment with their primary care provider (PCP). Procedures are in place to determine if appointments are scheduled and completed. UnitedHealthcare will work with members, their PCP, and Local Health Departments to schedule and complete the necessary appointment(s). Monthly and quarterly Productivity Report analysis are used to determine the number of members receiving telephonic or written outreach; the number and type of follow-up attempts made; and the number of appointments scheduled.

UnitedHealthcare's Network Management Partnership

UnitedHealthcare Community Plan works collaboratively with UnitedHealthcare Network Management. The goal is to provide information to providers about their quality performance scores and promote adherence to State of Maryland quality performance criteria while providing support resources to aid in accomplishing goals. The collaboration between the health plan and network providers is to help ensure adequate knowledge of their contractual and regulatory obligations to promote and support the well-being of UnitedHealthcare members; their patients.

Summary of Overview

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

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

Communication with internal departments, including operations, case management, special needs, member services, and utilization review and provider relations is ongoing to promote the continuity of care and to work collaboratively on individual cases, when indicated.

Educational and member-specific information is submitted to providers by the Senior Quality RNs on a routine basis to provide up-to-date screening guidelines and notification of members among their panel who are due for screening. On-site visits to providers 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 provider educational efforts. These resources may also be used to coordinate services and/or to identify additional means of contact for hard-to-reach members.

UnitedHealthcare emphasizes and encourages preventive health education and management of chronic conditions regularly, which includes completing an annual physical, age-appropriate immunizations, and routine screenings. UnitedHealthcare staff work with community organizations, such as the Healthy Kids Program and Local Health Departments to help ensure there are no access barriers to the care they need.

UnitedHealthcare's current multifaceted outreach efforts, tracking databases as well as continued evaluation of strategies, will continue in 2018. The objective is to exceed performance expectations of our customers and partners such as members, government and providers, by providing important information to members and providers about health plan activities, benefits, and community events while consistently identifying strategies to improve member, provider and community partnerships.

II. Membership Profile
Note: *Data is from 1/2017– 10/2017*

A. Population Assessment
UnitedHealthcare is comprised of the following groups (1) families receiving Temporary Assistance for Needy Families (TANF), and (2) individuals receiving Supplemental Security Income (SSI) benefit.

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

Special Needs Population	Calendar Year 2015	Calendar Year2016	Calendar Year 2017
Children with special health care needs	2,643	2,588	2,529
Individuals with a physical disability	3,612	2,654	2,390
Individual with a developmental disability	1,126	3,822	3,886
Pregnant and postpartum women	6,302	4,796	4,225
Individuals who are homeless	641	812	728
Individuals with HIV/AIDS	724	805	859
Individuals with a need for substance abuse treatment	9,341	6,720	4,972
Children under State supervision	2,673	3,098	2,950

Figure 1 – 2017 Membership

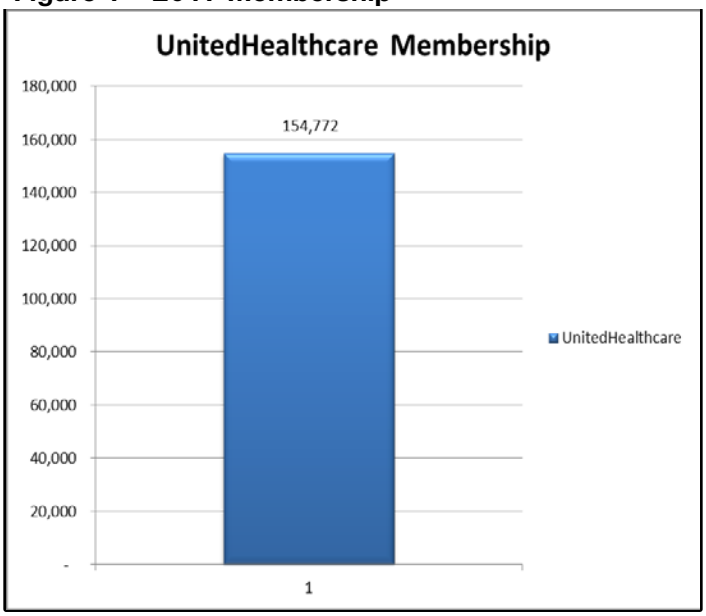


Figure 2 - Medicaid Managed Care Market Share

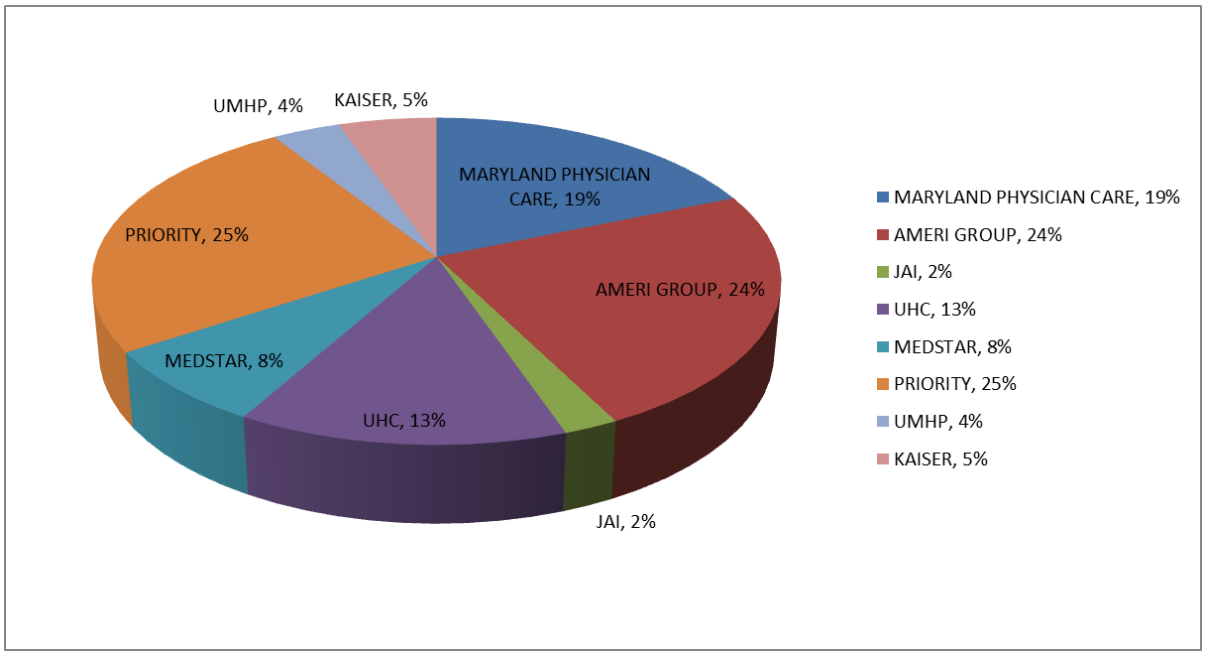


Figure 3 – Membership Race and Ethnicity

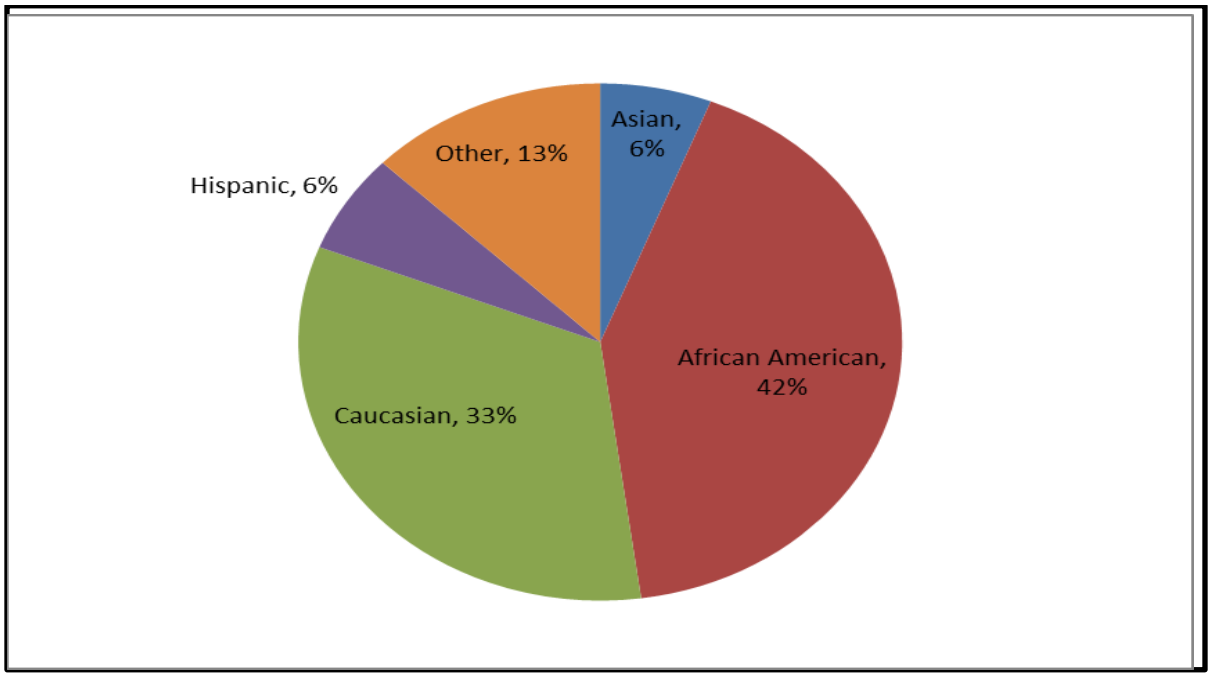
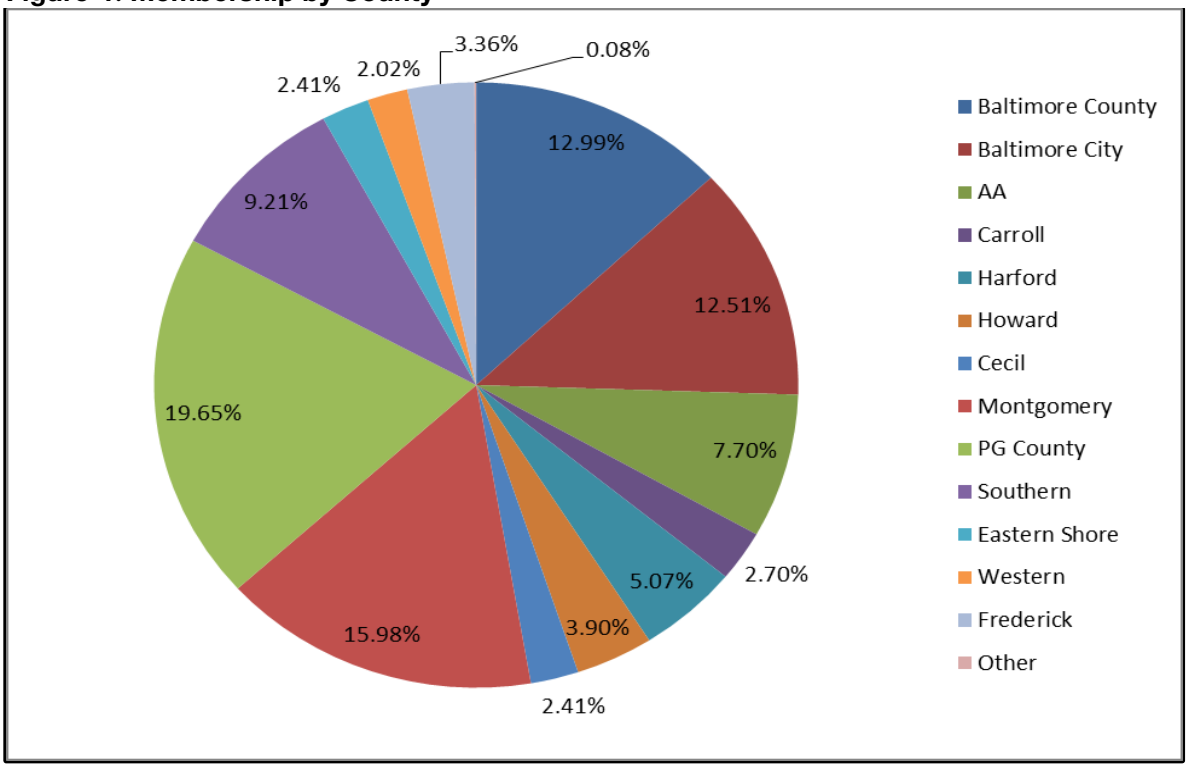


Figure 4: Membership by County



B. Common Health Diagnoses

The following is an analysis of UnitedHealthcare's most common inpatient, outpatient and Emergency Department utilization by diagnosis:

Top 10 Inpatient Diagnoses	Top 10 Outpatient Diagnoses
1. Sepsis, unspecified organism	1. Acute upper respiratory infection
2. Post- term pregnancy	2. Chest pain unspecified
3. Maternal care for low transverse scar from previous C/S	3. Unspecified abdominal pain
4. Muscle weakness generalized	4. Other chest pain
5. Abnormality in fetal heart rate and rhythm complicating labor & delivery	5. Viral infection unspecified
6. Chronic obstructive pulmonary disease with acute exacerbation	6. Headache
7. Single live born infant delivered by C/S	7. Unspecified asthma with acute
8. Streptococcus B carrier state complicating childbirth	8. Urinary tract infection, site not specific
9. Alcohol dependence with withdrawal	9. Low back pain
10. Acute kidney failure unspecified	10. Fever unspecified

Top 5 Emergency Department Diagnoses
Acute upper respiratory infect
Unspecified abdominal pain
Chest pain unspecified
Viral infection unspecified
Headache

Based on the varying diagnoses for the three settings, different outreach and care management strategies are employed. With UnitedHealthcare's cross-departmental, provider and community outreach approach, all three populations (children, women, and adults with disabilities) are managed differently, but appropriately.

C. Quality Performance

Maryland Department of Health (MDH) measures UnitedHealthcare's performance individually and all Managed Care Organizations (MCOs) collectively through several initiatives, including audit and analysis of the Medicaid HEDIS and Maryland State Value Based Purchasing (VBP) encounter reports. In addition to the clinical inpatient, outpatient, and Emergency Department outreach opportunities identified, the following HEDIS and Value Based Performance (VBP) measures are tracked to help ensure initiatives are implemented to close gaps in care:

Quality Performance Measures	
Well-Child Services	Controlling Blood Pressure
Immunizations	Adult Body Mass Index Assessment
Comprehensive Diabetes Care	Asthma
Pregnancy Related Services	Lead Screening
Well-Women Services	Supplemental Security Income (SSI) - Adult and Child

Managed Care Organization Dimensions	Performance Measures	UnitedHealthcare Rate HEDIS 2016 Calendar Year 2015	UnitedHealthcare Rate HEDIS 2017 Calendar Year 2016
Access to Care	% of adolescents 13 years of age during the measurement year who had one dose of meningococcal vaccine and either one Tdap or Td vaccine by their 13th birthday	71.11% Admin** 84.80% Hybrid**	69.98% Admin 86.37% Hybrid (reported hybrid)
Access to Care	% of SSI adults enrolled 320 or more days with at least one ambulatory service during the year	81%**	79%*
Access to Care	% of SSI children enrolled 320 or more days with at least one ambulatory service during the year	80%**	79%*

Access to Care	% of deliveries by a pregnant woman who had a postpartum visit on or between 21 and 56 days after delivery	66%	70.62%
Use of Services	% of children ages 12-21 receiving at least one well-child visit with PCP during the year	65%	62.63%
Use of Services	% of children ages 3-6 receiving at least one well- child visit with PCP during the year	81%	82.59%
Effectiveness of Care	% of children who turned two and who received combo 3 (all childhood immunizations) by their 2nd birthday	81%	77.86%
Effectiveness of Care	% of children ages 12-23 months enrolled 90 or more days who received lead testing during the measurement year.	57%**	58%*
Effectiveness of Care	% of women ages 21-64 receiving at least one PAP test during the last 3 years	60%	68.61%
Effectiveness of Care	% of diabetics that received a dilated fundoscopic eye exam during the year	55%	56.93%

Note: *Rate received from the State **Rate Adjusted

D. Identified Barriers to Care

Based on member and provider reports, UnitedHealthcare develops targeted outreach to reduce barriers to care. A number of strategies are employed to contact members as soon as possible after enrollment. For example, a contracted vendor is used to search for updated member demographic information and contracted vendor provides the medical service in the member's home. All contact attempts are documented to ensure all options have been exhausted. Members who cannot be contacted after several attempts are referred to their Local Health Department for follow up in accordance with Code of Maryland Regulations (COMAR).

Member Barriers

- Knowledge deficit occurs because the member may not possess sufficient knowledge of and/or adherence to the treatment plan after diagnosis. The member may also have poor understanding of the cause of the disease/condition and the medical treatment and management of the disease/condition. There may be inconsistent adherence to prescribed medications because the medication is perceived as not helping or causing other symptoms, which the member relates to the medication.

- Lack motivation/ability to visit primary care provider (PCP) for monitoring of their condition or difficulty making and attending appointments due to competing priorities. Additional reasons can include lifestyle changes, behavioral challenges, substance abuse, homelessness, as well as presence of multiple comorbidities requiring multiple PCP and specialist visits.

- Insufficient member knowledge of covered benefits, for instance transportation coverage to PCP's office, durable medical equipment or formulary versus non-formulary medications.

- Inaccurate member contact and demographic information makes it difficult to contact the member to provide health education or schedule appointments.

- Supervision for multiple children may be a barrier to keeping an appointment. Attempting to schedule appointments for multiple children on the same day and approximate time can also be a challenge for the member.

- Lack of timely responses from social workers and the Maryland Department of Health pose a unique challenge for children in foster care as does identifying the physical location of member.

Provider Barriers

- Providers may have a knowledge deficit of HEDIS specifications and/or current treatment guidelines.

- Providers may not realize the number of missed appointments within their patient population.

- There may be a knowledge deficit of MCO resources to assist in member compliance, such as member outreach initiatives, available benefits and health education opportunities.

Regional Barriers

- Rural regions present the greatest challenges to successful outreach efforts. There are fewer specialists in Western Maryland and the Eastern Shore than in suburban and urban locations.

In 2018, outreach interventions will continue making every effort to contact members to schedule their appointment, address social or language/cultural barriers, provide health education to support and promote good health and well-being as well as reduce inpatient admissions and Emergency Department/Urgent Care visits.

III. Organizational Resources and Outreach Activities

Outreach is based on 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's Outreach Program offers services that address the entire continuum of clinical and preventive needs utilizing analytical data capabilities to assist in providing evidence on the improvement of care and services.

Multiple departments and vendors conducting member and provider outreach services both independently and interdependently are used to meet the goal of getting the member into care. Areas that perform outreach include the Departments of Quality Management and Performance (QM, Outreach and HEDIS unit), Marketing, Operations, Customer Service and Case Management.

Quality Management and Performance Department

Chief Medical Officer
The Chief Medical Officer (CMO) is a Maryland licensed physician with experience in quality management who is responsible for implementation of the Quality Management and Performance Programs. The Clinical Services Team meets with network providers to discuss their individual or practice profiles, which emphasize practice utilization and quality performance.

Director of Quality Management
The Director of Quality Management is responsible for oversight of the implementation of the Quality Management and Performance Program, including monitoring the quality of care and service UnitedHealthcare provides and the evaluation of quality improvement initiatives involving member and provider outreach. In addition, the Director of Quality Management maintains oversight of activities designed to increase performance on HEDIS; prepares annual quality improvement (QI) program documents; submits quality regulatory reports; has day-to-day responsibility for implementation of quality improvement studies; and patient safety initiatives. The Director of Quality Management works with the Compliance Officer to ensure quality programs are aligned with regulatory and accreditation standards. The Director of Quality Management reports to the Vice President of Quality, Northeast Region to ensure fiscal and administrative management decisions do not compromise the quality of care and service UnitedHealthcare provides to members.

Clinical Quality Manager
The Quality Manager supports Quality Improvement activities at the health plan level. The Quality Manager reports to the Director of Quality Management and communicates routinely with the Chief Medical Officer regarding quality of care issues. The Quality Manager prepares quarterly regulatory reports, manages quality of care issues and interfaces with the Chief Medical Officer (CMO), Health Services, Medicaid Operations and Administrative Management to ensure appropriate resolution of quality of care issues throughout the health plan.

The results of these activities are reviewed at the Service Quality Improvement Sub-committee (SQIS), Physician Advisory Committee (PAC) and Quality Management Committee (QMC) meetings.

HEDIS Quality Manager
The HEDIS Quality Manager is responsible for the direction and guidance on clinical quality improvement and management programs including accreditation. Conducts clinical quality audits and may be responsible for National Committee for Quality Assurance (NCQA) requirements. Responsibilities also include analysis and reporting of member care quality and the development of plans and programs to support continuous quality improvement using HEDIS and other tools.

The HEDIS Quality Manager works co-jointly with the Clinical Quality Manager, Health Educator and Outreach Supervisor to maximize work efforts. The Quality Manager present HEDIS updates to the appropriate Quality Management Committees. This position reports to the Director of Quality Management.

Senior Quality RN
The Senior Quality RN is responsible for analysis and reviews of quality outcomes at the provider level, provides education on quality programs, and monitors and reports on key measures to ensure providers meet quality standards**.** The Senior Quality RN reports to the HEDIS Quality Manager.

EPSDT Quality Nurse
The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Quality Nurse is responsible for ensuring EPSDT certified providers are fulfilling the MD Healthy Kids Program requirements outlined in the Healthy Kids Preventive Health Schedule via chart review. Additional responsibilities include, but not limited to offering education to support compliance of the Preventive Health Schedule, identify and share ESPDT on-line resources as well as confer with Chief Medical Officer to develop additional interventions to support compliance. The EPSDT Quality Nurse reports to the Clinical Quality Manager.

Outreach Supervisor
The Outreach Supervisor oversees the Clinical Administrative Coordinators, ensuring telephonic and mail outreach is maximized to reduce the total number of gaps in care by members. The primary goal of the Outreach staff is to improve UnitedHealthcare's member compliance with preventive and chronic health services. The Outreach Supervisor is also responsible for ensuring staff is well-versed on HEDIS measures, covered benefits, and resources to reduce barriers to care. The Outreach Supervisor reports to the Director of Quality Management.

Clinical Administrative Coordinators
Clinical Administrative Coordinators are dedicated to providing multifaceted outreach activities to bring the member into care to support chronic condition management and preventive services. Various data sources are used to determine members in need of care. The Clinical Administrative Coordinators report to the Outreach Supervisor

Senior Health Coach
The Senior Health Coach is responsible for the management of the Health Education Program including, but not limited to, assessing health education and information needs for members and providers; developing appropriate learning materials and programs; assessing program effectiveness and provide analytical summaries of the program participation.
The Senior Health Coach also writes topic-specific articles for the member and provider newsletter and participates in community or quality sponsored events. The Physician Advisory Committee (PAC) reviews oversight of these activities. This position reports to the Director of Quality Management.

Outreach Activities
Initial Health Appointment
New enrollees are called by the Hospitality Assessment Reminder Call (HARC) team to determine if an 'Initial Health Appointment' has been made and kept. If not, the Outreach staff assists the member in obtaining an appointment with their assigned PCP. A review of claims data is used to determine if the member kept the appointment. Several attempts are made to ensure the member keeps the appointment. If after several attempts, the member cannot be reached, a referral is sent to the Local Health Department for assistance.

Members Scheduled Appointment
A report is generated monthly to identify members who state they will independently schedule an appointment. Those members are called to confirm the appointment was either made and kept, or not kept. If the appointment was not scheduled or kept, the member is asked if they would like assistance rescheduling. If the member cannot be located, the member is referred to the Local Health Department for follow-up. The Local Health Department forwards their findings to UnitedHealthcare no later than 30 days of receipt of UnitedHealthcare's referral. All calls and dispositions are documented for future analysis.

Habitual No-Show or Missed Appointment
Providers practices are offered assist with outreaching to UnitedHealthcare members who are either a 'no-show' or who have missed three consecutive appointments. The practice can email or fax the "Missed Appointment' letter template to the Outreach staff. The staff makes every attempt using all available resources to contact the member; determine if there are barriers to keeping the appointment and reschedule the appointment.

If unable to contact the member after three attempts, a Local Health Department referral form is completed and forwarded for follow-up. The Local Health Department forwards their findings to UnitedHealthcare no later than 30 days of receipt of UnitedHealthcare's referral. All calls and dispositions are documented for future analysis.
Member Rewards Program
UnitedHealthcare provides members in need of specific medical services the opportunity to receive gift card rewards to select companies by completing those services by years end. Eligible members receive a mailer outlining the program including mailing back the attestation form as evidence that the service was rendered.

Baby Blocks
To support a healthy pregnancy and delivery of a healthy baby, pregnant and new moms are sent a mailer to register for the Baby Blocks Program. Members completing registration receive appointment reminders, gestational-age related health tips, and the opportunity to receive gift card rewards from select companies for completing varying milestone during the pregnancy, post-delivery visit, and the baby's initial pediatric visit .

UnitedHealthcare Community Plan Case Management Program

Unitedhealthcare's Case Management Program is a population-based, disease management program that prioritizes Transition Case Management and High-risk Case Management using member-centric interventions.

Transition Case Management
Transition Case Management (TCM) is a member-centric intervention designed to improve care for patients with care needs as they transition from the inpatient setting (acute inpatient, rehabilitation and SNF) to home. It is designed for members who are identified as highest risk for readmission within 30 days of discharge. The Registered Nurses (RN) assigned to manage the inpatient utilization of United Healthcare members complete a Risk Scoring Tool (RST) that assesses the risk of readmission for approximately 20% of their members who the RNs feel are at highest risk for readmission.

This assessment captures the member's hospitalization history, age, current length of stay, diagnosis, clinical condition, complexity of discharge needs, mental health status and the member's use of medications. United Healthcare has also created a Readmission Predictive Model (RPM) that is run against 100% of the members with an inpatient admission. This proprietary predictive model focuses on age , sex, current and historical admitting diagnoses, history of admissions, most recent length of stay, outpatient specialist's visits, use of durable medical equipment, use of prescriptions, and whether or not the most recent readmission was, itself a readmission.

Members with qualifying scores on the RST and /or the RPM are eligible for the TCM intervention. TCM is a short-term intervention that attempts to engage members in a discussion about their outpatient needs, barriers to accessing care, and to encourage compliance with timely ambulatory follow up. The goal of TCM is to improve care transitions by providing members with the tools and support to promote knowledge and self-management skills to prepare them for and support their transition between settings. Members identified as appropriate for High-Risk Case Management are referred for ongoing case management at the conclusion of the TCM intervention. The case management model consist of a multi-disciplinary team that includes health care physicians, psychiatrists, pharmacists, case management and maternity nurses, social workers, and field-based community health workers who are able to do face–to-face and telephonic case management. The case management model emphasizes the importance of a team approach by working with its members, providers, and other health care team members to promote a seamless delivery of health care services.

TCM focuses on four conceptual areas:

1. Medication self-management: Member is knowledgeable about medication and has a medication management system.

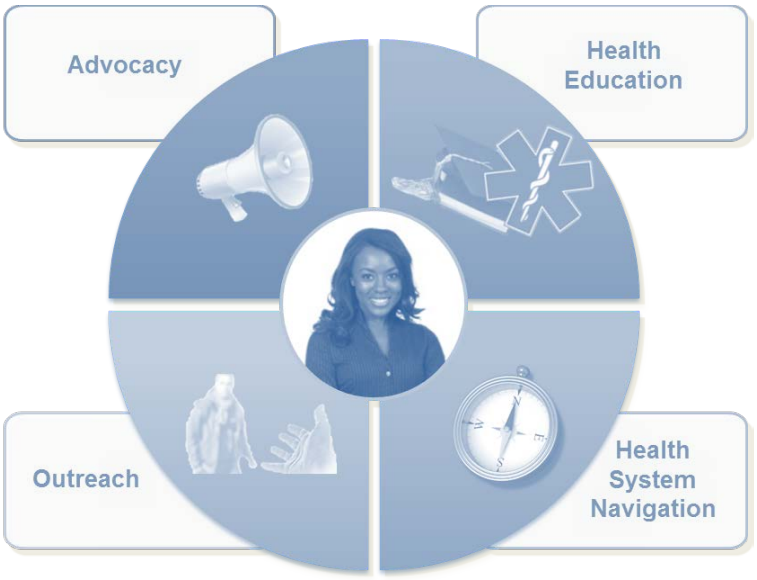
2. Primary Care and Specialist Follow-up: Member schedules and completes follow-up visits with the PCP or specialist physician and is empowered to be an active participant in these interactions.

3. Knowledge of Red Flags: Member is knowledgeable about indications that their condition is worsening and how to respond, and is educated regarding crisis resources in their community.

4. Educate member on use of a Personal Health Record to facilitate communication and ensure continuity of care across provider and settings.

High-Risk Case Management

High-Risk Case Management (HRCM) is a specialized, member-centric program for members identified as high-risk for out-of-home placement. All member claims data and demographics are run through a predictive model to identify those members who are Persistent Super Utilizers (PSU). PSUs are members who either have been high utilizers of emergency department/inpatient services or are predicted to be high utilizers of the same services in the coming year or they are predicted to be at high need of case management services in the coming year. Members who are identified and stratified as high-risk are eligible for HRCM. The goals of the program are to assess for compliance barriers, address any the unmet needs, and provide education and support to improve member self-care management skills.



Members appropriate for HRCM, are assigned a Case Manager who is responsible for member engagement, assessment and re-assessment. Case Managers monitor member's progress, collaborate with member and their caregiver or PCP and community resources.

At a minimum, Case Management 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. Coverage for after-hours includes the use of NurseLine services, which provide call escalation, triage and medical advice 24 hours per day, 7 days per week. The member service line is available 24 hours per day, 7 days per week.

The Case Management telephone line is accessible to all Case Management Program members and vendors, including providers, agencies, members, parents and caregivers. Contact information for the Case Management Line is included in all Case Management Program materials, including handbooks, newsletters, brochures and the web-site, and is advertised in Spanish.

In our effort to make Case Management services accessible and user-friendly, we employ Community Health Workers (CHW) with diverse foreign language capabilities, including Spanish. This effort is 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 hire nurses that can accommodate these prevalent languages and communicate with our members in their preferred language.

To supplement the staff's capabilities, a Language Line vendor and call center translation services are contracted. To address the needs of our hearing-impaired members, UnitedHealthcare relies on the capabilities of the National Relay System. In accordance with program performance standards and expectations, the UnitedHealthcare Case Management Program services routine after hour calls through a voice mailbox. A member of our Case Management staff responds to all messages left in this mailbox the next business day.

The Community Health Workers provide field based interventions to locate and engage members and connect them to the PCP, which includes coordinating appointments as necessary. The CHWs refer member to RNs or Behavioral Health Advocates for complex needs to address/remove barriers to care and access community resources and ultimately improve their ability to access care.

Whole Person Care (formerly known as Person-Centered Model – PCCM)
Optum Operations Department deployed a Whole Person Care (WPC) case management model. The WPCM folded Optum' s licensed Behavioral Health Department under the same management structure as the Case Management Team. It incorporates enhanced screening tools to capture a larger range of behavioral health issues to ensure a holistic approach to member needs, including medical, behavioral and social/environmental needs. The primary goal is to ensure the person receives the right care from the right providers in the right place and at the right time. At the member level, this Model ultimately leads to the development of Person-Centered Care, which leverages interdisciplinary teams and combines the resources of UnitedHealth Group with medical homes and other integrated care organizations to reduce costs and improve outcomes. The Person-Centered Care Model seeks to empower members, providers and our community partners to improve care coordination and improve outcomes for individuals with the most complex conditions. This is performed by providing market designated, field-based care management with the integration of medical, behavioral, social and environmental care, and Integrated Care Management Team, including Registered Nurses, Behavioral Health Advocates and Community Health Workers.

Whole Person Care High-Risk Behavioral Medical Case Management
The intensive case management identifies members; assesses treatment options and opportunities to coordinate care; designs treatment programs to improve quality and efficacy of care; controls cost; and ensure optimal outcomes. Members are outreached and engaged by the appropriate staff to ensure the member's needs are met as well as the goals of the program.

The goals are:

- Improve access to services – physical, behavioral, social, and environmental
- Improve coordination of care through assignment of dedicated staff to facilitate access to care and community resources to meet unique needs
- Improve systems of care and engages with the community and provider networks to assure access to affordable care and the appropriate utilization of services
- Improve health outcomes demonstrated by improved access to preventive care and compliance with evidence-based guidelines
- Empower the individual member to become successful in managing their chronic disease or condition and care transition

Healthy First Steps
The National Healthy First Steps Program leverages best practices across UnitedHealthcare Community Plan and OptumHealth Services to achieve best infant and maternal health outcomes
The scope of the Healthy First Steps™ Program includes activities that support recommended standards of care and key treatment elements as described in the following evidence-based practice guidelines for pregnant members:

- American College of Obstetricians and Gynecologists
- Center for Disease Control (CDC) Recommendations for HIV Screening of Pregnant Women
- MCG formerly Milliman Care Guidelines

The Health Management Program includes activities to enhance the provider-patient relationship and the member's compliance with their plan of care. It actively monitors the member's adherence to the recommended treatment plan. In addition, Healthy First Steps™ emphasizes activities and treatments that prevent pregnancy-related complications, using cost-effective and patient-involvement strategies.

Healthy First Steps™ seeks to identify all pregnant members early in their pregnancy. Assessment and risk stratification enable prospective outreach and education to the appropriate population. The intervention is designed to address member needs within the continuum, which may include educational materials and/or counseling, targeted case management, and collaboration with providers and community resources to effectively support an improved pregnancy outcome.

Care Management services support increased member compliance through patient education related to normal pregnancy, the recognition and reporting of signs and symptoms of potential complications, lifestyle and preventive health counseling in conjunction with increased awareness of community resources.

High-Risk Case Management monitors and coordinates care for those members at greatest risk for pre-term labor, pre-term delivery or other adverse perinatal outcomes. The ultimate goal of Healthy First Steps™ is to attain the healthiest pregnancy outcome possible for both mother and infant perspective.

Healthy First Steps Population Identification

The population for Healthy First Steps™ program may be identified by several methods:

- State Health Plan Eligibility files
- Obstetrical Risk Assessment Forms (OBRAF)
- Provider Referrals without clinical data
- Health Communications/Health Assessment Reminder Calls (HARC) new member welcome calls
- Antepartum Inpatient Daily Census reports
- Member self-referrals
- Internal referrals from Member Services
- Claims and Pharmacy data
- Emergency Department and Observation Data

Once the pregnant member is identified, outreach is initiated. All referrals received proceed with outbound telephonic outreach to members to ascertain risk factors. Members who complete an assessment receive a level of care assigned based on risks identified. Inpatient Census Reports identify members with antepartum or postpartum complications. Healthy First Steps Inpatient Care Managers review and authorize care while the member remains in the facility. Referral for Care Management occurs when member is an inpatient.

Pregnant members accessing care through hospital Emergency Departments are identified and reassessed by OB Care Manager for additional risks. All identified pregnant members are eligible for

Healthy First Steps™ and are included in program enrollment unless they specifically request to be excluded. These members are reported as “opted out.”

Healthy First Steps™ (HFS) Interventions
Level One
Welcome Packet

- Letter with HFS team member direct contact number to HFS
- Healthy First Steps™ brochure
- Smoking cessation information
- Text4Baby brochure
- State-specific information
- Post-partum outreach to educate and remind of post-partum exam

OB experienced Nurse Case Manager provides telephonic outreach at a frequency based on individual member needs. Calls may occur as frequently as daily but should occur no less often than every three weeks. These calls educate and reinforce member behaviors for pregnancy management, preventive health behaviors, recognition and reporting of potential complications and provider visit compliance. Level-of-Care assignments may change throughout pregnancy based on member’s health care needs and preference.

Providers are actively involved in Healthy First Steps™ processes from the level of the individual member to program level input through committee participation. They also are involved with development and revision of Clinical Guidelines within the scope of the Healthy First Steps™ maternity management program.

Annual updates are given to providers regarding Clinical Practice Guidelines and program changes through:

- Provider web-site
- Provider Services Manual and newsletters located on the provider web-site specify details on program referral and access, as well as other resources and tools
- Each provider who has a member receiving care management services receives a letter of notification with staff contact information and an invitation to participate in the HFS plan of care. The Care Manager may contact the PCP or sub-specialist to design interventions for the member. Care Managers may contact the obstetrical provider to report concerns, barriers to care, or for recommendations and assistance with completing interventions. HFS Medical Directors with obstetrical and related board specialties are available for peer-to-peer discussions. These contacts are intended to facilitate effective communication and partnerships between HFS staff and obstetrical providers while coordinating care for optimal maternal and infant outcomes.
- Consultant notification is completed keeping with American College of Obstetricians and Gynecologists (ACOG) Guidelines for Perinatal Care. Providers may receive notification their patient has an identified risk factor and consultation with an obstetrician or maternal fetal medicine specialist is recommended.

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 objective and based on appropriateness of care and service as well as the existence of coverage. UM decision makers are not rewarded for issuing denials of coverage of care nor do they receive financial incentives that encourage decisions that result in underutilization. The primary goal of UnitedHealthcare's Utilization Management Program is to ensure that all members seeking services receive timely and appropriate care. Services are provided through the use of contracted inpatient facilities, residential facilities, partial hospital programs, intensive outpatient programs and a multidisciplinary network of outpatient providers.

United Behavioral Health: -

The State of Maryland designated Beacon Health Options as the provider of behavioral and substance abuse services as an Administrative Services Organization. UnitedHealthcare does provide Behavioral Health Case Management Services to its member as an integrated service under the Whole Person Care Model.

Customer Service Department:

UnitedHealthcare Customer Service Representatives educate members when they call in with questions about benefits, procedures, and services. The same services are provided for the hearing impaired or foreign language speaking members through the use of AT&T's Language Line (this Line offers translation services to members speaking foreign language) and TTY (this program offers translation services to those with hearing impairments).

Additionally, if a member is put on 'hold' while waiting for a Customer Service Representative, they are able to hear educational promotions on UnitedHealthcare's phone lines. These pre-recorded promotions educate members on several topics including, but not limited to, heart disease prevention, asthma, outdoor safety, sun protection, immunizations, breast awareness, nutrition, flu prevention, diabetes management and behavioral health education.

IV. Tracking and Monitoring Outreach Activities

Database and Software Applications

UnitedHealthcare uses several data systems to manage and perform outreach services to members. These data systems include Facets, Community Care, Microsoft's suite of applications (Word, Excel, and Power Point), Outreach database and MedMeasure. A Health Risk Assessment reporting program is utilized to tailor the enrollment data received from the Maryland Department of Health (MDH) 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 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.

Case Management utilizes Community Care and Impact Pro. 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 MedMeasures software for specific HEDIS measures. The application identifies members who are missing specific clinical services, such as childhood immunizations or well visits. The database system is supplemented through the SMART Data Warehouse for claims research, member demographics and provider to enhance appointment scheduling.

V. Community Partnerships

UnitedHealthcare continues to develop and maintain various partnerships within the community it serves. These relationships are nurtured in an effort to reach out to current and potential members with the goal of responding to individual and community health concerns.

In 2017, UnitedHealthcare remained focused on strengthening our relationships in the community with our partners and members. UnitedHealthcare enhanced current marketing initiatives and programs to encourage our members and the community to become more engaged with their health, and the health of their families. Each program included components to ensure members were educated on their benefits, able to navigate the health plan, and access care. UnitedHealthcare continues to bridge the gap between the member and the access to social needs through community partnerships.

The following 2017 community activities included, but not limited to:

- KidFit
- KidFit Jr.
- KidFit Teen
- Adult Fit
- Back to School Event
- Wellness Forums
- Member Appreciation
- Member Orientation
- Community Events and Health Fairs
- Consumer Advisory Board Meeting
- Community Advisory Committee Meeting
- National Health Center Week
- Heart Smart Sisters
- Healthy Cooking Demonstrations
- Red Dress Sunday 2016
- Stay Fit Adult
- On My Way
- Community HUB Site
- Men's Health
- Community Baby Showers

A series of health education sessions focusing on good nutrition, healthy eating, expecting moms, bullying, heart health, asthma, substance abuse, cold & flu, smoking cessation, women's health and health plan overview were provided at the community events. The educational sessions were hosted alone or in conjunction with other marketing initiatives and/or community partners. The sessions provided an opportunity to educate members and the community on valuable resources to maintain a healthy lifestyle, and health plan services and benefits. UnitedHealthcare's participation with community partners will continue in 2018.

The locations of these events included:

- Adelphi/Langley Park Family Support Center
- Anne Arundel County Head Start Program
- Baltimore County YMCA Head Start
- Community Assistance Network
- Community Clinic Inc. – Takoma Park
- Creative Kids Essex
- Fontana Village Community Center
- Jefferson Hill Elementary School
- Loving Arms, Inc.
- Orchard Mews Apartments
- Sandy Plains Elementary School
- St. Vincent de Paul (SVDP) Head Start Program
- VESTA Inc.

Consumer Advisory Board

The UnitedHealthcare Community Plan Consumer Advisory Board is a valuable relationship between UnitedHealthcare and its members. The Consumer Advisory Board is mandated by the State of Maryland for the purpose of facilitating the receipt of input from members of the health plan. The meetings are hosted six times a year at the UnitedHealthcare office in Columbia and have eleven active members.

The Board's format encourages open dialog between the members and the health plan. Each meeting is designed to provide health education, community resources, address member concerns and share updates on the health plan. The Board members are also asked to review and provide feedback on new member materials, advertising materials, benefit changes and community initiatives.

Topics Discussed at the 2017 Consumer Advisory Board Meeting:

- CAB Survey Results
- Feedback on Health Education and Promotion
- Staying Healthy
- Health Education Program Review
- Shared Decision Making: Connecting the Dots
- Opioids
- Medication Adherence
- Healthy Cooking Demo

Consumer Advisory Committee
Additionally in 2017, UnitedHealthcare continued to improve our health services through our Community Advisory Committee. The Committee is dedicated to Local Health Departments, providers, community and faith-based organizations that serve the Medicaid population. UnitedHealthcare meets quarterly to discuss opportunities and address challenges that may plague specific counties. The goal is to improve services and learn specifically from those utilizing services. The counties visited in 2017 were:

- Anne Arundel County
- Cecil County
- Charles County
- Montgomery County

VI. Partnerships with Local Health Departments
UnitedHealthcare collaborates with the Local Health Department (LHD) in various ways. UnitedHealthcare attends LHD's monthly meetings where concerns, barriers and potential interventions are discussed. UnitedHealthcare works with the LHDs to find solutions to problems, determine better methods of access and care coordination, and identify opportunities for greater provider involvement. Evidence of this partnership is the coordination of efforts to address specific health disparities based on geographic location and level of disparity amongst race. Lead screening and postpartum visits are examples of HEDIS measures being addressed with the LHD in Prince George's County.

The LHD also assists in locating and/or contacting UnitedHealthcare members and encourage them to get preventive or chronic health services. If the LHD is successful in finding the member, the Outreach Team updates the demographic information and proceeds with efforts to assist the member with obtaining an appointment. If the LHD is not successful in finding the member, the health plan will use other modalities in an attempt to locate the member. UnitedHealthcare will continue working in partnership with all LHDs on outreach efforts, local events, and other activities to better serve members in calendar year 2018.

VII. Role of the Provider
To ensure UnitedHealthcare members have every opportunity to access needed health-related services, network providers participate in telephonic audits to ensure they are meeting UnitedHealthcare's appoint schedule standards as well as EPSDT requirements.

Network providers are encouraged and expected to review the Provider Care Manual that outlines their responsibilities as it relates to caring for the Medicaid population and interact with their Provider Advocate to obtain information on benefits, regulations, policies and procedures for referral/pre-authorizations, drug formulary etc. It is also encouraged they participate in Town Hall Meetings, listen to Provider Podcasts that offer provider-specific information of a variety of topics, review articles on their website as well as their newsletter.

Evaluation of the Outreach Program

Outreach approaches are monitored, data analyzed, and appropriate interventions employed. The current approaches and partnerships are to ensure members are:

- Reminded of their need for service(s)
- Educated about the importance of completing these services
- Informed about their covered benefits including directing them to sites that provide information
- Assisted with addressing barriers to care

2017 Local and National Outreach Activities

Activity	Volume
Local Live Telephonic Outreach	26,756 Calls 17,324 Reminder/sorry-we-missed-you letters mailed 613 Appointments scheduled or rescheduled
Live Telephonic Outreach by Vendor	16,070 Unique member calls
Interactive Voice Recordings (IVR)	24,837
EPSDT Preventive Letters	64,674
Member Incentives (AWC)	24,271 Mailings 673 Gift cards redeemed
Baby Blocks Program (YTD)	21,921 Program mailers to members 4717 Members registered for the program 4819 Member completed all 13 segments of the
Clinical Quality Nurse Office Visit/Chart Chase	260 Unique provider office visits 230 provider office interactions
Vendor In-home Assessments	768 Home assessments completed

Note: *Volumes are YTD (11/2017)*

VIII. Conclusion

In 2017, several outreach approaches were employed to encourage members to schedule and keep their appointment. The outreach staff performed live calls, which provided health information, explained the importance of keeping appointments, offered resolution to specific barriers to care issues expressed including language or cultural barriers, and provided information on covered benefits within the scope of the Clinical Administrative Coordinators role responsibilities.

The Clinical Quality Nurses offered additional education to providers to ensure members are seen for their preventive services in a timely manner to meet regulatory requirements. The nurses performed chart audits and assisted providers in addressing non-compliant members. The outreach staff may assist providers in addressing members with several no-shows and missed appointments. This can include soliciting assistance from the Local Health Department

Our contracted vendor was an additional modality used to support our efforts by providing care in the member home if there are barriers preventing the member from going to the provider's office. Those barriers include, but are not limited to, age, physical or mental disability, childcare issue and/or transportation.

Member outreach will continue in 2018 using all the aforementioned approaches to promote, support and assist members into care to improve or sustain their health and well-being. Health information/education efforts, thorough community events and partnerships, will be used to assist the member in becoming an active participant in their care through self-care management, when appropriate and possible. Additionally, auxiliary services such as case/care management or special needs coordination will be an important part of the member outreach.