OFFICE OF THE GOVERNOR
Walter Sillers Building | 550 High Street, Suite 1000 | Jackson, Mississippi 39201

MISSISSIPPI DIVISION OF
MEDICAID

December 28, 2018

Honorable Buck Clarke
Honorable Dean Kirby
Honorable Brice Wiggins
Mississippi Senate
New Capitol
Jackson, MS 39215

Honorable Chris Brown
Honorable Sam Mims
Honorable John Read
Mississippi House of Representatives
New Capitol
Jackson, MS 39215

Re: Progress Report on the Miss. Delta Population Health Demonstration Project

Dear Committee Chairs:

I write in accordance with Section 19(2) of House Bill 1598 (2018), which directed the Mississippi Division of Medicaid ("DOM") to provide a progress report on the Mississippi Delta Medicaid Population Health Demonstration Project (the "Project") to the Chairmen of the Senate and House Public Health Committees, Senate and House Medicaid Committees and the Senate and House Appropriations Committees on or before December 31, 2018.

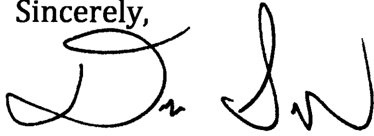
For State Fiscal Year 2019, DOM has sent $3.379M in state funds to the Delta Health Alliance ("DHA") for the continuation of the program as contemplated in Section 19(1) and for the Patient Centered Medical Model Home in Section 17. DHA hired five more care coordinators and appears to have started a postpartum program, broadening the Project's scope. For the remaining $1.066M, DOM is preparing a menu of options for your review that would expand the Project in a way to qualify for federal funds and to accomplish the objectives of the Mississippi Medicaid Law and HB1598 in a fiscally responsible manner.

While I am able to speak favorably on a number of the people involved in the Project and the overall concept, I remain unable to endorse the Project in its existing form as a cost-effective use of taxpayer dollars. In four years, more than $10.6 million in state support dollars have been sent to DHA. According to the most recent information available to DOM, the Project has served a few hundred beneficiaries. The Project also involves activities that could be led by the managed care companies at a 76% federal match, overlaps in part with the Department of Health's PHMR/ISS case management program that DOM is required to fund, and commits nearly $80,000 per month to a health care information technology subcontractor for a predictive algorithm tool that hasn't been utilized to identify high-risk pregnant women for the study.

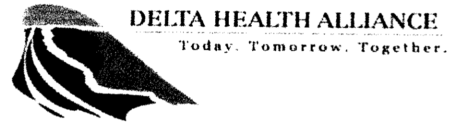
According to DHA's bimonthly reports provided to DOM in SFY19 (attached), DHA will provide a summary of program activities for SFY19 once it completes a transition to a new care management solution in January 2019. These reports may help shed some more light on who has been served, what the outcomes have been, what has worked, and what hasn't worked over the past 4 ½ years of the Project.

I welcome the opportunity to discuss further and to answer any questions you may have.

Sincerely,



Drew L. Snyder, JD
Executive Director



MS DELTA MEDICAID POPULATION HEALTH DEMONSTRATION PROJECT

Budgetary Updates for the July 1, 2018 – August 31, 2018 Reporting Period

EXPENSE SUMMARY REPORT (JULY 1, 2018 – AUGUST 31, 2018)

CATEGORY	EXPENSES
Salaries / Wages	$132,372.09
Fringes	$36,111.98
Indirect	$25,417.74
Travel	$6,854.05
Supplies	$83.40
Contractual / Consulting	$78,162.23
Other	$1,500.03
Total Expenses	$280,501.52

SALARIES/WAGES (JULY 1, 2018 – AUGUST 31, 2018)

A total of **$132,372.09** was expended towards the salaries and wages of programmatic and supporting personnel based on the following categories:

- **Administrative** – includes percentages of FTEs for members of DHA's Executive Leadership team and area team leads. These positions include the CEO, CFO, Associate Vice – President of Health & Technology Programs and Directors of Health Information Technology and Information Technology. The administrative team is responsible for the oversight of the entire program.
- **Healthy Pregnancy Program** – includes the salaries of the Healthy Pregnancy Coaches at one full time equivalent (FTE) each. It also includes 0.5 FTE for the Program Director. The program consisted of three Healthy Pregnancy Coaches until an additional two began employment on July 30, 2018.

- **Prediabetes Program** – includes the salaries of the Care Coordinators at one full time equivalent (FTE) each. It also includes 0.5 FTE for the Program Director. The program consisted of three Care Coordinators until an additional three began employment on July 30, 2018.
- **Health Information Technology** – includes percentages of FTEs for Clinical Analysts, Interface & Reporting Analysts and Nurse Informaticists. These positions support the validation and maintenance of both the Prediabetes and Preterm Birth Registries. Tasks include daily clinical data uploads to Cerner, monthly Medicaid claims data uploads to Cerner, overseeing DHA's data onboarding processes for new clinical data sources and data reporting.
- **Information Technology** – includes percentages of FTEs for Systems Administrators who are responsible for maintaining data storage and security protocols according to Medicaid, HIPAA and industry standards. They also oversee the Network and servers needed to house clinical data.

The chart below represents a summary of Salary/Wage expenses by category.

SALARIES/WAGES BY CATEGORY	AMOUNT BY CATEGORY
Administrative	$ 36,434.87
Healthy Pregnancy Program	$ 27,393.24
Prediabetes Program	$ 30,247.45
Health Information Technology	$ 31,737.56
Information Technology	$ 6,558.97
Total Salaries/Wages Expenses	[illegible]

FRINGES (JULY 1, 2018 – AUGUST 31, 2018)

A total of **$36,111.98** was expended for Fringes during this reporting period. DHA provides comprehensive employee health insurance and retirement benefits for its full-time employees. Fringe benefits for employees of DHA have been refined utilizing historical costs reflecting full operations for multiple years. Based on actual historical expenditures the rate has been calculated at 29.75% for direct employee costs.

The chart below represents a summary of Fringe expenses by category.

FRINGES	AMOUNT BY CATEGORY
Administrative	$ 8,354.85
Healthy Pregnancy Program Team	$ 8,187.23
Health & Information Tech. Team	$ 8,393.45
Information Tech. Team	$ 1,614.65
Prediabetes Program Team	$ 9,561.80
Total Fringes:	**$36,111.98**

INDIRECT COSTS (JULY 1, 2018 – AUGUST 31, 2018)

A total of **$25,417.74** was expended for Indirect Costs during this reporting period.

TRAVEL (JULY 1, 2018 – AUGUST 31, 2018)

A total of **$6,854.05** was expended for travel during this reporting period. Travel is necessary for the facilitation of grocery store tours, home visits and participant group meetings.

SUPPLIES (JULY 1, 2018 – AUGUST 31, 2018)

A total of **$83.40** was expended for office supplies during this reporting period.

CONTRACTUAL/CONSULTING (JULY 1, 2018 – AUGUST 31, 2018)

A total of **$78,162.23** was expended for contractual obligations during this reporting period. The entire expenditure was for Cerner Corporation's monthly maintenance costs for HealtheRegistries.

OTHER (JULY 1, 2018 – AUGUST 31, 2018)

A total of **$1,500.03** was expended for Other expenses during this reporting period. Other expenses include payment of new employee background checks, rent for office space, telephone and postage/shipping costs. The chart below represents a summary of Other expenses by category.

OTHER	AMOUNT BY CATEGORY
Background Checks	$ 16.00
Rent	$ 840.00
Telephone	$ 594.83
Shipping	$ 49.20
Total Other:	$1,500.03

MS DELTA MEDICAID POPULATION HEALTH DEMONSTRATION PROJECT

Programmatic Updates for the July 1, 2018 – August 31, 2018

The *Mississippi Delta Medicaid Population Health Demonstration Project*, a partnership between Delta Health Alliance and Cerner Corporation, in coordination with the Mississippi Division of Medicaid, uses population health strategies and technologies to identify high-risk patients and to help clinics to provide patients with clinical care coordination, education and support. The goal of the project is to reduce the incidence of type II diabetes and preterm births by 5% each among the Medicaid population in a 10 – county service area. The service area includes: Bolivar, Coahoma, Holmes, Leflore, Panola, Sunflower, Tunica, Warren, Washington and Yazoo counties.

Programmatic Interventions supported by this project include:

- The Prediabetes Program
- The Healthy Pregnancy Program
- The Postpartum Program

Activities supported by this project include:

- Integration of Medicaid claims data and clinical Electronic Health Records data into Cerner's HealtheRegistries
- Health coaching for patients with prediabetes and for pregnant women
- Implementation of new clinical workflows and processes at clinics to improve data quality, documentation and provider adherence to clinical standards of care for prediabetes and prenatal patients
- Data Registry support for 132,823 Medicaid recipients in the 10 – county service area

PREDIABETES PROGRAM

Program Summary – Initiated in August 2016 with a goal of developing and implementing strategies to aid in reducing the incidence of diabetes by identifying and enrolling prediabetes patients and patients at risk of developing diabetes patients into the program. Enrolled patients living or receiving clinical care within the 10-county service area receive telephone health coaching, home visits, physical activity opportunities, grocery store tours, education classes and referrals to needed resources within their communities.

Program Enrollment Summary

1. Identifying patients: A patient list is generated from Cerner's Prediabetes Registry. This list includes demographics and some clinical data for patients the Prediabetes Registry has identified as either having an existing prediabetes diagnosis or at-risk of developing diabetes. The following steps are taken to determine which patients will be contacted for program enrollment:
   - The Cerner Prediabetes Registry generated list is decreased to include only patients with encounters at one of the participating clinical sites
   - A deidentified list is provided to DHA's evaluation team for randomization (Random Control Trial) – patients are either assigned to the treatment or control group. The control group is not contacted by the Care Coordinators

# of Patients Identified in Cerner's Prediabetes Registry	# of Patients Randomized to Treatment Group as of August 31, 2018

2. Enrolling patients:
   - Letters are mailed to Treatment Group patients advising them of the program and including the name and contact number of the Care Coordinator who will contact them
   - Care Coordinators are provided their Treatment Group patient lists. They call every patient to discuss the program and offer to enroll the patient. The patient either declines to participate or consents to participate. If the patient consents, an initial home visit is scheduled with the patient

3. Program activities:
   - Home visits (minimum of four)
   - Grocery store tours and nutrition classes/referrals
   - Six-week chronic disease self-management education classes
   - Weekly or biweekly phone calls depending on need
   - Development of patient specific care management care plans
     - Clinical office visits and bloodwork
     - Patient-centered goals
     - Socioeconomic needs
       - Identify resources and provide referrals
     - Exercise/nutrition
   - Monthly group meetings

- A summary of program activities for the reporting period will be provided once DHA completes its transition to a new Care Management solution, Efforts to Outcomes (ETO), in January 2019. DHA has previously utilized Allscripts' Care Director Care Management solution to document home visits, phone calls, to create patient care plans and patient-centered goals. Care Director did not allow the level of robust data reporting needed to provided details regarding program activities. ETO will enable DHA to provide charts, graphs, etc. detailing the following:

    - Program attrition rates for the current reporting period
    - # of phone calls (attempted) for the current reporting period
    - # of phone calls (successful) for the current reporting period
    - # of home visits scheduled for the current reporting period
    - # of home visits completed for the current reporting period
    - # of goals met during the current reporting period
    - # offered to enroll for the current reporting period
    - # declining enrollment for the current reporting period
    - # enrolled/consented during the current reporting period
    - # completing the program during the current reporting period
    - # reenrolled in the program during the current reporting period
    - # new diabetes diagnosis during the current reporting period
    - # of provider office visits scheduled by enrolled patients during the current reporting period
    - # provider office visits completed (encounters) by enrolled patients during the current reporting period
    - # of grocery store tours scheduled during the current reporting period
    - # of grocery store tours completed during the current reporting period
    - # of enrolled patients completing a grocery store tour during the current reporting period
    - # of community/patient family members completed a grocery store tour during the current reporting period
    - # of Health Chats scheduled during the current reporting period
    - # of Health Chats completed during the current reporting period
    - # of enrolled patients attending a Health Chat during the current reporting period
    - # of community/patient family members completed a Health Chat during the current reporting period
    - # of exercise/nutrition classes scheduled during the current reporting period
    - # of exercise/nutrition classes completed during the current reporting period
    - # of enrolled patients attending an exercise/nutrition class during the current reporting period
    - # of community/patient family members attending an exercise/nutrition class during the current reporting period
    - # of Chronic Disease Self-Management Education classes scheduled during the current reporting period

- # of Chronic Disease Self-Management Education classes completed during the current reporting period
- # of enrolled patients attending Chronic Disease Self-Management Education classes during the current reporting period
- # of community/patient family members attending Chronic Disease Self-Management Education classes during the current reporting period
- # of enrolled patients referred to community service providers for assistance with socioeconomic, domestic violence and/or mental/behavioral health needs

4. Enrollment Status: No additional patients were enrolled into the Prediabetes Program during this reporting period due to the following:
   - Cerner and DHA continued working to deploy the HealtheRegistry test/validation environment. DHA requested Cerner create a test/validation environment to allow new data sources to be added to the test/validation environment before going into the HealtheRegistries production environment. Historically, all data flowed directly into the production environment before validation could be initiated increasing the potential of disrupting the Program teams' ability to use HealtheRegistries. The test/validation environment allows DHA to validate new data without impacting the Production site. The test/validation environment was begun active in August 2018.
   - DHA made changes to Allscripts Touchworks which created a need for Cerner to change its mappings. Cerner and DHA worked to complete the transfer, processing and upload of the new DHA Allscripts consolidated data file which was placed in the new test/validation environment in August 2018.
   - A new Prediabetes patient list could not be generated for randomization until the DHA Allscripts Touchworks data file was added to Production.
   - The Program Team utilized this time to hire and train three new Care Coordinators. They also reviewed existing patient recruitment strategies to identify different means of engaging patients.

# Enrolled July 1, 2018 - August 31, 2018	# Enrollment Declinations July 1, 2018 - August 31, 2018	Total Enrolled Since August 2016
0	0	101

5. Challenges/Lessons Learned: There were no additional challenges encountered during this reporting period.

Program Staff – Includes a total 6 Care Coordinators each at 1 full-time equivalent (FTE) and the Program Director at 0.5 FTE. Three of the six began employment on July 30, 2018.

Project Team	Role	Role Description	FTE
Shauna Aguilar, RN	**Director, Population Health**	Oversight of daily activities and coordination of participant services; Maintains clinic communications; Assists with reports	0.5
RyAnne Williams, RN	**Lead Care Coordinator**	Provides nutrition and chronic disease self-management education; Conducts home visits and grocery store tours; Provides care coordination	1.0
Camilla Butler, MPH	Care Coordinator		1.0
Cassonya Lampkin, LPN	Care Coordinator		1.0
Gwendolyn Chambers	Care Coordinator		1.0
Sylvia Thomas	Care Coordinator		1.0
Darrius Moore, MS, CHES	Care Coordinator		1.0

HEALTHY PREGNANCY PROGRAM

Program Summary – initiated in January 2017 to develop a prenatal program aimed at reducing the pre-term birth rate by creating customized care plans, providing education, support, encouragement and connections to needed social services to enrolled pregnant women living or receiving care within the 10-county service area.

Program Enrollment Summary

1. Identifying patients: A patient list is generated from Cerner's Prediabetes Registry. This list includes demographics and some clinical data for patients the Prediabetes Registry has identified as either having an existing prediabetes diagnosis or at-risk of developing diabetes. The following steps are taken to determine which patients will be contacted for program enrollment:
    - The Cerner Prediabetes Registry generated list is decreased to include only patients with encounters at one of the participating clinical sites
    - A deidentified list is provided to DHA's evaluation team for randomization (Random Control Trial) – patients are either assigned to the treatment or control group. The control group is not contacted by the Care Coordinators

2. Enrolling patients:
    - Letters are mailed to Treatment Group patients advising them of the program and including the name and contact number of the Care Coordinator who will contact them
    - Care Coordinators are provided their Treatment Group patient lists. They call every patient to discuss the program and offer to enroll the patient. The patient either

declines to participate or consents to participate. If the patient consents, an initial home visit is scheduled with the patient

3. Program activities:
   - Home visits (monthly)
   - Weekly phone calls
   - Development of patient specific care management care plans
     - Completion of assessments
     - Clinical office visits and bloodwork
     - Patient-centered goals
     - Socioeconomic needs
       - Identify resources and provide referrals
     - Exercise/nutrition
   - Monthly group meetings
   - A summary of program activities for the reporting period will be provided once DHA completes its transition to a new Care Management solution, Efforts to Outcomes (ETO), in January 2019. DHA has previously utilized Allscripts' Care Director Care Management solution to document home visits, phone calls, to create patient care plans and patient-centered goals. Care Director did not allow the level of robust data reporting needed to provided details regarding program activities. ETO will enable DHA to provide charts, graphs, etc. detailing the following:
     - Program attrition rates for the current reporting period
     - # of phone calls (attempted) for the current reporting period
     - # of phone calls (successful) for the current reporting period
     - # of home visits scheduled for the current reporting period
     - # of home visits completed for the current reporting period
     - # of goals met during the current reporting period
     - # offered to enroll for the current reporting period
     - # declining enrollment for the current reporting period
     - # enrolled/consented during the current reporting period
     - # completing the program during the current reporting period
     - # reenrolled in the program during the current reporting period
     - # full-term births during the current reporting period
     - # of preterm births during the current reporting period
     - # of Health Chats scheduled during the current reporting period
     - # of Health Chats completed during the current reporting period
     - # of enrolled patients attending a Health Chat during the current reporting period
     - # of community/patient family members completed a Health Chat during the current reporting period
     - # of exercise/nutrition classes scheduled during the current reporting period
     - # of exercise/nutrition classes completed during the current reporting period
     - # of enrolled patients attending an exercise/nutrition class during the current reporting period

- # of community/patient family members attending an exercise/nutrition class during the current reporting period
- # of enrolled patients referred to community service providers for assistance with socioeconomic, domestic violence and/or mental/behavioral health needs

4. Challenges/Lessons Learned – There were no challenges encountered during this reporting period.

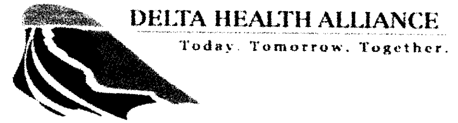
Program Staff – Includes a total 5 Healthy Pregnancy Coaches each at 1 full-time equivalent (FTE) and the Program Director at 0.5 FTE. Two of the five began employment on July 30, 2018.

Project Team	Role	Role Description	FTE
Shauna Aguilar, RN	**Director, Population Health**	Oversees daily activities of the program and the coordination of participant services; Maintains clinic communications; Develops educational and program curriculum; Assists with reports	0.5
LaToya Atkins, MS	Lead Healthy Pregnancy Coach	Identifies needs and aids in connecting pregnant women to services; Provides pregnancy and health-related education; Conducts home visits; Builds relationships throughout service area	1.0
LaTasha Leggett, MS	Healthy Pregnancy Coach		1.0
Brianna Jackson	Healthy Pregnancy Coach		1.0
Constance Coleman	Healthy Pregnancy Coach		1.0
KaTara Tyler	Healthy Pregnancy Coach		1.0
TBH	Healthy Pregnancy Coach		1.0

POST-PARTUM PROGRAM

Program Summary – engages women who have delivered babies within the most recent 8 weeks preceding identification to aid in ensuring contraceptive plans are in place and the mother and baby are receiving proper postnatal care. Enrollment periods generally do not extend more than 3 months.

- A summary of program activities for the reporting period will be provided once DHA completes its transition to a new Care Management solution, Efforts to Outcomes (ETO), in January 2019. DHA has previously utilized Allscripts' Care Director Care Management solution to document home visits, phone calls, to create patient care plans and patient-centered goals. Care Director did not allow the level of robust data reporting needed to provided details regarding program activities. ETO will enable DHA to provide charts, graphs, etc. detailing the following:
    - Program attrition rates for the current reporting period
    - # of phone calls (attempted) for the current reporting period
    - # of phone calls (successful) for the current reporting period
    - # offered to enroll for the current reporting period
    - # declining enrollment for the current reporting period
    - # enrolled/consented during the current reporting period



MS DELTA MEDICAID POPULATION HEALTH DEMONSTRATION PROJECT

Budgetary Updates for the September 1, 2018 – October 31, 2018 Reporting Period

EXPENSE SUMMARY REPORT (SEPTEMBER 1, 2018 – OCTOBER 31, 2018)

CATEGORY	EXPENSES
Salaries / Wages	$116,263.01
Fringes	$33,047.69
Indirect	$31,376.61
Travel	$10,752.58
Supplies	$8,543.33
Contractual / Consulting	$93,478.85
Other	$50,774.02
Total Expenses	$344,236.09

SALARIES/WAGES (SEPTEMBER 1, 2018 – OCTOBER 31, 2018)

A total of **$116,263.01** was expended towards the salaries and wages of programmatic and supporting personnel based on the following categories:

- **Administrative** – includes percentages of FTEs for members of DHA's Executive Leadership team and area team leads. These positions include the CEO, Associate Vice – President of Health & Technology Programs and Directors of Health Information Technology and Information Technology. The administrative team is responsible for the oversight of the entire program.
- **Healthy Pregnancy Program** – includes the salaries of the Healthy Pregnancy Coaches at one full time equivalent (FTE) each. It also includes 0.5 FTE for the Program Director and a Research Assistant. The program consisted of three Healthy Pregnancy Coaches until an additional two began employment on July 30, 2018.

- **Prediabetes Program** – includes the salaries of the Care Coordinators at one full time equivalent (FTE) each. It also includes 0.5 FTE for the Program Director and a Research Assistant. The program consisted of three Care Coordinators until an additional three began employment on July 30, 2018.
- **Health Information Technology** – includes percentages of FTEs for Clinical Analysts, Interface & Reporting Analysts and Nurse Informaticists. These positions support the validation and maintenance of both the Prediabetes and Preterm Birth Registries. Tasks include daily clinical data uploads to Cerner, monthly Medicaid claims data uploads to Cerner, overseeing DHA's data onboarding processes for new clinical data sources and data reporting.
- **Information Technology** – includes percentages of FTEs for Systems Administrators who are responsible for maintaining data storage and security protocols according to Medicaid, HIPAA and industry standards. They also oversee the Network and servers needed to house clinical data.

The chart below represents a summary of Salary/Wage expenses by category.

SALARIES/WAGES BY CATEGORY	AMOUNT BY CATEGORY
Administrative	$ 23,784.62
Healthy Pregnancy Program	$ 31,568.63
Prediabetes Program	$ 45,295.03
Health Information Technology	$ 15,614.73
Information Technology	$ 0
Total Salaries/Wages Expenses	$116,263.01

FRINGES (SEPTEMBER 1, 2018 – OCTOBER 31, 2018)

A total of **$33,047.69** was expended for Fringes during this reporting period. DHA provides comprehensive employee health insurance and retirement benefits for its full-time employees. Fringe benefits for employees of DHA have been refined utilizing historical costs reflecting full operations for multiple years. Based on actual historical expenditures the rate has been calculated at 29.75% for direct employee costs.

The chart below represents a summary of Fringe expenses by category.

FRINGES	AMOUNT BY CATEGORY	
Administrative	$	4,865.68
Healthy Pregnancy Program Team	$	9,573.97
Health & Information Tech. Team	$	4,049.47
Information Tech. Team	$	0
Prediabetes Program Team	$	14,558.57
Total Fringes:		$33,047.69

INDIRECT COSTS (SEPTEMBER 1, 2018 – OCTOBER 31, 2018)

A total of **$31,376.61** was expended for Indirect Costs during this reporting period.

TRAVEL (SEPTEMBER 1, 2018 – OCTOBER 31, 2018)

A total of **$10,752.58** was expended for travel during this reporting period. Travel is necessary for the facilitation of grocery store tours, home visits and participant group meetings.

SUPPLIES (SEPTEMBER 1, 2018 – OCTOBER 31, 2018)

A total of **$8,543.33** was expended for office supplies during this reporting period.

CONTRACTUAL/CONSULTING (SEPTEMBER 1, 2018 – OCTOBER 31, 2018)

A total of **$93,478.85** was expended for contractual obligations during this reporting period. The expenditures were for Cerner Corporation's monthly maintenance costs for HealtheRegistries and for program evaluation. The chart below represents a summary of Contractual/Consulting expenses by category.

OTHER	AMOUNT BY CATEGORY	
Cerner Corporation	$	78,162.23
Christian Brothers University	$	5,417.32

University of TN	$	4,999.30
Wesley James	$	4,900.00
Total Other:		**$93,478.85**

OTHER (SEPTEMBER 1, 2018 – OCTOBER 31, 2018)

A total of **$50,774.02** was expended for Other expenses during this reporting period. Other expenses include payment of new employee background checks, program participant gift cards, rent for office space, data reporting consulting, telephone and postage/shipping costs. The chart below represents a summary of Other expenses by category.

OTHER	AMOUNT BY CATEGORY	
Gift Cards	$	1,995.00
Consulting (Futura Mobility)	$	30,669.00
Background Checks	$	138.00
Advertising	$	2,000.00
Data Support	$	700.00
Design	$	767.22
Rent	$	133.34
Telephone	$	14,261.00
Shipping	$	110.46
Total Other:		**$50,774.02**

MS DELTA MEDICAID POPULATION HEALTH DEMONSTRATION PROJECT

Programmatic Updates for the September 1, 2018 – October 31, 2018

The *Mississippi Delta Medicaid Population Health Demonstration Project*, a partnership between Delta Health Alliance and Cerner Corporation, in coordination with the Mississippi Division of Medicaid, uses population health strategies and technologies to identify high-risk patients and to help clinics to provide patients with clinical care coordination, education and support. The goal of the project is to reduce the incidence of type II diabetes and preterm births by 5% each among the Medicaid population in a 10 – county service area. The service area includes: Bolivar, Coahoma, Holmes, Leflore, Panola, Sunflower, Tunica, Warren, Washington and Yazoo counties.

Programmatic Interventions supported by this project include:

- The Prediabetes Program
- The Healthy Pregnancy Program
- The Postpartum Program

Activities supported by this project include:

- Integration of Medicaid claims data and clinical Electronic Health Records data into Cerner's HealtheRegistries
- Health coaching for patients with prediabetes and for pregnant women
- Implementation of new clinical workflows and processes at clinics to improve data quality, documentation and provider adherence to clinical standards of care for prediabetes and prenatal patients
- Data Registry support for 132,823 Medicaid recipients in the 10 – county service area

PREDIABETES PROGRAM

Program Summary – Initiated in August 2016 with a goal of developing and implementing strategies to aid in reducing the incidence of diabetes by identifying and enrolling prediabetes patients and patients at risk of developing diabetes patients into the program. Enrolled patients living or receiving clinical care within the 10-county service area receive telephone health coaching, home visits, physical activity opportunities, grocery store tours, education classes and referrals to needed resources within their communities.

Program Enrollment Summary

1. Identifying patients: A patient list is generated from Cerner's Prediabetes Registry. This list includes demographics and some clinical data for patients the Prediabetes Registry has identified as either having an existing prediabetes diagnosis or at-risk of developing diabetes. The following steps are taken to determine which patients will be contacted for program enrollment:
    - The Cerner Prediabetes Registry generated list is decreased to include only patients with encounters at one of the participating clinical sites
    - A deidentified list is provided to DHA's evaluation team for randomization (Random Control Trial) – patients are either assigned to the treatment or control group. The control group is not contacted by the Care Coordinators. During this reporting period, a patient list was generated from the Cerner Prediabetes Registry. The list was limited to include patients of participating clinic locations as follows:

# of Patients Identified in Cerner's Prediabetes Registry	# of Patients Randomized to Treatment Group as of October 31, 2018
1,646	1,173

2. Enrolling patients:
    - Letters are mailed to Treatment Group patients advising them of the program and including the name and contact number of the Care Coordinator who will contact them
    - Care Coordinators are provided their Treatment Group patient lists. They call every patient to discuss the program and offer to enroll the patient. The patient either declines to participate or consents to participate. If the patient consents, an initial home visit is scheduled with the patient

3. Program activities:
    - Home visits (minimum of four)
    - Grocery store tours and nutrition classes/referrals
    - Six-week chronic disease self-management education classes
    - Weekly or biweekly phone calls depending on need
    - Development of patient specific care management care plans
        - Clinical office visits and bloodwork
        - Patient-centered goals
        - Socioeconomic needs
            - Identify resources and provide referrals
        - Exercise/nutrition
    - Monthly group meetings

- A summary of program activities for the reporting period will be provided once DHA completes its transition to a new Care Management solution, Efforts to Outcomes (ETO), in January 2019. DHA has previously utilized Allscripts' Care Director Care Management solution to document home visits, phone calls, to create patient care plans and patient-centered goals. Care Director did not allow the level of robust data reporting needed to provided details regarding program activities. ETO will enable DHA to provide charts, graphs, etc. detailing the following:

    - Program attrition rates for the current reporting period
    - # of phone calls (attempted) for the current reporting period
    - # of phone calls (successful) for the current reporting period
    - # of home visits scheduled for the current reporting period
    - # of home visits completed for the current reporting period
    - # of goals met during the current reporting period
    - # offered to enroll for the current reporting period
    - # declining enrollment for the current reporting period
    - # enrolled/consented during the current reporting period
    - # completing the program during the current reporting period
    - # reenrolled in the program during the current reporting period
    - # new diabetes diagnosis during the current reporting period
    - # of provider office visits scheduled by enrolled patients during the current reporting period
    - # provider office visits completed (encounters) by enrolled patients during the current reporting period
    - # of grocery store tours scheduled during the current reporting period
    - # of grocery store tours completed during the current reporting period
    - # of enrolled patients completing a grocery store tour during the current reporting period
    - # of community/patient family members completed a grocery store tour during the current reporting period
    - # of Health Chats scheduled during the current reporting period
    - # of Health Chats completed during the current reporting period
    - # of enrolled patients attending a Health Chat during the current reporting period
    - # of community/patient family members completed a Health Chat during the current reporting period
    - # of exercise/nutrition classes scheduled during the current reporting period
    - # of exercise/nutrition classes completed during the current reporting period
    - # of enrolled patients attending an exercise/nutrition class during the current reporting period
    - # of community/patient family members attending an exercise/nutrition class during the current reporting period
    - # of Chronic Disease Self-Management Education classes scheduled during the current reporting period

- # of Chronic Disease Self-Management Education classes completed during the current reporting period
- # of enrolled patients attending Chronic Disease Self-Management Education classes during the current reporting period
- # of community/patient family members attending Chronic Disease Self-Management Education classes during the current reporting period
- # of enrolled patients referred to community service providers for assistance with socioeconomic, domestic violence and/or mental/behavioral health needs

4. Enrollment Status: Enrollment of additional Prediabetes Program participants initiated in October 2018.
   - DHA retrieve a list of patients from Cerner's Prediabetes Registry. The list was limited to patients of participating clinical locations which totaled 1,646 patients. DHA's evaluation team removed patients who had previously been randomized and used a stratified random sampling to randomize 1,071 patients to the treatment group and 102 patients to the control group (90-10 ratio).
   - The program team mailed letters to all 1,071 patients advising of the program and including the name of the assigned Care Coordinator
   - Initial phone calls were initiated to attempt to enroll and consent patients

5. Challenges/Lessons Learned: There were no additional challenges encountered during this reporting period.

Program Staff – Includes a total 6 Care Coordinators each at 1 full-time equivalent (FTE) and the Program Director at 0.5 FTE. Three of the six began employment on July 30, 2018.

Project Team	Role	Role Description	FTE
Shauna Aguilar, RN	**Director, Population Health**	Oversight of daily activities and coordination of participant services; Maintains clinic communications; Assists with reports	0.5
RyAnne Williams, RN	**Lead Care Coordinator**	Provides nutrition and chronic disease self-management education; Conducts home visits and grocery store tours; Provides care coordination	1.0
Camilla Butler, MPH	Care Coordinator		1.0
Cassonya Lampkin, LPN	Care Coordinator		1.0
Gwendolyn Chambers	Care Coordinator		1.0
Sylvia Thomas	Care Coordinator		1.0
Darrius Moore, MS, CHES	Care Coordinator		1.0

HEALTHY PREGNANCY PROGRAM

Program Summary – initiated in January 2017 to develop a prenatal program aimed at reducing the pre-term birth rate by creating customized care plans, providing education, support, encouragement and connections to needed social services to enrolled pregnant women living or receiving care within the 10-county service area.

Program Enrollment Summary

1. Identifying patients: A patient list is generated from Cerner's Prediabetes Registry. This list includes demographics and some clinical data for patients the Prediabetes Registry has identified as either having an existing prediabetes diagnosis or at-risk of developing diabetes. The following steps are taken to determine which patients will be contacted for program enrollment:
   - The Cerner Prediabetes Registry generated list is decreased to include only patients with encounters at one of the participating clinical sites
   - A deidentified list is provided to DHA's evaluation team for randomization (Random Control Trial) – patients are either assigned to the treatment or control group. The control group is not contacted by the Care Coordinators

2. Enrolling patients:
   - Letters are mailed to Treatment Group patients advising them of the program and including the name and contact number of the Care Coordinator who will contact them
   - Care Coordinators are provided their Treatment Group patient lists. They call every patient to discuss the program and offer to enroll the patient. The patient either declines to participate or consents to participate. If the patient consents, an initial home visit is scheduled with the patient

3. Program activities:
   - Home visits (monthly)
   - Weekly phone calls
   - Development of patient specific care management care plans
     - Completion of assessments
     - Clinical office visits and bloodwork
     - Patient-centered goals
     - Socioeconomic needs
       - Identify resources and provide referrals
     - Exercise/nutrition
   - Monthly group meetings
   - A summary of program activities for the reporting period will be provided once DHA completes its transition to a new Care Management solution, Efforts to Outcomes (ETO), in January 2019. DHA has previously utilized Allscripts' Care Director Care Management solution to document home visits, phone calls, to create patient care plans and patient-

centered goals. Care Director did not allow the level of robust data reporting needed to provided details regarding program activities. ETO will enable DHA to provide charts, graphs, etc. detailing the following:

- Program attrition rates for the current reporting period
- # of phone calls (attempted) for the current reporting period
- # of phone calls (successful) for the current reporting period
- # of home visits scheduled for the current reporting period
- # of home visits completed for the current reporting period
- # of goals met during the current reporting period
- # offered to enroll for the current reporting period
- # declining enrollment for the current reporting period
- # enrolled/consented during the current reporting period
- # completing the program during the current reporting period
- # reenrolled in the program during the current reporting period
- # full-term births during the current reporting period
- # of preterm births during the current reporting period
- # of Health Chats scheduled during the current reporting period
- # of Health Chats completed during the current reporting period
- # of enrolled patients attending a Health Chat during the current reporting period
- # of community/patient family members completed a Health Chat during the current reporting period
- # of exercise/nutrition classes scheduled during the current reporting period
- # of exercise/nutrition classes completed during the current reporting period
- # of enrolled patients attending an exercise/nutrition class during the current reporting period
- # of community/patient family members attending an exercise/nutrition class during the current reporting period
- # of enrolled patients referred to community service providers for assistance with socioeconomic, domestic violence and/or mental/behavioral health needs

4. Challenges/Lessons Learned – There were no challenges encountered during this reporting period.

Program Staff – Includes a total 5 Healthy Pregnancy Coaches each at 1 full-time equivalent (FTE) and the Program Director at 0.5 FTE. Two of the five began employment on July 30, 2018.

Project Team	Role	Role Description	FTE
Shauna Aguilar, RN	**Director, Population Health**	Oversees daily activities of the program and the coordination of participant services; Maintains clinic communications; Develops educational and program curriculum; Assists with reports	0.5
LaToya Atkins, MS	Lead Healthy Pregnancy Coach	Identifies needs and aids in connecting pregnant women to services; Provides pregnancy and health-related education; Conducts home visits; Builds relationships throughout service area	1.0
LaTasha Leggett, MS	Healthy Pregnancy Coach		1.0
Brianna Jackson	Healthy Pregnancy Coach		1.0
Constance Coleman	Healthy Pregnancy Coach		1.0
KaTara Tyler	Healthy Pregnancy Coach		1.0
TBH	Healthy Pregnancy Coach		1.0

POST-PARTUM PROGRAM

Program Summary – engages women who have delivered babies within the most recent 8 weeks preceding identification to aid in ensuring contraceptive plans are in place and the mother and baby are receiving proper postnatal care. Enrollment periods generally do not extend more than 3 months.

- A summary of program activities for the reporting period will be provided once DHA completes its transition to a new Care Management solution, Efforts to Outcomes (ETO), in January 2019. DHA has previously utilized Allscripts' Care Director Care Management solution to document home visits, phone calls, to create patient care plans and patient-centered goals. Care Director did not allow the level of robust data reporting needed to provided details regarding program activities. ETO will enable DHA to provide charts, graphs, etc. detailing the following:
    - Program attrition rates for the current reporting period
    - # of phone calls (attempted) for the current reporting period
    - # of phone calls (successful) for the current reporting period
    - # offered to enroll for the current reporting period
    - # declining enrollment for the current reporting period
    - # enrolled/consented during the current reporting period