Community Health Network of Connecticut, Inc.

Elements of ENGAGEMENT

2017 Annual Report

What's Inside:

CHNCT at a Glance

Community Health Network of Connecticut, Inc. (CHNCT) is a not-for-profit health plan that strives to improve the health of underserved and vulnerable populations by providing access to high quality and comprehensive healthcare. CHNCT was founded in 1995 by federally qualified health centers that sought to bring non-profit oversight to Medicaid managed care in Connecticut.

The CHNCT Way

Taking a person-centered approach, CHNCT provides innovative and compassionate care for Connecticut's vulnerable populations to ensure members get the right care, in the right place, at the right time.

- Ensuring access to quality healthcare for CT's Medicaid population
- Providing care coordination
- Social responsibility

URAC ACCREDITED CASE MANAGEMENT

URAC ACCREDITED DISEASE MANAGEMENT

URAC ACCREDITED HEALTH UTILIZATION MANAGEMENT

HITRUST CSF Certified

A Letter From

Ludwig Spinelli & Sylvia Kelly

At Community Health Network of Connecticut, Inc. (CHNCT), we believe that engagement is the foundation upon which our success is built. We utilize diverse tools and strategies to connect with both members and providers. By reviewing the outcomes of these connections, we are able to adapt our methods to generate better results.

With nearly 800,000 members and 25,000 providers involved with the HUSKY Health program, we strive to connect with each of them in the best way possible. In 2017, we made concerted efforts to reach our members and providers in new ways, while continuing to expand on approaches known to be effective. We implemented a digital communications solution that allows us to send mass emails securely. In doing so, we were able to target specific cohorts of individuals with messages tailored to their health needs. Further, we continued to build on our other methods of outreach to ultimately establish a far-reaching, multi-platform engagement strategy.

Our dedication and hard work are evident in our 2017 health outcome results. CHNCT continues to compare our performance against benchmarks for important health measures that address satisfaction, chronic illnesses, and utilization in an effort to maximize the quality of life for HUSKY Health members. The interventions we developed and deployed showed improvements year over year. This is an exciting time for us and we could not be more proud and humbled to continue serving our members.

Ludwig Spinelli
Chairman of the Board

Sylvia B. Kelly
President & CEO

Improving Outcomes through Engagement

Improving the health outcomes of our members is our top priority. To do this, we have to engage with both members and providers in ways that will best communicate our messages. Our Member and Provider Engagement committee helps us achieve this goal.

The Member and Provider Engagement committee develops, implements, and manages interactions on behalf of the HUSKY Health program. The president and CEO, vice presidents, directors, managers, analysts, nurses, and other CHNCT staff participate in this committee, combining their diverse set of skills and experiences to create engagements that are both comprehensive and appealing. Each interaction is tailored to its audience, ensuring we reach out to members and providers in the manner that is most likely to generate results.

Using robust data sets of both aggregate and specific member and provider data, we are able to strategically plan quality interventions. The Member and Provider Engagement committee fulfills these interventions through various engagements, which ultimately leads to an increase in positive health outcomes.

CHNCT designs, implements, and evaluates all initiatives and activities that support our overall aims of improving member health outcomes, the care experience for both members and providers, and the services we provide as the medical administrative services organization (ASO) from a person-centered approach.

We Increased

The rate of Post-Admission Follow-Up Visits within 7 Days of an Inpatient Discharge for physical health **by 4.21%**

The rate of Developmental Screening in the First Three Years of Life **by 17.40%**

The rate of Behavioral Health Screening in Children Ages 1-18 **by 28.04%**

We Reduced

The total rate of Hospital Readmissions for physical health **by 2.61%**

The Heart Failure Admission Rate (ages 18 and older) per 1,000,000 MM **by 6.76%**

The Asthma Inpatient Admission Rate per 1,000 Members **by 9.13%**

The Asthma Emergency Department Visit Rate (Ages 2 to 20) **by 2.57%**

The Uncontrolled Diabetes Admission Rate (ages 18 and older) per 1,000,000 MM **by 8.95%**

Highlights:

Health Measure Improvements by HUSKY Health Plan

Increase in the rate of HbA1c Control (<8%)

HUSKY A & B	HUSKY C	HUSKY D
13.06%	5.88%	5.83%

Reduction in the rate of Ambulatory Care-Emergency Department Visits

HUSKY A & B	HUSKY C	HUSKY D
5.88%	4.66%	7.58%

Increase in the rate of Controlling High Blood Pressure

HUSKY A & B	HUSKY C	HUSKY D
5.83%	9.48%	10.22%

HUSKY Health plan descriptions

HUSKY A covers children, their parents, and pregnant women.
HUSKY B covers children and teens up to age 19.
HUSKY C covers people with disabilities, low-income seniors who also have Medicare, and people receiving long-term care.
HUSKY D covers adults who don't have minor children.

Promoting positive health outcomes has always been the focus of the Member and Provider Engagement committee and the numbers show it has been successful. Using all the tools and resources available to us, CHNCT has been able—and continues—to create engagements that help to promote good outcomes.

Intensive Care Management (ICM)

13,248
ICM Caseload

13,043
Unique Members

95%
of members had a care plan within 14 days of initial assessment

The Model

Identification and Enrollment
Members enroll in ICM after receiving a referral from their provider, hospital staff, another internal department, or a state agency.

Assessment and Care Plan
A personal nurse care manager assists the member in identifying strengths and barriers to care, basic and social needs, and behavioral health needs.

Coordination and Collaboration
Our staff share the care plan with the provider. It includes the member's medications, barriers, strengths, and goals.

Coaching, Education, and Opportunities
The member receives coaching based on their specific needs from their nurse care manager, as well as community health workers, dietitians, pharmacists, certified specialty educators, or behavioral health care coordinators.

Achievement of Care Plan Goals
Once the member has achieved their goals, they have the opportunity to continue to work with the program or retain continued access to other HUSKY Health services.

The Impact

Emergency Department (ED) usage for members engaged in ICM
by 25.18%

Inpatient Admissions usage for members engaged in ICM
by 44.07%

Readmissions for members receiving Inpatient Discharge Care Management services
by 45.87%

Care Coordination

Addressing Medical and Social Needs

CHNCT's Intensive Care Management (ICM) program is a prime example of our commitment to using care coordination to serve the whole person. Through the seamless integration of engagements, the ICM program is able to help members achieve positive health outcomes.

ICM is a program developed to help members manage their medical, behavioral, functional, and social health needs. The program strives to meet the unique needs of members and encompasses a broad scope of services to promote active member participation in achieving the best possible health outcomes. We aim to empower members to allow them the tools to make informed decisions about their options and to encourage participation in their self-care.

This assistance goes beyond traditional healthcare, incorporating many of the social needs our members have. These social determinants of health, when left unaddressed, can have a tremendous impact on an individual's well-being. That's why we also assist members with housing, food needs, employment, and other community resources.

ICM engages with members in a variety of ways. Care managers communicate with members face-to-face and telephonically, conducting assessments, coaching, and mailing educational resources. ICM staff will meet with members out in the community, at the members' homes, shelters, hospitals, skilled nursing facilities, providers' offices, and other community settings. When members require educational resources and information on community programs, we send these via secure email.

ICM's comprehensive approach to helping members with their healthcare and their social determinants of health allows us to give these members the support they need and deserve.

Engagement by the Numbers

Community Health Workers (CHWs) Outreach

15,992
CHW total referrals

13,430
Total number of resources provided to members

Transitional Care

4,932
Total number of members managed by Inpatient Discharge Care Managers (IDCMs) in hospital

14,525
Total number of members provided care coordination post-hospital discharge

20,353
Total number of referrals and/or notifications to Connecticut Behavioral Health Partnership (CT BHP) in 2017

E-mails

217,000
Head of Household Email addresses

910,000+
Emails Sent

325,000+
Emails Opened

Automated Calls

2.4 Million
Automated Calls Made

1.1 Million
Successful Calls

Member Engagement Services (MES)

299,478
Inbound Calls

90,027
Outbound Calls

96%
Calls answered in under 60 seconds

38,930
Member Surveys Completed

97%
Member Satisfaction Survey

10,017
Total number of cases referred to the Escalation Unit

5,344
Referrals to ICM from MES

Provider Engagement Services (PES)

3,602
Number of Primary Care Providers

17,764
Number of Specialty Providers

2,375
Number of unique practices visited by PES

Person-Centered Medical Home (PCMH)

113
Total number of PCMH program practices

665
Total Practice Visits

1,691
Primary Care Providers in PCMH Practices:

361,542
Members attributed to PCMH Practices

Community Practice Transformation Specialist team assisted the following number of practices with renewal and initial recognition.

Renewal: **62** *Initial Recognition:* **7**

Digital Expansion

Personalization in a Digital World

Since 1995, we have continually explored new trends and methods of connecting with our members. In 2017, we expanded our digital offerings to include a communications cloud.

The communications cloud allowed us to expand how we use email to engage with members. It provided us with an opportunity to use email as a tool to securely engage with large groups of members while maintaining a level of personalization. We are able to identify members and send them relevant condition-specific material, while also reaching out to broader groups to send general health and wellness information. We can measure the impact of these communications which allows us to adjust our messages as needed.

In 2017, we created more than 15 email campaigns that reached over 180,000 members. The topics of these email campaigns included a welcome message, how to find a doctor, our health risk questionnaire, missed call follow-up, well-visit reminders, colonoscopy screening reminders, program benefits and changes, and flu shot reminders. We measured and tracked the engagement level of each email and found that our engagement rate was above the industry average.

The impact of these emails goes beyond open and click rates. When emails are paired with other elements of engagement, our messages spread considerably. For example, having a primary care provider (PCP) has a positive effect on health outcomes for individuals. In 2017, we used an email campaign to help increase the number of members who are attributed to a PCP and have seen positive results.

Conversations

Connecting the Dots

While many of our engagement methods support our care coordination activities, conversations with members on the telephone help us to provide real-time answers to their questions and gives them resolutions to their immediate needs. This leads to timely care and improved health outcomes.

In 2017, our Member Engagement Services (MES) staff answered approximately 299,000 calls from members, over 96% of which were answered within 60 seconds. With a Customer Relationship Management (CRM) system that is kept up-to-date with all new engagements and quality initiatives, we ensure that all staff can help our members efficiently and accurately, regardless of what department is assisting.

Our Transitional Care team calls members who have recently been to the hospital to provide care coordination and answer questions that members may have. In 2017, our Transitional Care team provided care coordination for over 14,500 members, ensuring that each member had a follow-up appointment scheduled, understood their discharge instructions, and provided referrals for any other needs.

Although we offer digital and face-to-face communication options, members appreciate the ability to reach out to us, by telephone, when they need us.

Online

Telephone

Face-to-Face

CHNCT staff out in the community

Relationships

Getting Closer to Those We Serve

Strong relationships are the foundations of successful health outcomes. This is why, at CHNCT, we are committed to connecting with people out in the community—where they live, work, and play.

Our members often have needs that we can best address when we speak to them face-to-face. This is especially true when assessing social determinants of health. In 2017, our Community Health Workers (CHWs) met with 1,184 members, in person, to help them with those social needs. Additionally, our Inpatient Discharge Care Managers (IDCMs) worked with over 7,300 hospitalized members—also face-to-face—to ensure they would have confidence in their recovery plan after discharge. IDCMs helped these members schedule their post-discharge appointments and made sure they had confidence in their recovery.

We established seven Community Engagement hubs and developed a presence in the communities with the highest concentrations of HUSKY Health members. Through the hubs, we empowered members to improve their health outcomes and reduce their health risk factors through health education, appointment assistance, referrals to ICM, community resources, and more.

Providers also benefited from face-to-face visits. Provider Engagement Services conducted over 4,000 office visits. At these visits, we delivered educational materials, assisted with enrollment/re-enrollment in the Connecticut Medical Assistant Program (CMAP) network, and answered any of the providers' questions. These visits can result in renewed collaborations where practices join initiatives because they have the opportunity to talk, in person, with someone they trust. As an example, during face-to-face visits in 2017, we informed providers about our suboxone program, which lead to a 5% increase in program participation.

We also kept providers informed about the ever-expanding Person-Centered Medical Home (PCMH) program. Our Community Practice Transformation staff conducted over 660 practice visits to provide support and education on the PCMH program and other topics of significance.

It is on the strength of these member and provider relationships that we are able to better understand the needs of those that we serve and deliver services that lead to better health.

Member Advisory Workgroup

Keeping Members at the Center of Service Development

Our members have always been a central part of what we do, and our ability to collect feedback from them helps us gain a deeper understanding of their lives and their needs.

The Member Advisory Workgroup was established to give members the opportunity to share their experiences and voice their opinions. These discussions give us insight into the lives of the people we serve—the barriers they face, the influences on their lives, and the needs that they have.

The Member Advisory Workgroup meets on the first Thursday of every month and includes members and staff from both CHNCT and the Department of Social Services (DSS). When CHNCT is starting a new initiative, making changes to the website, or drafting member-centric materials, we collect opinions and feedback from the workgroup. During these lively discussions, members will brainstorm, share their experiences, and provide suggestions to help us improve the value of our materials.

One of our goals in 2017 was to increase teen participation in their healthcare by going to their yearly physical. Teen participation in healthcare is a pressing issue because lack of well-visits can delay care and the identification of medical and behavioral health issues.

The Member Advisory Workgroup, many of whom are parents themselves, helped us to understand the larger factors at play. Teens and parents have lots of questions about the changes teens go through and how it affects their health, but may not know that they can address these questions with their provider or know how to ask these questions. With this valuable insight, we developed two brochures, one for teens and one for adults, detailing essential questions they can ask their provider.

By including members in these important processes and engaging with them on a monthly basis, it allows them to be both seen and heard. The Member Advisory Workgroup is one of many reasons we've built such trusting relationships with the people we serve.

Teen Brochures

Problem

A large number of teens don't get their yearly physicals, which delays the identification of health problems and corresponding treatment.

Insight

Understood that teens and their parents have lots of questions.

Solution

The Member Advisory Workgroup input helped us to develop brochures for teens and parents, filled with topics that teens can talk to their healthcare provider about.

Members engaged in a Member Advisory Workgroup Meeting

Community Engagement

Building and Sustaining Community Partnerships

Food insecurity can have a large impact on the health of some of Connecticut's most vulnerable residents. It can be a struggle for some to put nutritious, fresh food on the table, which can lead to negative health outcomes.

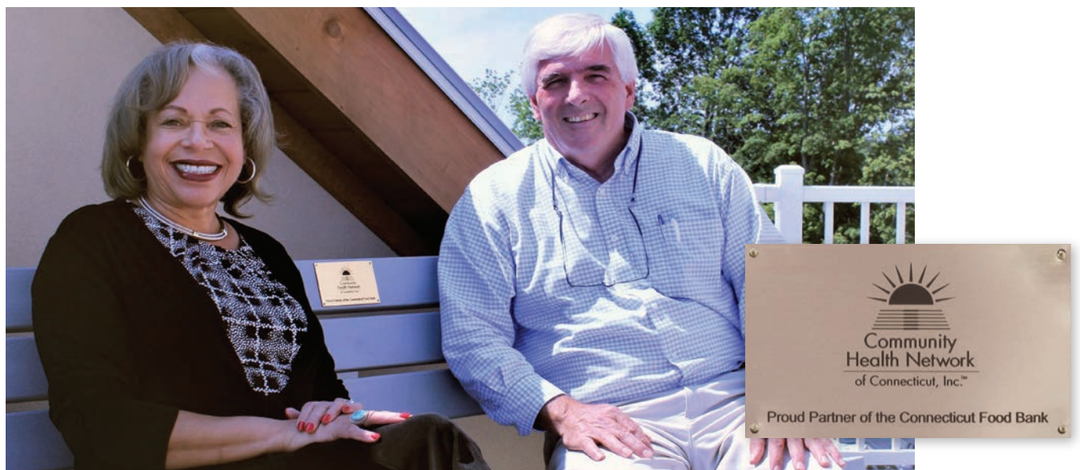
To help support organizations that help to fight food insecurity, we joined forces with the Connecticut Food Bank (CT Food Bank). The goal of the partnership is to help educate and help improve health outcomes of underserved populations.

This partnership has two elements. The first is a commitment from CHNCT staff to volunteer their time at the CT Food Bank. A total of 113 employees volunteered to help pack food and get it ready for distribution. In addition to volunteering, staff donated 851 pounds of food and $550 to the CT Food Bank.

The second element is a company-driven initiative where CHNCT staff joined the CT Food Bank mobile pantries during food deliveries to provide HUSKY Health members with one-on-one assistance to obtain ID cards, schedule doctors' appointments, and inform them of the variety of community services available. The ICM team educated members about the benefits and services available to them under the ICM program.

To solidify this partnership, CHNCT purchased a bench that is located at the CT Food Bank Headquarters in Wallingford with a plaque that reads:

Community Health Network of Connecticut, Inc. Proud Partner of the Connecticut Food Bank



Sylvia Kelly, President & CEO, CHNCT, and Bernard Beaudreau, CEO, CT Food Bank

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Financials

Consolidated Statement of Operations and Other Comprehensive Income Years ended December 31, 2017 and 2016

	2017	2016
REVENUE:		
ASO revenue	$75,591,415	$80,519,400
Program contract revenue	$410,900	$467,031
Other revenue	$210,506	$298,030
Net investment income	$396,215	$220,160
Total revenue	$76,609,036	$81,504,621
EXPENSES:		
ASO expenses	$72,787,732	$77,913,060
Program contract expenses	$407,493	$463,544
Medical costs (benefits)	($41,410)	($84,874)
Other administrative expenses	$1,442,281	$1,037,140
Total expenses	$74,596,096	$79,328,870
Excess of revenues over expenses	$2,012,940	$2,175,751
OTHER COMPREHENSIVE INCOME:		
Changes in net unrealized (losses)/gains on investments	$335,181	$143,701
Comprehensive income	$2,348,121	$2,319,452

Consolidated Balance Sheets December 31, 2017 and 2016

ASSETS	2017	2016
CURRENT ASSETS:		
Cash and cash equivalents	$20,401,827	$22,304,293
Investments in mutual funds, at fair value	$10,441,924	$9,543,070
Short term investments	$10,000,000	-
Accounts receivable	$2,955,543	$2,754,327
Interest receivable	$20,157	-
Deposits	$36,343	$36,343
Other current assets	$3,264,449	$3,154,132
Total current assets	$47,120,243	$37,792,165
Investments in preferred stock, at cost	-	$375,000
Property and equipment - net	$4,157,331	$5,737,335
Total assets	$51,277,574	$43,904,500
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES:		
Unearned revenue - DSS ASO	$6,848,596	$1,350,662
Accounts payable and accrued expenses	$6,649,791	$5,972,772
Total liabilities	$13,498,387	$7,323,434
NET ASSETS:		
Contributed capital	$748,984	$748,984
Unrealized losses	$288,862	($46,319)
Accumulated earnings	$36,741,341	$35,878,401
Total unrestricted net assets	$37,779,187	$36,581,066
Total	$51,277,574	$43,904,500

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