ARHOME Strategic Plan 2023

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Preventative Care and Health Screenings

Actionable Gaps:

- To our call center platform, allowing our **Member Services** call representatives to coach members to close gaps;
- To our platforms supporting **utilization and care management** for behavioral health so behavioral health team members can support members in closing gaps;
- And to **digital applications** we make available to members such as our Special Delivery app that supports pregnant members with information and tools to support them during pregnancy and postpartum.
- Actionable gaps are communicated to providers to enable them to conduct **patient engagement activities** to close gaps

Member Incentives:

- Scheduling an Annual Wellness Visit
- Scheduling a cervical cancer screening
- Scheduling a breast cancer screening
- Chronic condition management:
  - Asthma medication Adherence
  - Controlling high blood pressure
  - Diabetes HbA1c control

Improve Maternal and Child Outcomes

Operating our Special Delivery Program

Assessment

- Members have the options to self-enroll in the program
- Majority are identified through claims and other data sources.
  - Triaged to assess high-risk members that may need additional services and more intensive intervention

Education

- Expectant mothers receive educational materials encouraging good health
- Utilization of our website with contact information on organizations that support women who are pregnant and their families
- Text4Baby, a free text messaging service that sends reminders around member's due data and information on prenatal and infant care

Intervention

- Low-risk pregnancies: Special Delivery OB will contact members each trimester and postpartum.
- High-risk pregnancies: Special Delivery OB contacts members monthly at minimum.
  - Behavioral health, diet/nutrition, health conditions, and safe sleep practices (to name a few) are all discussed
- The Special Delivery Mobile App, telehealth, and 24/7 care advocate are available to assist members when they need it the most

- **Member Incentives:**
  - Enroll with an ABCBS-sponsored care manager
  - Receiving recommended prenatal and postpartum care

Improve Behavioral Health Outcomes

- **Member outreach**
  - Both telephonic and targeted face-to-face outreach are used to engage members
  - Our CM team works closely with providers to schedule follow-up, within 7 days of a hospitalization
- **Care management, coordination, and tracking**
  - Connecting members with community providers and resources to move toward recovery and self-management
  - Care transitions assist members transitioning from impatient and residential care to lower levels of care in the home
  - Member education, discharge and medication assistance to determine if a member is taking medications as prescribed
- **Specialized Behavioral Health Interventions**
  - Coordinating care for members with autism spectrum-disorder
  - Substance use prevention program helps members and physicians prepare for the risks that come with acute and chronic pain management
  - Social determinates of Health Support (SDOH) coordinates with community resources, our social work, and care management team to assess and recommend services in a member's community

Arkansas Blue Cross Behavioral Health Care Management Program

- Engage in alcohol or other abuse-dependent treatment
- Follow up after hospitalization for substance use disorder
- Adherence to anti-psychotics for individuals with schizophrenia
- Follow up after hospitalization for mental health

Member Incentives

Reduce Health Inequities for Rural and Minority Populations

Created **a medical director role** specifically focused on health equity and community programs

- Goal is to continuously evaluate our role in health equity; where lasting improvements can be made, and where deeper analysis is needed to coordinate a strategy to address issues affecting our communities

Increased utilization of **data analytics and data science** to identify barriers unique to this population

- Identification of high-risk and/or high-utilizers that need additional care management support
- Identification of SDOH challenges specific to rural and minority populations

Embedding a **health equity framework** across all operations and points of contact

Increased used of **extenders and collaborators** in communities across the state.

- Actively engaged in Arkansas Rural Health Partnership

Member Incentives

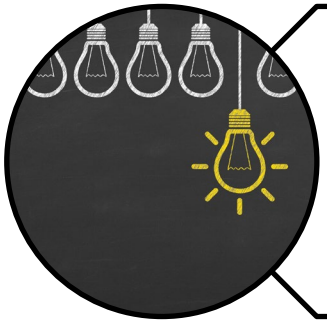
- Establish a primary care provider
- Participate in a health fair or healthcare community event

Reduce the Proportion of ARHOME Members Living in Poverty

Through the promotion of participation in activities that help members secure or improve upon a current job

Referral of members to the Arkansas Department of Workforce Services for assistance with job seekers

- Specifically, direct members to the free Career Readiness Certificate program



Train our social work and care management teams around options in communities throughout the state for members seeking options for employment

Member Incentives

- Completion of continuing education classes towards a degree or trade
- Earn a Career Readiness Certificate through ADWS

THANK YOU