2010 Performance Improvement Project Abstracts featuring Pediatric Obesity Prevention Projects (2009 - 2010)

Introduction

This compendium of Performance Improvement Projects (PIP) summarizes the various projects conducted by New York State Medicaid managed care plans in 2009 and 2010. These projects have been reviewed by IPRO, the external quality review organization for New York State, in accordance with the protocol developed by the Centers for Medicare and Medicaid Services in response to the Balanced Budget Act of 1997.

If you have any questions or comments about this Compendium, please contact Judy White of the Division of Quality and Evaluation at 518-486-9012 or at jhw02@health.state.ny.us.

Note that there are 20 PIPs in all, with 18 focusing on Obesity and 2 (Affinity and Gold Choice) focusing on non-obesity topics.

Tables appear on pages 25 through 31, which display the outcome data for each plan to assist the reader in interpreting data in the abstract. All rates are based on HEDIS/QARR, unless otherwise specified.

GLOSSARY OF ACRONYMS

AWC – Adolescent Well-Care Visits
BMI – Body Mass Index
CDC – Centers for Disease Control and Prevention
CI – Confidence Interval
CM – Case Management
HEDIS – Healthcare Effectiveness Data and Information Set
HRA – Health risk assessment
MY – measurement year
NYS – New York State
OB/GYN – Obstetrics and Gynecology
PCP – Primary Care Provider
QARR – Quality Assurance Reporting Requirements
WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children / Adolescents
WC34 – Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

[1] HEDIS is a registered trademark of the NCQA

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Amerigroup (2009-2010)
Childhood Obesity

Project Topic / Rationale / Aims
National survey results indicate that over the past 20 years, the prevalence of childhood overweight has increased 11.3% on average among those ages 2 – 19 years. Data reveal that childhood overweight/obesity in NYS is greater than the national average, which ranks 33rd nationwide. Additionally, in NYS, disparities are seen between children with public health insurance and those with private insurance, and that black and Hispanic youth are disproportionately affected.

The aim of this study was to increase member, provider, health plan and community/school awareness of the importance of BMI screening and nutrition and exercise counseling and to enhance knowledge of good nutrition and increased physical activity. The specific goal was to increase the rates for three measures (BMI screening, documentation of nutrition counseling, and documentation of physical activity counseling) by 2 percentage points.

Methodology
Ten high volume providers (individual and group practices whose panels comprised at least 100 members) representing 40% of the membership, were recruited to participate in the project. A targeted chart review (n = 200) for these ten providers was conducted to establish the baseline for evidence of BMI screening and anticipatory guidance for nutrition and exercise for children ages 7-11 years. Baseline rates (MY 2008 data) were compared to re-measurement rates (MY 2009 data). In addition, the rates for the HEDIS® WCC measure for MYs 2008, 2009, and 2010 were tracked.

Interventions
Provider-focused interventions consisted of educational office visits and follow-up calls, and provision of tools and resources including the *Let's Go!* childhood obesity resource toolkit, growth charts, BMI wheels, 5210 clinical guideline charts and Amerigroup *PowerZone Paks* for member education. The *PowerZone Paks* contained a welcome letter and information for parents/guardians, a recipe book with healthy snacks and food ideas, activity sheets, posters on nutrition and physical fitness, a healthy habits tracking chart, and a weight chart. Member-focused interventions included ongoing outreach via phone and/or letter to those in need of a well care visit with assistance in scheduling a PCP appointment. Community-focused interventions involved providing educational materials and conducting two series of four session workshops at afterschool programs.

Results/Conclusions
The project met its objectives. Rates for two of the three indicators increased, with a 19 percentage point increase in BMI screening, a 20 percentage point increase for exercise counseling, and no change in the rate for nutrition counseling. In addition, outreach was conducted to 2,145 members and over 82% of the calls resulted in a well care visit. This project also improved provider knowledge of screening for childhood obesity and the importance of educating members on nutrition and physical activity. Finally, member/family and community awareness of childhood obesity, nutrition, and exercise was enhanced.

Next Steps include expanding education on childhood obesity to all participating providers, providing Power Zone Paks for use for high-risk patients, and encouraging all providers to subscribe to an electronic medical record system which will make documentation simpler.

Capital District Physicians' Health Plan (CDPHP) (2009-2010)
Improving the Care of Children at Risk for Obesity in Managed Medicaid Population

Project Topic / Rationale / Aims
CDPHP focused on improving the care of children at risk for obesity. According to the CDC, the prevalence of overweight/obesity has dramatically increased among children (on average, 11%) since the 1970's. This has significant implications for the future health of today's children due to risk for chronic health problems. NYS was ranked 33rd nationally for childhood weight problems, and it was estimated that 35.6% of children with public insurance were overweight/obese. Using this estimate, approximately 9,000 of CDPHP's 25,000 child members were potentially at risk for overweight/obesity.

CDPHP's goal was to reduce and/or prevent adverse health outcomes for its Medicaid child population by improving the rate of screening, detection, and treatment of overweight/obesity. The specific goal was to achieve statistically significant improvement in measures related to well care visits, documentation of BMI and counseling for nutrition and physical activity, and rates of breastfeeding among new mothers.

Methodology
The project indicators included: QARR/HEDIS® WCC - documentation of BMI percentile, counseling for nutrition and counseling for physical activity (baseline MY 2008, interim MY 2009, re-measurement MY 2010); QARR/HEDIS® WC34 and AWC – children/adolescents with a well-visit (baseline 2009; remeasurement 2010, due to change in measure specifications); use of V codes for BMI/overweight/obesity (baseline MY 2008; interim MY 2009; remeasurement MY 2010); children with a BMI percentile indicating obesity who had an LDL test (baseline MY 2009; unable to remeasure); and breast feeding rates among Medicaid mothers (baseline MY 2008; interim MY 2009; remeasurement MY 2010). Process measures included: the number of well-visit reminder postcards sent and telephone outreach calls conducted.

Interventions
CDPHP developed and executed interventions to support members, providers, and the community. Members received education on the importance of BMI measurement, healthy eating, food shopping, and exercise. Providers received screening tools to support documentation and education on communication strategies. Both members and providers received reminders for annual well-visits. Key interventions included: distribution of BMI Toolkits to providers and via the CDPHP website; *Body Works*, an 8-week parent/care-giver-focused obesity prevention program; an online *Kid Power* weight management program; sponsoring Radio Disney's *Move It* program; partnering with OB/GYNs to promote breast feeding; and partnering with the Community Gardens to sponsor the *Veggie Mobile.*

Results/Conclusions
Results of this project are encouraging. Care of children at risk for childhood obesity has improved. Comparing baseline to measurement, an increased number of providers are documenting BMI (+55%), as well as counseling for nutrition (+16%) and physical activity (+49%). The rates for well-visits remained stable; however, infrequent use of V-codes to document high BMI prevented remeasurement. There was a 24% increase in breastfeeding among new mothers in the Medicaid population. Outreach efforts were well received by members, providers, and the community. Addressing the ongoing problem of childhood obesity remains a priority for CDPHP. A new three-year partnership with the Alliance for a Healthier Generation has been forged, and opportunities to partner with new community groups and schools are being explored.

EmblemHealth (2009 – 2010)
Improving Pediatric Obesity Assessment, Treatment and Prevention for our Members and Providers

Project Topic / Rationale / Aims
In 2003, the New York City Department of Health & Mental Hygiene and the New York City Department of Education conducted a study that found only half (53%) of elementary school children in NYC were at healthy weights. Additionally, the 2003 National Survey of Children's Health indicated that 30.9% of New York children ages 10-17 years were considered to be overweight or obese. EmblemHealth serves over 300,000 children age 0-17 years in New York State and is estimated that approximately 45,000 of these children are at risk. The plan's HEDIS 2008/QARR 2007 BMI screening rate demonstrates room for improvement as only 40% of adolescent Medicaid members had a documented BMI.

The aim of this study was to increase the percentage of health plan members aged 3-17 years who have evidence of BMI percentile assessment, documentation of counseling for nutrition/referral for nutrition education, and documentation of counseling for physical activity/referral for physical activity. Additionally, the plan aimed to increase provider diagnosis of overweight/obese members in claims.

Methodology
EmblemHealth utilized the HEDIS/QARR WCC measure as the key project indicator. Reporting periods included HEDIS 2009 (baseline), HEDIS 2010 (re-measurement year 1) and HEDIS 2011 (re-measurement year 2).

Interventions
The health plan developed a multimodal intervention strategy for members, providers and the communities they live in that included direct mail and health promotion newsletters and electronic messaging, provider academic detailing, collaboration with the American Academy of Pediatrics, community events to promote BMI screening and education to encourage healthy lifestyles.

Results/Conclusions
During the 2009 baseline year, the health plan's BMI screening rate for Medicaid (40%) was lower than the statewide average (43%); the counseling on nutrition rate (57%) was at the statewide average (57%); and the rate for counseling on physical activity (47%) was above the statewide average (43%). The 2011 re-measurement year 2 data showed that the plan's BMI screening rate (67%) and counseling on physical activity rate (61%) were above the statewide averages (65% and 58%, respectively), while the counseling on nutrition rate (67%) was just below the statewide average (71%).

Based on the knowledge gained in the last two years, EmblemHealth is better positioned to be more focused and proactive in its effort to provide appropriate education and tools to address the prevalence of childhood obesity for members and providers. Next steps for EmblemHealth include: a review of coding and reimbursement opportunities; targeted programming to children identified as obese/overweight; continuation of work to understand community resources; continuation of academic detailing; and continuation of work with the provider network to identify overweight/obese children in their panels and to provide resource guidance to patients and their families for better health management.

Excellus/MVP Healthcare (2009-2010)
'Staying in the Range' program: Focus on nutrition, healthy behaviors, and weight gain during pregnancy and encouragement of breast-feeding practices

Project Topic / Rationale / Aims
Currently almost half of U.S. women exceed weight gain recommendations during pregnancy. Infants of mothers who gain more than the recommended amount of weight during pregnancy are more likely to be overweight as children. The results of a meta-analysis on the health benefits of breast-feeding and impact on childhood overweight and obesity were reported by the CDC, July 2007. Babies who have been fed breast milk exclusively and for an extended period are less likely to become overweight or obese as children. Our objectives were to encourage more women who have public insurance to stay within recommended parameters of weight gain during pregnancy, encourage appropriate nutrition referrals, encourage more women to breastfeed their babies, and to breastfeed exclusively for at least the first six months.

Methodology
Medical record review was conducted, baseline 2008 vs. re-measurement 2009/10. For weight gain during pregnancy, indicators included proportion of women gaining weight in excess of IOM pregnancy weight gain guidelines, nutrition referrals for excessive weight gain during pregnancy and pregnancy BMI documentation. For breastfeeding, indicators included intent to breastfeed at delivery, breastfeeding at post-partum follow-up, and lactation consultation support provided post-delivery.

Interventions
Interventions included:

- The "Staying in the Range" program implemented by the Perinatal Network of Monroe County to help women maintain a healthy weight gain during pregnancy. Working with an assigned program care coordinator, each woman received a personal diary in which she recorded her BMI change over the course of her pregnancy.
- Implemented the "Baby Basics" program with eight OB/GYN Practices, incorporating the importance of breast-feeding messaging to providers as well as members.
- Educated members through health plan case management efforts.
- Raised awareness through the University of Rochester Medical Center's Baby Love program in Monroe County and the Healthy MOMs programs in Dutchess and Ulster counties.
- Raised provider awareness through health plan provider office detailing.

Results/Conclusions
Women are entering pregnancy overweight/obese and are gaining excessive weight. Excessive weight gain during pregnancy is still not being widely addressed although there have been some improvements since the baseline period indicating that community awareness has been raised. Greater community awareness is being raised in Rochester and Monroe County through efforts of the Greater Rochester Health Foundation's policy advocacy group for breast-feeding. BMIs are not consistently documented. Nutrition referrals are consistently documented, and there were more nutrition referrals seen in the re-measurement period compared to the baseline for the indication of obesity; however, the number of these referrals remains small. More women are initiating breast-feeding after delivery on re-measurement than in the baseline review. However, the breast-feeding discontinuation rate at the post-partum visit remains high.

Fidelis Care (2009-2010)
Promotion of Breastfeeding and Healthy Pregnancy Weight to Reduce Pediatric Obesity

Project Topic / Rationale / Aims
The objective of the project was to provide education to members and providers that stressed the importance of healthy pregnancy weight gain and breastfeeding for the first 6 months of life as a means to prevent and reduce the prevalence of pediatric obesity, based on scientific studies showing that a mother's weight gain during her pregnancy, and her decision to breastfeed her infant, can strongly influence her child's long-term risk of obesity. Fidelis Care utilized its fully implemented BabyCare data management tracking system to measure maternal weight and monitor breastfeeding for up to 6 months following delivery. The benchmarks included the Institute of Medicine (IOM) standards for weight gain and the Healthy People 2010 national standards for breastfeeding. The goals for weight gain and breastfeeding were set at achieving a statistically significant improvement in the number of women who did not exceed the IOM recommended weight gain during their pregnancy and to bring the breastfeeding rate to the Healthy People 2010 national goal of 50% still breastfeeding at six months after delivery.

Methodology
The study population was members in their first, second and third trimester of pregnancy who had contact with BabyCare Case Managers. The baseline used for the study was a population of members (138 contacted) who were enrolled in the BabyCare program before the start of the project. The measure was the percentage of women (326 contacted) who had their first contact with a BabyCare case manager during pregnancy who did not exceed the recommended weight gain based on the IOM standards. The breastfeeding measure was the percentage of members who had their initial contact with a BabyCare Case Manager during pregnancy who initiated and continued breastfeeding for up to six months. Data were gathered by placing outreach calls to the members during the second, fourth and six months after delivery.

Interventions
Member interventions included intensive counseling by dedicated BabyCare Case Managers on appropriate pregnancy weight gain and education on the positive benefits of breastfeeding for the first six months of life. Pregnant members were provided with educational literature, self-management tools, and supportive referrals. A member newsletter printed in English, Spanish, and Chinese was mailed to all members. Provider interventions included letters mailed to the top 50 OB/GYN practitioners (by volume) advising them of the project's breastfeeding and healthy pregnancy weight goals, including the benchmark standards for each. Member educational materials were distributed to high-volume pediatric offices and OB/GYN provider sites. A provider newsletter article was sent to all Fidelis Care providers. Representatives from the BabyCare program attended three community health events to raise awareness about the importance of healthy weight gain during pregnancy and the benefits of breastfeeding. Barriers encountered, including language barriers and difficulties with member contacts were addressed by use of language interpreters and Member Services associates to assist with outreach calls.

Results/Conclusions
The post-intervention rate of women breastfeeding remained unchanged from the baseline rate of 37% which is below the Healthy People 2010 goal of 50% of women breastfeeding at 6 months. For the weight gain measure, the rate of members exceeding the IOM weight gain standards decreased from 18% pre-intervention to 11% post-intervention; a seven percentage point decrease. Using a 95% CI in a z-test for proportion, the overall result for both weight gain and breastfeeding rates were not significant. However, at a 90% CI, the weight gain measure was improved for both the overall post-intervention result and for the 2nd trimester group result.

Healthfirst (2009-2010)
Improving the Process of Identification of Obesity Risk in the 2-18 years old Medicaid population: A 2-year Pilot Study

Project Topic/ Rationale / Aims
This project was aimed at improving the process of identification of children and adolescents who were at risk for obesity and were in need of appropriate counseling on nutrition and physical activity. The institution of the HEDIS 2009 measure (WCC) and the National Initiative for Children's Healthcare Quality's (NICHQ) determination that the Body Mass Index (BMI) percentile assessment is an effective means of identifying children/adolescents who are "at risk for overweight" or "obese" led to the following study objectives:

- A 5% improvement in the claim/encounter submissions for BMI percentile assessment, Counseling for Nutrition, and Counseling and for Physical Activity for the 2-18 year old population by the targeted group of providers
- A rate of 10% above the statewide average on each of the above indicators for the WCC measure (3-17 year olds) in QARR 2010.

Methodology
Healthfirst selected four provider groups for this study that represent diverse examples of the providers in Healthfirst's network. Performance Indicators included QARR/HEDIS rates for each BMI percentile assessment, Counseling for Nutrition, and Counseling for Physical Activity. Process Measures tracked quarterly were the number of onsite visits to targeted providers, the number of claims submitted with codes for the performance indicators, and the number of members identified as being "overweight," "obese," or ≥ 99 percentile. Process measures tracked annually were the number of providers and members sent educational mailings. Provider progress and member outcomes were measured through claims with the appropriate codes for BMI percentile assessment, Counseling for Nutrition, and Counseling for Physical Activity for the 2-18 year old population. A random sample of 50 medical records per provider group were reviewed at baseline and remeasurement.

Interventions
Provider interventions involved onsite education and "Dinner and Learn" events that were facilitated by speakers endorsed by NICHQ. Clinical assessment tools, member educational materials, and community resources were distributed and posted on Healthfirst's provider portal as well as published in "The Source" newsletter. Member interventions included the promotion of childhood obesity awareness through telephonic outreach, Healthfirst's Got 2B Fit obesity program, and member website and newsletter articles. The strategic display of a billboard advertisement regarding obesity and the participation in a Farmer's Market series, parent-teacher appreciation events, and a health fair comprised our community-based interventions. Healthfirst developed a member Registry to help identify members who were deemed as "at risk for overweight" or "obese" by their provider.

Results/Conclusions
Claim/encounter submissions of all WCC by the targeted group of providers increased by 5.3% for services in 2010 (vs. Baseline). The goal was met and the increase was statistically significant (p-value <0.0001). Although the aim of achieving 10% above the statewide average for WCC was not met in 2010, there was a substantial improvement in this measure's rates from QARR 2008 to QARR 2010. Sixty-six members from the study's registry and 181 non-study members were enrolled in the Healthfirst Got 2B Fit obesity program.

HealthNow New York, Inc. (dba BCBS WNY) (2009-2010)
Addressing Pediatric Obesity

Project Topic / Rationale / Aims
A 2003 national survey revealed the percentage of New York children considered overweight/obese exceeded the national average, with African Americans and Hispanics and children with public health insurance disproportionately affected. As of 2009, HealthNow's rates for BMI screening, nutrition counseling, and well care visits remained below the SWA.

HealthNow's aim was to improve the proportion of members at normal weight by increasing awareness, screening, and counseling. Specific targets were: achieve statistically significant improvement for at least two HEDIS numerators: WCC, WC34, and AWC, and to gain 3-4 percentage points for at least one numerator of a medical record documentation audit (BMI, BMI percentile, nutrition and physical activity counseling).

Methodology
Data collection for HEDIS® measures followed technical specifications. For the medical record audit, random samples were selected among children ages 2-17 years, with criteria for continuous enrollment and PCP encounters. Process measures were tracked: counseling on breast feeding; outreach for well care visits; children linked with PCPs; provider tool kits distributed; and member attendance at health programs. Data sources included claims, medical records, CM software, newborn enrollment data; and internal tracking databases.

Interventions
Health Plan interventions included revised documentation standards and contracting with a CM vendor specializing in the Medicaid population. Provider interventions included education, tool kits, and financial incentives. Member/family interventions included promoting breast feeding, outreach to parents of children needing well-care visits, an online interactive tool and educational library, coverage for health education and fitness classes, and a discount program for fitness, dance, gymnastics, martial arts, and wellness centers. Community interventions included partnering with pro sports teams (*What Moves You*, *Play 60*, *Hat trick for Health)*, sponsoring school activities on healthy nutrition and physical activity and a school grant to link children with a PCP, sponsoring the *Country Market* to bring fresh produce to downtown Buffalo and *Grass Roots Gardens of Buffalo* to create city community gardens, promoting health lifestyles in the African American and Hispanic communities; and programs at Boys and Girls Clubs and the YMCA.

Results/Conclusions
Awareness among children, families, providers, and the community was achieved. The project goal was met. At least two HEDIS® WCC numerators achieved statistically significant improvement - BMI percentile (+27 percentage points); counseling for nutrition (+11 percentage points); counseling for physical activity (+14 percentage points). Rates for WC34 and AWC remained stable and did not achieve significant improvement. The medical record audit showed mixed results: BMI (+1 percentage point), BMI percentile (-17 percentage points), nutrition counseling (+4 percentage points), physical activity counseling (+4 percentage points). The goal to obtain a 3-4 percentage point increase in one numerator was met, but further improvement is needed. Tracking of the process measures showed that the education and support efforts were robust and well received. Interventions and community programs will continue in 2011.

HealthPlus (2009-2010)
Turning the Tide: Neighborhood Collaborative to Assist Overweight Adolescents in Sunset Park, New York

Project Topic / Rationale / Aims
The prevalence of obesity is particularly high in the first generation Latino community in Sunset Park. By improving the care of overweight adolescents, we hope to reduce the rate of adult obesity and its correlates: diabetes, arthritis, and heart disease.

The project was designed to test the ability of a multifaceted program, developed by a health plan, an integrated safety net heath system, and local public schools, to increase identification and to improve the care of overweight and obese children in a low income, Hispanic population. The collaborating organizations were to develop a program for the medical, nutritional and activity management of adolescents and younger children who are obese, have diabetes, or are at risk for developing diabetes (children of diabetics) or other complications.

Methodology
The project was directed at a sample of adolescent patients at Lutheran Family Health Center (LFHCN) who are at risk for developing diabetes, specifically overweight and normal-weight children of diabetic parents. The majority of participants were Hispanic. Adolescents were classified into three risk categories (normal, elevated, high) based on their BMI percentile, family history, and risk factors. Based on risk category, patients were either directed to usual care, usual care with periodic labs screenings, nutrition referral, or enhanced care with additional referrals, including a weight loss program. LFHCN pediatricians received training on the algorithm, and patient navigators were assigned to keep patients in care.

Clinical performance was measured at baseline, at one year, and at project end. Data collection was conducted through care review and claims review.

Interventions
Interventions included clinical training, assessment and changes to clinic operations, and the establishment of community resources for overweight and obese adolescents. Health Plus purchased “Dance Dance Revolution” for LFHC for a planned clinical program for overweight patients. Five schools were identified in Sunset Park and were approached to develop afterschool exercise programs using “Dance Dance Revolution”. In addition, Health Plus sent pediatric BMI calculator wheels to all pediatricians and family practitioners. In the community, Health Plus met with a school to reestablish an afterschool exercise program in cooperation with the local YMCA.

Results/Conclusions
There was marked improvement in the recording of BMI in pediatric charts, and modest improvement in monitoring for diabetes and other metabolic problems. There was little change in the use of nutritional counseling or weight loss programs. Health Plus was unable to establish sustainable school based exercise programs for overweight children or adolescents.

Health Plus was able to drive limited clinical improvement but found multiple barriers to establishing community based resources for overweight adolescents. Reimbursement for weight loss programs, lack of established models, and limited resources for afterschool programs may be barriers to offering these services in a clinical setting.

Hudson Health Plan (2009-2010)
It's a Family Affair

Project Topic / Rationale / Aims
Full year data for 2007 indicated that Hudson Health Plan affiliated primary care professionals were under-coding the diagnoses overweight, obese and morbidly obese among Hudson's pediatric population. The analysis also indicated that while nutritional counseling is available, members have only rarely been referred for such counseling.

Goals:

- Increase by 100% (double) the baseline rate of PCP documentation and coding of BMI percentile for members aged 2-17 years.
- Improve identification of overweight and obese members aged 2-17.
- Increase nutritional counseling rates for overweight & obese children.

Methodology
Measures, calculated plan-wide and at the Open Door Family Medical Center, were: the HEDIS 2010 WCC measure; percentage of enrolled members 3-17 years of age with evidence of BMI percentile documentation using claims data; the number of enrollees who were diagnosed as overweight or obese and the number of enrollees identified as overweight or obese who also received counseling for nutrition and physical activity using ICD-09 codes.

Interventions
A provider toolkit was developed that included: An information packet, a BMI wheel, assessment documents, laminated Children's Portion Plate, list of plan Nutritionists, a height assessment wall chart, and tear off pad for patient education and goal setting.

Community presentations and cooking classes were conducted on good nutrition and to promote family activity.

Results/Conclusions
Hudson Health Plan saw a seven-fold increase in claims data coding of BMI status for members aged 3-17 years of age and increases in the number of claims for nutrition and exercise counseling. An increase in BMI documentation was observed from 69.28% to 78.8% using hybrid methodology including chart review. QARR/HEDIS results based only on administrative data increased from 2.4% to 9.6%.

Our principal collaborator, Open Door Family Medical Center also substantially increased (by almost ten-fold) the percentage of their patients who had a BMI status coded in claims data but did not increase the number with claims for nutrition and exercise counseling.

We greatly exceeded our goal of doubling the percentage of members whose BMI status was documented in claims data. However, comparing results from our claims data with clinical data at Open Door and with BMI screening rates from hybrid QARR/HEDIS measures demonstrates that claims data does not accurately reflect the rate of BMI screening. BMI status is documented at a higher rate in the clinical record than in the coded claims data.

Independent Health (2009-2010)
Pediatric Obesity Initiative: Fitness for Kids Challenge & Patient Centered Medical Home

Project Topic / Rationale / Aims
The rate of overweight/obese children has tripled over 30 years to one of every three children. Medicaid children are nearly six times more likely to be treated for severe obesity than privately insured children. Independent Health's (IH) Fitness Challenge, an initiative to combat childhood obesity throughout Western New York (WNY), challenges elementary school children to increase physical activity and improve eating habits. IH also initiated a Pediatric Obesity Project as part of the Patient Centered Medical Home (PCMH), which puts a member's physician at the center of care-developing a comprehensive strategy for their care, communicating with each specialist and coordinating all medical care.

Methodology
Fitness Challenge*:* A self-report survey of diet and exercise was administered (pre and post-intervention) to participating children age $\leq$ 14, their guardians and coordinators of this program at the schools. Approximately 180 WNY schools agreed to participate in the Fitness Challenge. Of the 180 schools, 9 agreed to complete the surveys.
PCMH: Up to 15 patients (ages of 5-11 years with a well visit) were randomly selected; 50 for aggregate groups. Participants reviewed medical records and submitted data regarding process measures (e.g. BMI, blood pressure and review of dietary behaviors, physical activity, and family history) and outcome measures (e.g. diagnosis of overweight/ obesity). An adherence score, based upon how well each patient's management met recommendations, was developed for each survey returned. Individual patient scores were averaged for each physician and compared to peers.

Interventions
Fitness Challenge: IH developed physical and nutritional educational materials; established a website; developed and distributed the Fitness Challenge Diet and Exercise Survey to schools; developed program materials; and partnered with the Theatre of Youth to bring educational plays focused on the importance of 5-2-1-0 goals adopted by the Fitness Challenge to participating schools.
PCMH: IH developed a Pediatric Obesity Performance Tool and beta tested it with PCMH pediatricians and P4P-eligible providers.

Results/Conclusions
In the first 2-years of the Fitness Challenge, more than 200,000 fitness activities were completed, 100,000 youth reached in approximately 200 schools and 25,000 activity trackers submitted. The objectives of the Fitness Challenge were met with children in the program showing an increase in the amount they exercise and in awareness of healthy eating habits.

A PCMH baseline assessment and reassessment (72/74 and 73/74 pediatrician respondents) revealed a slight decrease in BMI calculated (95% to 93%) and slight increase in blood pressure obtained (94% to 95%). Dietary behaviors measures improved ($p < 0.01$) for discussion of: sugar sweetened beverages (32% to 50%); $\geq$5 fruits and vegetables (25% to 52%); eating away from home (20% to 42%); breakfast (19% to 43%); portion control (19% to 43%). Physical activity measures improved ($p < 0.01$) for discussion of: $\geq$2 hours of physical activity (33% to 51%); $\leq$1 hour of screen time (33% to 49%). There was modest improvement in documentation of family history related to obesity, diabetes, hypertension, hyperlipidemia, and cardiac events. The PCMH Pediatric Obesity Project found that pediatricians improved in discussions around obesity-related topics during visits.

MetroPlus (2009-2010)
Pediatric Obesity: Assessment and Treatment in a Provider Network

Project Topic / Rationale / Aims
For the identification and treatment of pediatric obesity, MetroPlus looked at five sites representing diagnostic and treatment centers (Cumberland Diagnostic and Treatment Center and East New York Diagnostic and Treatment Center) inpatient facilities (Kings County Hospital Center and Woodhull Medical and Mental Health Center) and a large community practice (National Pediatric Center) with the goal of understanding the delivery of care in these five settings. Through the use of structured site assessments, medical record reviews, reviews of pediatric obesity codes utilization, we gained a better understanding of how each site manages pediatric obesity.

Methodology
The Plan used the HEDIS WCC measure to understand the quality of care being delivered in each site, for members 3-17 years of age. We used HEDIS 2009 data as our baseline and the re-measurement period was completed using HEDIS 2010 data. Additionally, we gathered baseline data on the extent to which each site was utilizing the ICD 9 obesity codes (278, 278.01, 278.02, 278.0, V85.53 & V85.54) on claims. At the end of the project, we assessed year to year improvement in code utilization across each study site. To assess improvements in the delivery of care to the pediatric obesity population at the site level, we conducted a baseline and final medical record review of 250 members (50 members per site) who had a PCP visit from May to July 2009 and a diagnosis of obesity and or diabetes.

Interventions
MetroPlus conducted provider and member interventions and comprehensive facility assessments of each site. Provider interventions included an educational tool kit that contained wall-size BMI and plate planner charts (English & Spanish), obesity pocket guide and 5210 pediatric obesity clinical decision support chart, and a health promotion message encouraging providers to educate their patients about the dangers of sugar sweetened beverages. We also contributed jump ropes, pedometers, single-serve cereal and milk containers to the sites. We conducted facility site visits with key stakeholders to complete assessments that would help to inform the in-service that was conducted with each practice site. The in-service provided the site with the findings from the medical record review and facility assessments. We also completed two educational mailings to members that included information on maintaining healthy weight, and on avoiding high caloric sugar sweetened beverages-- “Don’t Drink Your Calories!”

Results/Conclusions
All five facilities made some improvement on the HEDIS WCC submeasures comparing 2010 to 2009, including National Pediatric Center and Cumberland (D&TC), which made dramatic improvement from 2009 to 2010 in all three submeasures. Improvement in ICD-9 coding was variable by site. East New York and Cumberland D&TC increased ICD-9 obesity coding utilization from 10% to 22% and from 10% to 38% respectively. The medical record review results highlighted the challenge in finding appropriate referrals for physical activities and a low number of referrals for nutritional counseling.

NHP (2009-2010)
Improving Diagnosis and Treatment of Childhood Obesity

Project Topic / Rationale / Aims
The aim of NHP's project is to improve diagnosis and treatment of obesity for children 3-17 years of age. The rationale is based on the fact that childhood obesity has reached epidemic proportions nationally and locally. The National Survey of Children's Health (2003) showed that the percentage of children in New York between 10-17 years of age considered overweight or obese was 30.9%.

NHP's goal is to demonstrate significant improvement in BMI screening and counseling for nutrition and physical activity for children 3-17 years of age. Improvement in care to the targeted population will be demonstrated by implementing various interventions aimed at both providers and members that are specific to prevention, diagnosis, and management of obesity.

Methodology
The HEDIS/QARR indicators WCC for the outcome measurement are BMI screening, counseling for nutrition, and counseling for physical activity. The baseline was based on NHP's QARR 2008 rate. Re-measurement was based on NHP's QARR 2010 rate. QARR sampling methodology was used. The method of data collection used was chart review and/or hybrid. The only exclusion criteria were members with a diagnosis of pregnancy.

Interventions
Member Interventions included direct mailings to NHP members with a diagnosis of obesity, including two brochures; member newsletters articles; and resource links in NHP Website.

Provider Interventions included direct mailings containing resource information to PCPs with patients 3-17 years of age who had diagnosed obesity in any of their patients, as well as provider newsletter articles.

A cover letter was sent to 122 NYC Public School Health Clinics, informing the schools on the prevalence of childhood obesity and NHP's commitment to help improve diagnosis and treatment of childhood obesity.

Community Interventions: established a partnership with Brookdale University Hospital and Medical Center's "Live Light, Live Right Childhood Obesity Program" to inform members of the program via newsletter articles and targeted mailing. Through collaborative efforts established a referral system for NHP members to enroll in the program.

Results/Conclusions
The overall goal of improving BMI screening and counseling for nutrition and physical activity among children 3-17 years of age was achieved. BMI screening rates improved from 31% to 68%; nutritional counseling rates improved from 57% to 72%, and the physical activity counseling rates improved from 44% to 61%. Statistical test results showed significant improvement across all three measures.

Based on the results, it appears that a multifaceted approach to improving BMI screening and counseling for nutrition and physical activity may work best. This includes intensive provider and patient education. The most frequently encountered barrier found among patients was their lack of understanding on how to prevent weight gain or sustain a healthy lifestyle.

Southern Tier Pediatrics (2009-2010)
Quantifying BMI Use in a Pediatric Population at Southern Tier Pediatrics in the Southern Tier of New York State

Project Topic / Rationale / Aims
The project topic was to quantify BMI use in the Pediatric Population at Southern Tier Pediatrics in the Southern Tier of New York State. Recognition, prevention and treatment of obesity in the pediatric population may yield long-lasting health benefits for individuals and society. For Year 1 of the study the main goal was to change the behavior of the Providers and Nursing Staff, making BMI performance at Well Child Visits for patients 2 –17 years of age the standard of care. Year 2 will focus on making BMI an educational tool used by Providers for patients and their families to serve as a guide for healthy weight. Developing and implementing educational materials such as the Provider Tool Kit, a BMI Report Card and a Screening/Referral process for patients with obesity/ comorbidities will help accomplish this and become the standard of care for the targeted practice.

Methodology
Randomly selected charts were utilized for chart review at established timeline points (0, 6 month, 1 year- for each study year). Each provider reviewed 20 charts of another provider looking at each of the performance indicators. The performance indicators for Year 1 of the study included: #1.The calculation and recording of the BMI in the chart, # 2.The graphing of the BMI on the appropriate BMI graph and #3. Documenting BMI % in the chart. For Year 2 of the study the performance indicators were #4.Documentation of BMI Sharing in the chart, #5. Healthy Habits Survey present in the chart, #6. Patient/Family Health Questionnaire and #7. Documentation of Obesity Referral Questionnaire completed for patients with BMI at certain criteria levels. The compliance goal for the six indicators was 90% or better.

Interventions
In the first year of the study, staff education was performed with providers, nurses, receptionists, and medical records staff by the Performance Improvement Project (PIP) committee regarding BMI and the performance improvement project for 2009 to 2011. The nurses were supplied with BMI calculators and trained on how to perform, document and graph a BMI and document the BMI% in the medical record. In the 2nd year of the study, all staff were trained by the PIP committee regarding the use of the Healthy Habits Surveys and the Enhanced Patient/Family Questionnaire. The BMI Report cards and other handouts were developed and selected for patient education. The BMI report cards offer healthy eating and lifestyle recommendations for the BMI% groupings of: less than 5%, 5-84%, 85-95% and 96% or greater. They are color-coded for ease of use by BMI category. We did not meet our goal of developing a screening/ referral form for obesity related medical conditions or for nutritional counseling.

Results/Conclusions
The first year goals and part of the second year goals were met successfully for the project. BMI data (BMI, BMI%, and BMI Sharing) are now part of the culture at Southern Tier Pediatrics. For the six performance indicators measured we achieved our goal of 90% or greater. In addition to our success with the performance indicators we have also been successful in making BMI data an integral part of the well visit. The percent of children in our random sample that had a BMI% of 85% or greater was equal to 31%. The provider group recommended continuing education on how to manage patients with obesity and potential medical conditions associated with obesity. These include: hyperlipidemia, hypertension, diabetes and liver conditions.

Total Care (2009-2010)
Pediatric Obesity

Project Topic / Rationale / Aims
Our goal was to increase screening for pediatric obesity by PCPs. The population included members age 3-17 at 3 high volume practices. The intent of the project was to increase the measurement and documentation of BMI, as well as Counseling for Nutrition and Physical Activity. For high-risk members we planned to facilitate referral for treatment. When members were identified as being high risk (i.e., obesity with comorbidity of diabetes, hypertension or hypercholesterolemia), we collaborated with a local medically supervised Childhood Obesity program that provides education to the member and family regarding obesity.

We worked with 3 PCP groups that performed below the statewide average in the QARR 2007 Adolescent Screening BMI measure. We expected to increase our rate by 10 percentage points from the baseline rate to re-measurement for each indicator.

Methodology
The performance indicators were measured using the HEDIS specifications for the WCC measure. We measured the percentage of members age 3-17 who had an outpatient visit with a PCP or OBGYN who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity. HEDIS 2009 was used for baseline measurement. HEDIS 2010 was used for re-measurement #1 and HEDIS 2011 was used for re-measurement #2.

Interventions
We targeted interventions to both members and providers. We reminded providers of expectations for BMI measurement in the provider newsletter and followed up the reminder by mailing BMI measurement tools to all PCP's and OB/GYN's in the network. After surveying our 3 targeted provider groups for their use of BMI documentation tools, we determined that the screening tools were not necessarily the issue, but compliance of staff to use them.

Based on feedback from our Peer Review Committee, we turned our focus into identifying community resources for weight management. We surveyed all area school districts and community programs and compiled a resource guide for distribution to both providers and members. We also highlighted the topic to members in the member newsletter and identified high risk members using claims data so we could distribute a toolkit including educational material and available community resources.

Results/Conclusions
Screening rates for all indicators in the WCC Measure increased for QARR 2009, but the rates for these 3 practices decreased in QARR 2010. It is difficult to determine if the rates for individual practices actually decreased overall because the composition of the sample varied due to membership increase over the last 3 years. Since the provider group and sample size varies each year, a separate chart review should be conducted to have a more focused review on the Providers Groups instead of depending on the random sampling of the QARR medical record review.
Total Care is continuing to update and revise the resource guide for providers every six months. We are also conducting a pilot program through our case management department in connection with a new childhood obesity program administered by a hospital. We will continue to remind providers as a follow up to QARR 2010 regarding measuring and documenting the BMI, exercise, and nutrition portions of the WCC measure.

UnitedHealth Care Community Plan (2009-2010)
Improving Care for Pediatric Members with Obesity

Project Topic / Rationale / Aims
The plan embarked upon a program to improve the diagnosis of and treatment of obesity. The project included multiple interventions to improve Pediatric Obesity care with current evidence and established guidelines. Childhood obesity is epidemic throughout the United States. In 1980, 7% of children ages six to 11 years were considered obese. By 2006, this figure more than doubled to 17%. Childhood obesity increases the likelihood of adult obesity, which is associated with heart disease and cancer. Both childhood and adult obesity are associated with diabetes, high blood pressure, and high cholesterol.

The aim of this project was to identify, intervene, and improve the care of childhood obesity. The objectives of this project were to improve prevention, diagnosis, and management of childhood obesity. The project included interventions to improve care and target members, families, providers, schools, and the health plan. Our target goal for improvement was a 10 percentage point difference between baseline and remeasurement scores.

Methodology
For our baseline measurement the Plan used the 2008 QARR rate for WCC; the results from QARR 2009 and QARR 2010 for this measure were used for our interim and final re-measurement, respectively.

Interventions
Interventions included:
- Distributed educational material for parents and members.
- Distributed BMI calculators/BMI charts to the providers.
- Developed a compendium of community resources for members and clinicians for weight management and nutrition resources
- Provided proactive case management/disease management for high risk patients.
- Provided educational materials on nutrition and exercise to providers to give to targeted members with a diagnosis of childhood obesity.
- Health fair for members and providers on September 10th, 2009 in collaboration with a community based organization, the Kips Bay Boy's and Girl's club distributing nutritional information on healthy choices devoted to the prevention of obesity.
- Partnered with Bronx- Lebanon Hospital addressed the medical and behavioral problems of children and expanded efforts by developing innovative educational initiatives like the Early Childhood Obesity Pilot Study "The Healthy Lifestyles Passport": Eat Right, Live Healthy.
- United Healthcare and Sesame Street partnered to develop Food for Thought: Eating Well on a Budget, a bilingual multimedia education outreach program aimed at helping low-income families make food choices that are affordable and nutritional.

Results/Conclusions
The results of the program showed an increase in our QARR scores from 2008 to 2010 of 28 percentage points in BMI, a 31 percentage point increase in nutrition counseling, and a 36 percentage point increase in physical activity counseling. The plan surpassed the goal of 10 percentage point increase between baseline and re measurement rates. Unfortunately, we have not seen a decrease in the incidence of childhood obesity. We see an increase in documented evidence of the discussions around the complications of obesity and the importance of healthy eating habits.

Univera Community Health (2009-2010)
Fun 2B Fit – Promoting Healthy Lifestyle Choices in the 2nd and 3rd Grade population

Project Topic / Rationale / Aims
Childhood obesity rates are escalating, and the long-term consequences, even into adulthood, have been well documented. The biggest increase in the rate of obesity occurs in the 6–11 year old population (Prevalence of Overweight and Obesity Among Children and Adolescents: United States, 1999-2002; Oct. 6, 2004). The 6–11 year old UCH population (n=2871) accounts for 11% of UCH membership. Results from the 2003 National Survey of Children's Health indicated that 36% of New York children with public health insurance were considered overweight or obese compared to 29.1% of children with private insurance. The promotion of a healthy lifestyle, including increased physical activity and healthy food choices, can decrease the incidence of becoming obese and reduce obesity related diseases.

As such, UCH developed the Fun 2B Fit® program, which was designed to promote physical activity and healthy food choices among children in the 2nd and 3rd grades. The program aimed at decreasing childhood obesity prevalence and reducing obesity- related diseases by focusing on children in the Buffalo City Schools.

The goals of the project were to increase the number of members reporting healthier food choices; to increase the number of members reporting increased physical activity; to increase physician awareness related to the importance of nutritional assessment and counseling and the importance of physical activity assessment and counseling; and to increase the number of physicians measuring BMI.

Methodology
The Fun 2B Fit® program was made available to all 2nd and 3rd grade children in participating schools. Baseline and remeasurement data was to be collected using self-reported surveys that were distributed to participating children and their parents/guardians (only post parent/guardian data was available for analysis). Provider adherence to guidelines was gauged by pre and post self-report survey, as well as the HEDIS/QARR WCC measure.

Interventions
Interventions for the children included physical activity lessons, taste testing of new foods, distribution of aprons, recipe cards and toolkits that contained an activity planner, stopwatch, grocery pad, and a copy of the Fun 2B Fit workout. Parents received information about the program via the program website. Academic detailing sessions were conducted for providers at 11 sites. In addition, each physician was provided an Obesity Focused Provider Tool Kit which focused on nutrition, physical activity, and BMI measurement tools.

Results/Conclusions
Reading and comprehension skills of the students made it difficult to obtain robust survey information; as a result no post student survey data were available. However, the providers who participated responded very favorably to the materials received as part of the provider detailing component of the project.

Full program objectives were not met due to key barriers that included a lack of parental and school involvement. Despite these hurdles, BMI screening, as well as counseling patients on the importance of nutrition and physical activity all increased from the 2009 baseline to the 2011 remeasurement years.

WellCare (2009-2010)
Pediatric Obesity among Medicaid WellCare Members

Project Topic / Rationale / Aims
Available literature indicates that there are many factors contributing to the rising obesity epidemic, including poor nutrition and physical inactivity. According to statistics available from the NICHQ, 30.9% of children in NYS between the ages of 10 and 17 are considered obese or overweight. For children with public health insurance, this percentage increases to 36.4%. In 2007 WellCare scored 12 percentage points below the statewide average for BMI screening, 22 points below for Nutrition and 16 points below for Exercise counseling/assessment.

The aim of this study is to increase by a statistically significant margin over the baseline, the proportion of Medicaid members aged 3-17 years who have their BMI for age calculated, and who receive assessment/counseling for nutrition and for physical activity.

Methodology
The HEDIS measure, WCC was used to assess project objectives. WellCare used HEDIS 2009 Specifications for the baseline, HEDIS 2010 Specifications for the interim measurement, and HEDIS 2011 Specifications for the re-measurement.

Interventions
The goal of member interventions was to raise awareness among members of the seriousness of childhood obesity and the effect it has on the quality of life. Member interventions included:

- Member mailings with educational materials, newsletters, offers of gift card incentives, and information on free or low-cost local exercise and /or weight management programs
- Member targeted calls providing education regarding the importance of a well visit, BMI, nutrition and physical activity

The goal of provider interventions was to raise awareness among providers of the importance of their role in screening, treating and controlling childhood obesity. Interventions included:

- Letters sent to PCPs identified through the denominator which included a list of their eligible members who were diagnosed as being overweight or obese
- A fax blast sent to PCPs, stressing the importance of the role of the PCP in identifying and controlling childhood obesity, and the appropriate codes to document BMI, nutrition, and exercise counseling
- Provider newsletter article on childhood obesity testing for those at risk
- One-on-one provider education from the Quality Improvement and Provider Relations staff

Results/Conclusions
The BMI measure component improved from 32% at baseline to 39% at re-measurement, although the increase was not statistically significant. The nutrition measure component achieved a statistically significant improvement from baseline at 41% to re-measurement of 52%. The improvement in the physical activity measure component, from the baseline of 31% to 36% at re-measurement was not of statistical significance.

The project was successful in educating members and reminding the providers of the importance of assessing members and documenting the assessment, counseling, and education given to their patients during an office visit. We still have opportunities to improve our rates. We will monitor our rates and continue obesity interventions to ensure quality of and access to care for our members.

Affinity (2009-2010)
A Plan to Improve Member Contact and Engagement Rates

Project Topic / Rationale / Aims
For 25 years, Affinity has strived to assure that its members engage with their PCPs, thus increasing the opportunity for health improvement. This project was designed to test new strategies to improve our contact and engagement rates, believing that, as a health plan, we can play a unique role in facilitating and ensuring optimum engagement between members, PCPs and the plan. "Contact" refers to the ability to have a communication reach someone, i.e., for that person to receive a communication, whether in writing, in person, by phone, or other means. "Engagement" refers to establishing a relationship and/or participating in a process. Affinity has experienced challenges in both contacting members and engaging them in a continuity relationship with the health plan and with their PCP. The aim of this project was to develop and test methods designed to increase the portion of new members who engage with Affinity upon activation of their enrollment; and to improve engagement of new members with their PCP.

Methodology
The population was comprised of new members who selected or were assigned to one of three in-network Federally Qualified Health Centers (FQHC's) selected for this study. Goal #1 was to achieve a 5% increase over baseline for new members engaging with Affinity in welcome calls, and successful completion of a HRA. Goal #2 was to achieve a 5% increase over baseline for new members who engage with their PCP within 6 months of enrollment using the following indicators: Percentage of members with a PCP encounter within the first 6 months of enrollment; Initial non-PCP engagement: Percentage of members using service benefits without evidence of PCP use within the first 6 months of enrollment. Non-users: Percentage of members with no evident use of service benefits within the first 6 months of enrollment.

Interventions
Affinity Health Plan Customer Service staff were trained to conduct outbound welcome calls, including administration of the HRA, to new members in the intervention group that the vendor failed to contact or reached but did not administer an HRA. In addition, for all members Affinity reached, the staff offered to assist in scheduling a PCP appointment.

Results/Conclusions
Welcome calls increased from 115 (16%) baseline, to 339 (58%). HRA completion increased from 63 (9%) baseline to 259 (44%). However, Goal #2, Member engagement with the PCP within 6 months of enrollment, was not achieved as evidenced by a decrease from 450 (63%) baseline to 327 (56%). This result was accompanied by an increase in visits not related to PCP services from 67 (9%) baseline to 89 (15%), and an increase in the proportion of members with no services from 201 (28%) baseline to 171 (29%). Affinity speculates that a portion of members may have been new to the health plan, but not new to the PCP practice, a factor that was not included in the selection of study subjects. If this was the case, these established patients may not have had the need to see their PCP within the first 6 months of enrollment. While Goal #1 was successfully achieved, results for engagement (PCP visits) must be interpreted with some caution due to the "new" patient cohorts including patients that were not new to the health centers or PCPs. Affinity will share the findings with each FQHC involved in the study, and take into consideration lessons learned during this study for future studies.

Gold Choice (2010)
Medicaid Managed Care Organization as Advanced Medical Home for Patients with Serious Mental and Emotional Disorders

Project Topic / Rationale / Aims
The Erie County Department of Mental Health SINGLE POINT OF ENTRY (SPOE) program has been developed for adults with severe mental illness. Care coordination services are intended for the high need consumer who has had difficulty maintaining linkages to their providers. Recent national reports have emphasized the relationship between physical and mental health and the need for a more integrated system for individuals with mental illnesses. Gold Choice, a partially-capitated Physician Case Management Program (PCMP) for mentally ill and/or chemically dependent Medicaid recipients in Erie County, New York, has developed a telephonic case management system to link its members with PCPs. Due to its past successes with linkage, Gold Choice was approached by the Erie County Department of Social Services and asked that they collaborate with local mental health agencies in this project. Gold Choice's activities would include linking its SPOE members to a PCP; ensuring these members complete a HRA; and making certain that those members who have a chronic condition are managed properly. Gold Choice hoped to see an increase of 5 percentage points in members having a PCP encounter, and to see all SPOE members completing an HRA.

Methodology
The target population for this project was all Gold Choice members also enrolled in the SPOE program (188 members). A Gold Choice staff member was designated as the Telephonic Case Manager (TCM) for these specific members, and helped members to schedule appointments. The indicators for this project were PCP linkage and HRA completion. PCP linkage was determined by analyzing encounter data monthly to determine if the member had a primary care encounter within the last 12 months. If there was no visit documented the member was encouraged to go and/or the care coordinator assisted them in making an appointment. Gold Choice checked the database to see if an HRA had been obtained. If not, one was obtained and evaluated and any health concerns addressed. The baseline measurement period for both indicators was 1/1/2009-12/31/2009. The re-measurement period was 1/1/2010-12/31/2010.

Interventions
The intervention consisted of two parts: 1) the use of a TCM to help member schedule all primary, specialty, and preventative services and obtain HRAs, and 2) greater coordination of care between the TCM, the special care agencies, and health care providers to ensure that the member is receiving appropriate treatment. Some of the barriers encountered include the inability to contact patients; the inability of patients to present to scheduled PCP appointments; and a lack of information sharing between the mental health agencies and the care coordinator.

Results/Conclusions
There were 188 cases in this project. The results indicate that by the end of the project, 63% of the members had been linked to a PCP. This represents an increase of 12 percentage points from a baseline of 51%. The results also indicate that by the end of the project year 24% of the members had completed an HRA. However, cumulatively over time, 50% of the members completed an HRA. Gold Choice saw an improvement in the number of SPOE members linked with a PCP. Not every SPOE member completed an HRA by project end; however, this number did increase as well. The use of a dedicated Care Coordinator proved a highly useful tool in linking severely mentally ill individuals to a PCP, thus ensuring that their health care needs, as well as their mental health needs, were met. The positive outcomes of this project have prompted Gold Choice to consider using a Care Coordinator model for further projects.

Southern Tier Priority (2010)
Raising Awareness- Adult Obesity

Project Topic / Rationale / Aims
Obesity among adults is increasing in NY State. According to the NYS DOH Obesity Prevention web site, cases of adult obesity more than doubled from 1997 to 2001. Southern Tier Priority Healthcare's (STPH) goal was to raise awareness of members, providers and Community Based Organizations (CBO's) of this growing concern and to share information related to nutrition, food preparation, weight management and assistance that is available to the community to all plan members. Another goal is to ensure correct and complete obesity related coding of encounter data and referrals submitted to the plan by all PCP offices.

Methodology
Two populations for this project were adults over the age of 18 years old that had been on the plan for 12 consecutive months This population was used to compare past encounter data to encounter data received during 2010 to determine if raising PCP awareness raised the number of members newly diagnosed (Indicator #1) and the number of members referred for obesity related diagnoses (Indicator #2). All new adult enrollees received a mass mailing to at the beginning of the year and in new member information packets mailed monthly.

Interventions
The plan reviewed encounter data to determine if existing plan members had ever been diagnosed with obesity or referred for obesity related care. Our first intervention was to raise awareness of PCP offices of the need for correct and complete coding related to obesity and to increase their knowledge of programs, assistance and services available to patients. A review of encounter data on a quarterly basis determined if existing members have new diagnosis codes or referrals related to obesity. Mass mailings to all adult members followed by monthly mailings to all new adult members contained obesity related information, educational information and information on services available in the community and through Cornell Cooperative Extension.

Results/Conclusions
The data used for comparison was as follows: In 2009 - 243 members were identified with an obesity related diagnosis, 50 of them newly diagnosed; 27 referrals were written for obesity related services. In 2010 - 338 members were identified with an obesity related diagnosis, 95 of them newly diagnosed; 28 new referrals were written for obesity related services. Mailings – 4161 existing adult members received a mass mailing and 1871 new members also received a mailing. Cornell Cooperative Extension Enrollments - Overall class size has increased over the past 12 months.

Our main objective, to increase awareness, knowledge and the services available for obesity appears to have worked well. The 2009 PIP project related to childhood obesity may have also helped in raising awareness with the adult population as well. There were 50 members that were newly diagnosed in 2009 and another 95 members in 2010. With this increase we believe that PCP offices are more aware and are sending complete diagnosis codes for existing patients. CCE feels that the information we distributed helped to increase the participation in its programs. STPH will continue to distribute information and reminders and work with CBO's, to keep providers and members up to date on services available.

MCOs' Selected Measures Used to Assess the Success of the Obesity Performance Improvement Project: Pre/Post and Interim Results

Plan	Measure	Baseline 2008	Interim 2009	Re-measurement 2010	Results Summary
Amerigroup* (2009-2010)	BMI	72%	N/A	91%	Demonstrated improvement
	Nutrition	65%	N/A	65%	Performance level was maintained
	Physical Activity	32%	N/A	52%	Demonstrated improvement
CDPHP (2009-2010)	BMI	40%	60%	62%	Demonstrated improvement
	Nutrition	61%	69%	71%	Demonstrated improvement
	Physical Activity	40%	48%	60%	Demonstrated improvement
	Well Child Visits ages 3 – 6	N/A	78%	77%	Performance level was maintained
	Well Child Visits ages 12 – 21years	N/A	52%	52%	Performance level was maintained
	Members with BMI/BMI percentile coded via V-codes**	0.68%	0.76%	0.49%	Performance declined
	Members with newborns who had evidence of breastfeeding***	38%	43%	48%	Demonstrated improvement
EmblemHealth (2009 – 2010)	BMI	40%	34%	67%	Demonstrated improvement
	Nutrition	57%	46%	67%	Demonstrated improvement
	Physical Activity	47%	34%	61%	Demonstrated improvement

* Amerigroup rates were based on a composite of 10 providers.

** CDPHP rates for coding via V-codes were based on administrative data at well visits.

*** CDPHP breastfeeding rates were based on chart abstraction during medical record review for HEDIS and Perinatal Care Study.

MCOs' Selected Measures Used to Assess the Success of the Obesity Performance Improvement Project: Pre/Post and Interim Results

Plan	Measure	Baseline 2008	Interim 2009	Re-measurement 2010	Results Summary
Excellus / MVP (2009-2010)*	Percentage of Women Gaining Weight In Excess of IOM Guidelines	33%	N/A	61%	Performance declined
	Nutrition Referrals for Excessive Weight Gain During Pregnancy	0%	N/A	16%	Demonstrated improvement
	Pregnancy BMI Documented	2%	N/A	17%	Demonstrated improvement
	Intent to Breastfeed at Delivery	44%	N/A	57%	Demonstrated improvement
	Breastfeeding at Postpartum Follow-up	31%	N/A	50%	Demonstrated improvement
Fidelis (2009-2010)**	Percentage of pregnant women who did not exceed the IOM standard for ideal weight gain	18%	N/A	11%	Demonstrated improvement
	Percentage of pregnant women who initiated and continued breastfeeding at 6 months	37%	N/A	37%	Performance level was maintained

* Excellus/MVP rates are based on medical record review from selected high-volume OB/GYN and Family Practice providers.
** Fidelis rates are based on phone contacts made with members enrolled in a management program for pregnant women

MCOs' Selected Measures Used to Assess the Success of the Obesity Performance Improvement Project: Pre/Post and Interim Results

Plan	Measure	Baseline 2008	Interim 2009	Re-measurement 2010	Results Summary
Healthfirst (2009-2010)	BMI	26%	40%	44%	Demonstrated improvement
	Nutrition	42%	39%	60%	Demonstrated improvement
	Physical Activity	30%	33%	40%	Demonstrated improvement
HealthNow New York (BCBS WNY) (2009-2010)	BMI	40%	41%	67%	Demonstrated improvement
	Nutrition	53%	61%	64%	Demonstrated improvement
	Physical Activity	36%	54%	50%	Demonstrated improvement
	Well Child Visits ages 3 – 6	76%	78%	78%	Demonstrated improvement
	Adolescent Well Care Visits	55%	54%	55%	Performance level was maintained
HealthPlus (2009 - 2010)	BMI	53%	56%	70%	Demonstrated improvement
Hudson (2009-2010)	BMI	63%	77%	75%	Demonstrated improvement
	Nutrition	65%	74%	80%	Demonstrated improvement
	Physical Activity	46%	58%	65%	Demonstrated improvement

MCOs' Selected Measures Used to Assess the Success of the Obesity Performance Improvement Project: Pre/Post and Interim Results

Plan	Measure	Baseline 2008	Interim 2009	Re-measurement 2010	Results Summary
Independent Health (2009-2010) *	BMI Calculated	95%	N/A	93%	Performance declined
	Blood Pressure Documented	94%	N/A	95%	Demonstrated improvement
	Discussion of Sugar Sweetened Beverages	32%	N/A	50%	Demonstrated improvement
	Discussion of eating 5 or more fruits and vegetables	25%	N/A	52%	Demonstrated improvement
	Discussion of eating away from home	20%	N/A	42%	Demonstrated improvement
	Discussion of eating breakfast daily	19%	N/A	43%	Demonstrated improvement
	Discussion of portion control	19%	N/A	43%	Demonstrated improvement
	2 or more hours of physical activity	33%	N/A	51%	Demonstrated improvement
	1 hour or less of screen time	33%	N/A	49%	Demonstrated improvement
MetroPlus (2009-2010)	BMI**	N/A	0%-96%	83%-100%	Demonstrated improvement
	Nutrition**	N/A	33%-100%	82%-100%	Demonstrated improvement
	Physical Activity**	N/A	17%-83%	52%-100%	Demonstrated improvement
	ICD-9 Coding 2009-2010 Overall***	N/A	10%	16%	Demonstrated improvement

* For Independent Health, rates were based on a chart review tool utilized by physicians at six pediatric practices.
** MetroPlus values represent the minimum and maximum range among five facilities. 2009 is considered the baseline period.
*** MetroPlus ICD-9 values are based on claims data combined among five facilities. 2009 is considered the baseline period.

MCOs' Selected Measures Used to Assess the Success of the Obesity Performance Improvement Project: Pre/Post and Interim Results

Plan	Measure	Baseline 2008	Interim 2009	Re-measurement 2010	Results Summary
NHP (2009-2010)	BMI	31%	41%	68%	Demonstrated improvement
	Nutrition	57%	69%	72%	Demonstrated improvement
	Physical Activity	44%	54%	61%	Demonstrated improvement
Southern Tier Pediatrics (2009-2010)*	Calculate/Recording BMI in Chart	N/A	88%	100%	Demonstrated improvement
	Graphing BMI in Chart	N/A	78%	100%	Demonstrated improvement
	Recording BMI% in Chart	N/A	96%	100%	Demonstrated improvement
	BMI Sharing in Chart	N/A	19%	100%	Demonstrated improvement
Total Care (2009-2010)**	BMI	61%/61%	70%/69%	59%/59%	Performance level was maintained
	Nutrition	72%/62%	82%/68%	69%/63%	Performance level was maintained
	Physical Activity	58%/54%	68%/54%	54%/43%	Performance declined
UnitedHealth Care Community Plan (2009-2010)	BMI	44%	48%	73%	Demonstrated improvement
	Nutrition	46%	46%	78%	Demonstrated improvement
	Physical Activity	32%	39%	68%	Demonstrated improvement

* Southern Tier Pediatrics' rates are based on chart data from 3 provider sites. 2009 is considered the baseline period.

** For Total Care, 1st value represents combined results for 3 provider groups; 2nd value represents QARR Total Care rates

MCOs' Selected Measures Used to Assess the Success of the Obesity Performance Improvement Project: Pre/Post and Interim Results

Plan	Measure	Baseline 2008	Interim 2009	Re-measurement 2010	Results Summary
Univera Community Health (2009-2010)	BMI	55%	50%	64%	Demonstrated Improvement
	Nutrition	69%	51%	73%	Demonstrated Improvement
	Physical Activity	52%	37%	63%	Demonstrated Improvement
WellCare (2009-2010)	BMI	32%	53%	39%	Demonstrated improvement
	Nutrition	41%	41%	52%	Demonstrated improvement
	Physical Activity	31%	33%	36%	Demonstrated improvement
Non - Pediatric Obesity PIPs					
Affinity (2009-2010) *	Welcome Calls	16%	N/A	58%	Demonstrated improvement
	Completed HRAs	9%	N/A	44%	Demonstrated improvement
	PCP encounter within 1st 6 months	63%	N/A	56%	Performance declined
	Non-PCP engagement within 1st 6 months	9%	N/A	15%	Performance declined
	No evidence of use of service benefits within 1st 6 months	28%	N/A	29%	Performance level was maintained

* Affinity’s rates are based on members in three in-network Federally Qualified Health Centers.

MCOs' Selected Measures Used to Assess the Success of the Obesity Performance Improvement Project: Pre/Post and Interim Results

Plan	Measure	Baseline 2008	Interim 2009	Re-measurement 2010	Results Summary
Gold Choice (2010) *	HRA	26%	N/A	50%	Demonstrated improvement
	PCP Linkage	51%	N/A	63%	Demonstrated improvement
Southern Tier Priority (2010) **	Number of Members Newly Diagnosed With Obesity	N/A	50	95	Demonstrated improvement
	Number of Referrals for Obesity Services	10	27	28	Demonstrated improvement

* Gold Choice's rates are based on members enrolled in the SINGLE POINT OF ENTRY (SPOE) program.
** Southern Tier Priority's rates are based on adult members who met the plan's inclusion criteria.