Effectiveness of Healthy Behaviors Programs

Care Management Department

Measurement period: July 1, 2023 – June 30, 2024

Report Date: October 1, 2024

Executive Summary

Aetna Better Health of Florida is committed to assisting members and their practitioners with daily habits which can have significant influence on their health. Behaviors, such as tobacco use, obesity and substance use can negatively affect an individual and dictate the overall state of their health and health outcomes. At Aetna Better Health we provide services and tools that encourage members to improve their health and wellness. Our Healthy Behaviors programs provide specific interventions for a subset of the population within the context of Integrated Care Management. These interventions are aimed at assisting members with tobacco cessation, weight management and substance use.

Aetna Better Health of Florida reports member active participation and member experience results to the Quality Management/Utilization Management, and the Quality Management Oversight Committees quarterly. Active participation criterion was met if the member agreed to enrollment in the Healthy Behaviors program, completed the written/verbal consent from member/responsible party and primary care physician, and agreed to the interventions applicable to each program as reflected in the Agency for Health Care Administration (AHCA) approved program descriptions which have been submitted and approved by AHCA.

Background

The Integrated Care Management (ICM) program was developed by Aetna Better Health in 2010 and initiated by Aetna Better Health of Florida in 2017. The care management program is integrated and addresses the continuum of acute, chronic, and long-term services and supports members with medical, behavioral, and social needs. Our care managers help members to understand the health risks of their behaviors and elicit changes in members' health-related behaviors that positively impact their current and future health and wellness. This is done through collaboration, engagement, identification of strengths and leveraging those strengths to enhance resiliency and result in members' improved health management and self-efficacy.

The ICM program manages the unique needs of each member's experience. Whether they have short term acute needs, longstanding chronic health issues, or need information, resources or care coordination, the program can be tailored to that specific member's situation. Healthy Behaviors interventions include telephonic and print member education, referrals for appropriate support, and assistance with techniques to better adhere to regimens and treatment plans. In addition, we assist with addressing member rationale for non-adherence, collaboration (with member's consent) with providers and caregivers, and provision of resources external to the organization, as appropriate. Further, as behavioral health and substance use issues are commonly co-occurring, each member identified as having problems in one of these areas (either by self-report, referral, initial assessment or claims data) is screened for both issues so that the appropriate resources and services can be arranged.

Members are identified for participation in Healthy Behaviors programs through active referral sources such as providers, community agencies, member self-referral, internal staff (e.g. Concurrent Review, Care Management and Utilization management staff), pharmacy, Health Risk Questionnaire/Health Risk Assessment/Outreach Risk Questionnaire [HRQ/HRA/ORQ], caregiver/guardian, emergency department/inpatient referrals. Passive referral sources include

claims and predictive modeling (CORE 2.0), pharmacy data, and data from health and wellness programs.

The Healthy Behaviors programs promote productive interactions between active and engaged members, as well as their family and caregivers, and a trained team of health professionals with the goal of delivering effective, timely, member centered efficient and equitable support. To encourage member motivation and engagement, the programs place emphasis on providing self-management support, an effective delivery system, and enhancing decision support and clinical information systems.

Aetna Better Health of Florida evaluates several indicators annually to assess the effectiveness of the Healthy Behaviors programs. These measures include active participation rate, program completion rate and member experience.

Purpose

The purpose of this analysis is to determine the effectiveness of the Healthy Behaviors Programs by evaluating active participation rates for members identified as eligible to receive Healthy Behavior services, program completion rates and member experience. Based on results, Aetna Better Health of Florida staff have developed strategies to improve active participation and completion rates and continue to evaluate and identify opportunities for improvement.

Methodology

Active Participation

Upon identification and initial stratification members were outreached for enrollment into healthy behaviors and integrated care management. During this process, Aetna Better Health provided members with information about Healthy Behaviors, what services and supports may be provided, how to use them, and how the member became eligible to participate. The member also had the right to decline participation (opt-out) in Healthy Behaviors and ICM. Members are considered actively participating in the program after receipt of attestation form, when both member and primary care practitioner have attested to participation, or an interactive contact listed in the interventions section have been initiated.

Overview of Program Components

Healthy Behaviors programs, criteria for enrollment, incentive value, and eligibility are outlined below. Additionally, the program descriptions are included at the end of the document (Appendices I-IV).

Program	Incentive Criteria	Incentive Value	Eligibility
Tobacco Cessation	Tobacco free for 3 months and 6 months	$20.00 gift card $20.00 gift card $40.00 total	Any eligible member with a tobacco/nicotine dependency
Weight Management	Meet established weight loss goals, attending appointments with nutritionist and PCP	Wearable Bluetooth fitness tracker (value $20.00) $20.00 gift card $40.00 total	Any eligible member who are classified as overweight or obese
Substance Use	Eliminate or reduce drug or alcohol use for 3 months and 6 months	$20.00 gift card $20.00 gift card $40.00 total	Any eligible member with a qualifying diagnosis who are 18 years of age or older

Aetna Better Health's programs, at all levels of integrated care management, include but are not limited to the following:

- Member and provider introductory letter to describe available services and the opt-out option
- Member communications including targeted educational mailings, condition specific member newsletters, access to online programs, website access to searchable data and additional educational information such as Krames materials
- Practitioner involvement including notification of member enrollment, collaboration on goals, and practitioner follow-up on member appointments and compliance with care plans
- Telephonic access to care management staff to answer member questions
- Access to Health Appraisal and Self-Management Tools from health plan website
- If member agrees, referral for behavioral health support therapy services
- Referral to community resources such as nutritional counseling, AA/NA, smoke free.gov

Indicators

Aetna Better Health of Florida evaluated active participation in the Healthy Behaviors programs by evaluating the ratio of members identified as eligible to receive services based on claims and encounter data to the number of identified eligible members who consented to participate. Care management staff generated the Outreach and Enrollment Report annually to evaluate active participation rates.

Population

All Medicaid members identified as candidates for the Healthy Behaviors Programs utilizing claims/encounter data.

Study Period

July 1, 2023 – June 30, 2024

Data Sources & Collections

Member data located in the Dynamo and QNXT business application systems.
Identifying Members as candidates for Health Behaviors
In addition to the active referral sources identified previously, passive referral sources include claims. Codes utilized to identify members include:

- Tobacco use: Z72.0, All F17 codes, F17.1, F17.2, 099.33
- Obesity: E66.0, E66.01, E66.09, E66.1, E66.2, E66.3, E66.8, E66.9, 099.21
- Substance use: All F11-F19 codes

Results

Active Participation/Completion Rates

Membership participation based on the process for becoming actively involved in the healthy behavior programs. Data is evaluated quarterly and annually.

Active Participation/Completion Rates	
Numerator	The number of identified eligible members who signed consent for participation
Denominator	Total number of members eligible to participate in the Healthy Behaviors programs as identified through claims and encounter data
Goal	Baseline: 2018-2019 results are baseline measurements therefore goals were not established. Subsequent years: Goals are based on a 2% increase in engagement and 2% increase in completion

Quantitative Analysis

Evaluation of the Healthy Behaviors program revealed that there were a total number of 24,142 individual members identified in 2023 – 2024 who were potentially eligible for outreach and enrollment in the programs. Included in this member count are individuals with multiple qualifiers, such as members who are also obese or use tobacco or substances. Most members were identified through State enrollment files, OB notifications, HRA/HRQ and claims review. Self-reporting continues to be the weakest source of referrals to Healthy Behaviors programs.

In 2021, we established an updated goal of a 2% increase year over year in enrollment and program completion rates. Although we did not have member participation in the 2023-2024 Substance Use program, we did increase our 2023-2024 enrollments and of those members enrolled, completion rates for the weight management and tobacco cessation programs were high, as per table 5.

Table 1: Active participation rate in the Healthy Behaviors Programs 2023-2024

Program	Number of identified eligible members who consented to participate	Number of identified eligible members through claims/encounter submissions	Active Participation Rate
Tobacco Cessation	9	4,979	0.18%
Weight Management	21	19,692	0.106%
Substance Use	0	5,974	0%
Total:	30	30,645	0.097%

Table 2: Active participation rate in the Healthy Behaviors Programs 2022-2023

Program	Number of identified eligible members who consented to participate	Number of identified eligible members through claims/encounter submissions	Active Participation Rate
Tobacco Cessation	5	7,913	0.063%
Weight Management	4	26,886	0.014%
Substance Use	0	9,618	0.00%
Total:	9	44,417	0.02%

Table 3: Program Completion 2023-2024*

Program	2023-2024		
	Number of members who completed program and received incentive	**Number of identified eligible members who consented to participate**	**Completion Rate**
Tobacco Cessation	7	9	78%
Weight Management	11	21	52%
Substance Use	0	0	0%
Total:	18	30	60%

*Members who enrolled throughout the Q2 2024 may not be included in this completion rate as this in an ongoing program that rolls from quarter to quarter

Table 4: Year over Year Active participation rate in the Healthy Behaviors Programs 2018-2024

Program	**Number of identified eligible members who consented to participate 2018-2019 (Baseline)**	**Number of identified eligible members who consented to participate 2019-2020**	**Number of identified eligible members who consented to participate 2020-2021**	**Number of identified eligible members who consented to participate 2021-2022**	**Number of identified eligible members who consented to participate 2022-2023**	**Number of identified eligible members who consented to participate 2023-2024**	**% Change in enrollment Rate from 2022-2023 to 2023-2024**
Tobacco Cessation	7	25	21	6	5	9	+80%
Weight Manage-ment	9	60	30	6	4	21	+425%
Substance Use	8	3	2	0	0	0	0%

Table 5: Year over Year Program Completion rate in the Healthy Behaviors Programs from 2019-2024

Program	**Percent of members who completed program 2018-2019 (Baseline)**	**Percent of members who completed program 2019-2020**	**Percent of members who completed program 2020-2021**	**Percent of members who completed program 2021-2022**	**Percent of members who completed program 2022-2023**	**Percent of members who completed program 2023-2024**	**% Change in program completion rate from 2022-2023 to 2023-2024**
Tobacco Cessation	42.8%	4%	0%	0%	20%	78%	58%
Weight Manage-ment	11.1%	6.67%	16.67%	0%	50%	52%	2%
Substance Use	0%	0%	0%	0%	0%	0%	0%
**Total:	64.5%	57.46%	52.16%	50.9%	33.3%	60%	26.7%

*Please note all healthy behaviors programs listed above can take over 6 months to complete potentially impacting completion rates for this report.
** Total= Total number of identified eligible members who consented to participate in all 3 programs/total number of members who completed program and received incentive in all 3 programs for an identified year of study.

Qualitative Analysis

Our programs continue to under-perform in the program enrollment but for those who do enroll the completion rates have increased. Our ability to identify members for participation has been effective when analyzing claims, encounter data, and HRQ/HRA data. We still have difficulty enrolling our members into the Substance Abuse program. As for the weight management and tobacco cessation programs, it is still challenging to enroll members but for those who are enrolled, successful completion rates have improved.

Throughout this study period we continue to have difficulty obtaining the required PCP consent, either written or verbal. Our staff leave messages for the PCP, often with no return call. Members have taken the attestation form to their PCP office when attending appointments have difficulty getting them signed, this may be due to PCP offices still recovering from the pandemic, seeing a large volume of patients daily with little time to complete the attestation. Attempts to obtain verbal consent from PCPs is also difficult to obtain. Staff are often on hold for long periods and then forced to leave a voice mail that often is unreturned. The times that our staff have been able to successfully obtain PCP consent, they have had to attend the office in person. This is not always possible as we only had one Community Health Worker (CHW) for each region and the regions cover a large geographic area.

In reviewing the data and exploring contributing factors to our low completion rates, there are other factors to consider such as: members terming before they meet their 6 months of enrollment in the program and inability to reach and maintain engagement with members once they are enrolled.

Members who are actively abusing substances are extremely difficult to reach and may express an interest in the program and then not follow up on completion of the attestation forms. These members have a higher than average "unable to reach rate" which makes enrolling and tracking these members challenging. When it comes to substance abuse, members experience stages of change to addiction that are not necessarily linear, and people do not stay in them for a set period of time. So, while a member may express a desire to get help while in the Preparation Stage, they can quickly move back to the Contemplation or Precontemplation stages especially when faced with stressors. The same can be said for tobacco users.

We continue to provide ongoing training to staff on program requirements, eligibility, and offer the programs to our members when enrolling in case management. We continue to promote the healthy behaviors' programs in our provider newsletters, which includes information on each program and how the members can enroll.

Barriers
Describe barriers related to member participation and completion:

- Inability to reach members to enroll in the program
- Losing contact with enrolled members limiting our ability to manage, coach, and determine progress towards program goals effectively and appropriately

Opportunities for Improvement / Actions

- Community Health Workers will complete The Freedom From Smoking Facilitator Certification Training Program offered through the American Lung Association. This program offers 7.5 hours of interactive training on the following: Tobacco Basics; How to Help People Quit; Freedom From Smoking; and a Facilitator Skill Builder Workshop. Following successful completion, CHWs will hold a 3-year certification and have access to the permission- only facilitator resource site Freedom From Smoking Program Resources and annual webinars on Emerging Tobacco Trends and regular curriculum updates.
- Increase number of nutritionists and dieticians who can work with members in person. We currently only have two providers available who only work with members virtually and some members are hesitant to utilize telehealth or have limited access to virtual services
- In Regions where the CHW is not able to attend a PCP office live to obtain PCP approval for the Healthy Behaviors Attestation due to distance, identify an alternative Florida ICM team member who may be able to attend in-person.
- Continue to educate the Case Managers on how to successfully engage substance using members through Motivational Interviewing techniques and psychoeducation on the importance of a healthy lifestyle.

Opportunity	Action
Participation Rates	
Member Outreach	Increase the required number of members staff attempt to outreach monthly to increase member outreach and program enrollment as well as have BH Case Managers outreach those with substance abuse needs
Provider Outreach	Annually inform primary care providers of the availability of healthy behavior programs and incentives to support enrollee engagement. As part of its tobacco cessation program, Aetna Better Health will provide participating PCPs with the Quick Reference Guide to assist in identifying tobacco users and supporting and delivering effective tobacco cessation interventions. This communication will occur via mail or email. As part of its medically approved alcohol recovery program or substance abuse recovery program, Aetna Better Health will offer annual alcohol or substance abuse screening training to its providers. The Managed Care Plan shall have all PCPs screen enrollees for signs of alcohol or substance abuse as part of prevention evaluation at the following times: • Initial contact with a new enrollee; • Routine physical examinations; • Initial prenatal contact; • When the enrollee evidences serious over-utilization of medical, surgical, trauma or emergency services; and • When documentation of emergency room visits suggests the need
Completion Rates	
Increase member completion rates	Provide approved Tobacco Cessation education to each CHW in each region. Increase number of dietitians and nutritionists who are available both in person and virtually to assist members with their weight loss goals
Member Experience	
Increase member satisfaction	Analyze data received from member surveys on ways to improve and grow the program.

Conclusion

Our Healthy Behaviors programs have been met with mixed results. While the overall number of participants is low, those who have participated have an increase in success rates than past years. We continue to analyze our program and have made changes in training and program oversight to increase success. We will also continue to gather feedback from members in order to increase member enrollment and program completion rates.

We plan to continue with our goal of increasing enrollment rates and completion rates 2% for the state fiscal year 2024-2025 and are optimistic it will be achieved.

We believe that effective communication is essential. A successful incentive program is dependent upon how well members are informed and engaged and that the interventions in the programs are understood, realistic, achievable and the incentives attractive enough to motivate participation.

Aetna Better Health of Florida has a continuous commitment to evaluating and improving. As part of this we will continue to explore what worked, areas of improvement, and will take appropriate action to achieve our goal and make a positive impact on the lives of our members.

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APPENDIX I – Tobacco Cessation Healthy Behaviors Program Description
Program description effective 3/1/2022

Statewide Medicaid Managed Care Program
Healthy Behaviors Program Description

Part I. Program Overview

Plan Name	**Aetna Better Health of Florida**
Program Name	**Tobacco Cessation**
Brief Description of Program	Aetna Better Health of Florida's Healthy Behaviors programs provide specific interventions for a subset of the population within the context of Integrated Care Management. These interventions are aimed at assisting members who use tobacco to support them toward successful tobacco cessation. Members are informed of the availability of Aetna Better Health of Florida's Healthy Behaviors programs (including incentives and rewards) during welcome calls, in their welcome packets and member handbooks, on the member website, in member and disease management newsletters, prenatal and post-partum education mailings, and during outreach telephone calls from the member services and case management staff. **Assumptions** This intervention was developed with the following assumptions. 1. Members who smoke, use smokeless tobacco, or use electronic cigarettes (e-cigarettes/vaping) will be identified through claims data, health risk assessments and other methods of surveillance (i.e., member or provider referral). 2. Members will be stratified for intervention based on our predictive modeling tool (CORE) and will be offered assistance through our Integrated Care Management program. 3. This intervention will be provided as an adjunct to our members' health plan benefit structure. The identification, risk stratification, interventions and communications are not intended and will not be used to replace the individualized health care provided by the enrolled members' primary care or other health providers.

	The overarching goal is health promotion to help our members to understand the health risks of tobacco use and elicit changes in members' health-related behaviors that positively impact their current and future health and wellness. This will be done through collaboration, engagement, identification of strengths and leveraging those strengths to enhance resiliency and result in members' improved condition management and self-efficacy. The goals of the Tobacco Cessation program are to: • Increase our members' ability to self-manage tobacco use with the goal of complete cessation • Increase the number of members using nicotine replacement therapy correctly, in both frequency and dosing • Reduce or delay morbidity (complications) and mortality associated with tobacco use • Teach wellness and better overall management of tobacco use, resulting in healthier lifestyle choices • Educate members about the addictive nature and health concerns with use of e-cigarettes • Refer members for Tobacco Cessation support programs for increased effective success • Enlist family or other support entities to aid in achieving and sustaining a tobacco free lifestyle • Engage the members' provider(s) in following nationally recognized and evidence-based guidelines for evaluation and treatment of tobacco use • Track outcomes to identify opportunities to improve the interventions **Incentives and Rewards** Incentives and rewards cannot be used for gambling, alcohol, tobacco or drugs (except for over-the-counter drugs). The program, including incentives and rewards, is made available to all members who meet the requirements of the program. Incentives and rewards are not used to direct the member to select a certain provider. The maximum reward dollar amount on incentives and rewards does not include money spent on transportation, child care provided during delivery of services; or healthy behavior program services. Incentives and rewards may take 90 to 180 days or greater to receive. Incentives and rewards are non-transferrable to other Managed Care Plans or other programs. Members will lose access to earned incentives and rewards if they voluntarily dis-enroll from the Aetna Better Health of Florida or lose Medicaid eligibility for more than one-hundred eighty (180) days.
Description of Enrollee	**<u>Identification</u>** Any eligible member who indicates they are a tobacco user and would like to reduce or quit use.

Identification Method	Active Referral Sources include: - Claims - Pharmacy data - Providers - Community Agencies - Member/Responsible party self-referral - Internal Staff [e.g. Care Management and Utilization management staff, pharmacy] - HRQ/HRA - Community Agencies **<u>Participant Stratification</u>** **Population Health** Members who have low-risk chronic conditions or state-mandated conditions in addition to tobacco use with a desire to reduce or quit and do not need or refuse Integrated Care Management at a higher level. **Supportive Care** Members who are identified as high-risk for chronic condition management in addition to indicating a desire to reduce or quit tobacco use but are not currently in Care Management are referred to Supportive Care management with a care manager. **Intensive Care Management** Members who are identified as bio-psychosocially complex, high-risk and have a chronic condition to manage co-morbid conditions in addition to indicating a desire to reduce or quit tobacco use are referred for Intensive Care Management.
Description of Written Agreement/Program Enrollment Process (if applicable)	**<u>Care Management</u>** • Follow all standard Integrated Care Management processes for Intensive or Supportive Care Management including documentation of goals, care plan actions and appropriate follow-up by Care Management • Confirm successful completion of program when member is engaged in a provider or community program to assist with reducing or quitting tobacco use, is using nicotine replacement therapy as prescribed, and reports a progressive reduction in tobacco use or has quit

	• Member may remain in Care Management for other issues at this point or may be discharged with information about how to re-contact Care Management at any time in the future **<u>Providers</u>** • Approve participation of moderate or high-risk member in Tobacco Cessation program by signing the Member Attestation or approving by means of a verbal consent. • Follow nationally-recognized guidelines for management of tobacco use • See member regularly for follow-up • Collaborate with Care Managers and the member's care team as needed, including providing clinical information needed to appropriately educate and direct the member to better manage tobacco use

Part II. Interventions and Incentives

Intervention	Incentive Type*	Incentive Value *	Incentive Criteria	Limitations
<u>Care Management</u> **Population Health** Obtain written or verbal consent from member and primary care physician to participate in Healthy Behaviors Tobacco Cessation Program using Member Attestation form • Provide member with information about health behaviors, co-existing medical and behavioral health conditions, psychosocial and behavioral health issues • Inform member about support group sessions in community • Provide information about online programs www.tobaccofreeflorida.com • Information to assist in understanding the barriers to reducing or quitting tobacco use and actions to take, to avoid, or overcome those barriers • Access to Health Appraisal and Self-Management Tools from health plan website	Rewards Card	$40.00 total	Completion of two separate three (3) month components of this program. -The first three (3) months utilizes CM support and medication to help the member establish initial success with smoking cessation. -Second three (3) months will continue with CM engagement, possible behavioral health referrals as	N/A

• Medication Adherence
• Provide contact information to access services should member decide that a higher level of care management is needed
 	
Supportive Care:
• Telephonic outreach to member to perform the appropriate assessment(s) based on the specific condition(s) for which the member was identified for this intervention which include:
  ○ Health Risk Questionnaire (HRQ) – includes assessment for co-existing medical and behavioral health conditions
  ○ Outreach Questionnaire (ORQ)
  ○ Condition Specific Assessment
• Care Plan development - Developed based on member needs including cultural, socio-economic, transportation, education, and barriers to tobacco cessation. The care plan is also sent to the health care provider to support communication and care coordination
• Regular telephonic follow up based on member's needs, willingness to participate and availability for calls
• Provide appropriate condition-specific education and assistance including the impact of tobacco use on chronic conditions
• Krames Educational Material
• Collaborate with the primary provider (with member consent) for the condition(s) and
			needed and the attending physician who will determine the need for continued medication.	

tobacco cessation interventions including nicotine replacement therapy • Consider additional individual specialty consultation, including behavioral health • Continue until member/caregiver demonstrate improved Chronic Condition Management and tobacco use management skills with a goal of discharge by consensus of member/caregiver, case manager and provider **Intensive Care** • Complete the comprehensive care plan interview (CPI) • Perform the appropriate assessment(s) based on the specific condition(s) and co-morbidities identified • Outreach to member as per the Intensive Care Management standards, at least once a month and more often as member's condition warrants • Offer face to face visits on a quarterly basis • Provide appropriate condition-specific education and assistance including the impact of tobacco use on these conditions • Follow standard Integrated Care Management processes to identify member-centered goals and an agreed-upon care plan				
<u>Tools & Supports</u> Educational information may include but is not limited to: ○ Condition-specific self-care, normal progression of tobacco use, common	N/A	N/A	N/A	N/A

complications, signs of complications, methods of reducing and/or quitting use ○ Referrals to National Quitline Program per state 1-800-QUIT- NOW and completion of program ○ Referrals to smokefree.gov website information ○ Collaborate with provider on possible Tobacco Cessation medication/patches ○ Medication Adherence for Tobacco Cessation ○ Tobacco Cessation Care plan for effective successful tobacco cessation ○ Nutrition, where applicable ○ Importance of physical activity as recommended by member's provider(s) ○ Details on tobacco use complications and risks ○ Additional educational information on barriers to reducing or quitting and interventions and supports to overcome barriers ○ The importance of working with the health practitioner in a partnership toward healthier behavior ○ Krames educational material ○ Web based resources				
<u>Measures of Effectiveness</u> Annual reporting • Reductions in inpatient admissions and avoidable ED utilization related to complications of tobacco use • Number of members on Tobacco Cessation medications				

• Number of members referred to Quitline program and completed • Number of members who are tobacco free for a six (6) month period from start of the program				

Part III. Milestones, Goals and Rewards

Milestone/Goal	Reward Type*	Reward Value*	Reward Criteria	Limitations
Reduction or elimination of tobacco use for three (3) months	Rewards Card	$20	Upon completion of the first phase (3 months) of the program the member will become eligible for the initial incentive	Members who do not complete the first phase of the program will not become eligible for the initial incentive
Reduction or elimination of tobacco use for six (6) months	Rewards Card	$20	Upon completion of the second phase (6 months total) of the program the member will become eligible for the second incentive	Members who do not complete the second phase will not be able to receive the reward.

Part IV. Evidence Base

Detailed Description of Research to	Research indicates that smoking is the leading preventable cause of death in the United States. It is estimated that cigarette smoking causes almost half a million deaths each year in the U.S. alone. This constitutes about one in every five deaths. It is estimated that smoking has a higher incidence of death

Support Effectiveness	than deaths related to illegal drug use, alcohol use, motor vehicle accidents, gun-related incidents, and Human immunodeficiency virus. In addition, smoking causes about 9 out of every 10 lung cancer deaths in men and women. In fact, more women die from lung cancer each year than from breast cancer. Smoking has been linked to higher incidence of chronic obstructive pulmonary disease (COPD), coronary heart disease, respiratory disease, stroke, and cancer. Smoking harms nearly every organ of the body and affects an individual's overall health. Research shows that quitting smoking cuts cardiovascular risk. In fact, within a year of quitting, the risk of heart attack drops significantly. The risk of stroke seems to show a significant decline within two to five years after an individual quits smoking. In addition, risk for cancers of the mouth, throat, esophagus, and bladder drop by 50% within 5 years of quitting. And, after 10 years, the risk of lung cancer also drops by 50%. There is a clear correlation between smoking cessation and a decrease in the risk associated with smoking-related diseases and it adds years to the life of the individual. Because smoking affects so many aspects of an individual's life, coordination of medical, behavioral and community support services promotes a smoke-free lifestyle. The coordination of services must be designed to provide engagement in treatment and motivation, treatment with the appropriate behavioral health and medical specialists, and support services that will enable the individual to maintain a smoke-free lifestyle. Case Management can facilitate all of these aspects of care. Research also indicates that tobacco use can lead to dependence of nicotine and tobacco and potentially serious health problems. There is evidence regarding the significant impact on the reduction of the risk of developing smoking-related diseases when an individual quits smoking. Tobacco/nicotine dependence is a condition may require repeated attempts for success, but there are available and effective treatments and nationwide community resources that can promote an increased likelihood of a smoke free life. Smokers can and do quit smoking every day. Below are specific characteristics related to Nicotine Dependence: • Tobacco products consist of Nicotine, which is the drug that actually produces dependence. Most smokers are not addicted to tobacco; they are addicted to Nicotine.

	• Research data indicates that the most common type of chemical dependence in the United States is Nicotine dependence. • Smoking cessation is not easy and may require several attempts with active individual engagement and participation. Many times, smokers' relapse because they experience withdrawal symptoms (i.e. anxiety, irritability, cravings, increased appetite, or difficulty concentrating), stress, and/or weight gain. **Health Benefits of Quitting** There are clear benefits to quitting. Scientific data shows that Tobacco smoke contains a harmful combination of thousands of chemicals, many of which are toxic and over 70 of which can cause cancer. Tobacco smoking can increase the likelihood of the development of serious health illnesses, diseases, and even death. Quitters significantly reduce their risk for disease and premature death. As per the U.S. Department of Health and Human Services, quitting is associated with the following health benefits: • Lowered risk for lung cancer and many other types of cancer • Reduced risk for coronary heart disease, stroke, and peripheral vascular disease • Reduced coronary heart disease risk within 1 to 2 years of quitting • Reduced respiratory symptoms, such as coughing, wheezing, and shortness of breath. The rate of decline in lung function is slower among people who quit smoking than among those who continue to smoke • Reduced risk of developing chronic obstructive pulmonary disease (COPD), one of the leading causes of death in the United States • Reduced risk for infertility in women of reproductive age. Women who stop smoking during pregnancy also reduce their risk of having a lower birth weight baby
References	-Reducing Tobacco Use (www.cdc.gov/tobacco) -Best Practices for Comprehensive Tobacco Control Programs (www.cdc.gov/tobacco) -Surgeon General (http://www.surgeongeneral.gov/initiatives/tobacco/index.html U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014.

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Part V. Definitions

Intervention	Any measure or action that is intended to improve/restore health or alter the course of disease (e.g. – counseling sessions, educational classes, etc.)
Milestone/Goal	Meaningful step toward meet a goal or actual goal to be attained.
Criteria	Condition(s) that must be met for the enrollee to receive the incentive/reward
Limitation(s)	Any restriction(s) that result in an enrollee not qualifying to receive the incentive/reward

APPENDIX II – Weight Management Healthy Behaviors Program Description
Program description effective 3/1/2022

Statewide Medicaid Managed Care Program
Healthy Behaviors Program Description

Part I. Program Overview

Plan Name	**Aetna Better Health of Florida**
Program Name	**Adult Weight Management**
Brief Description of Program	The aims of Aetna Better Health of Florida's Healthy Behaviors programs are to provide specific interventions for a subset of the population in the context of Integrated Care Management. The overarching goal is to elicit changes in members' health-related behaviors that positively impact their current and future health and wellness through collaboration, engagement, identification of strengths and leveraging those strengths to enhance resiliency and result in members' improved self-management and self-efficacy. The goal will be for the member to understand the health risks of being overweight and initiate at least one healthy behavior aimed at weight and health risk reduction. Members are informed of the availability of Aetna Better Health of Florida's Healthy Behaviors programs (including incentives and rewards) during welcome calls, in their welcome packets and

	member handbooks, on the member website, in member and disease management newsletters, prenatal and post-partum education mailings, and during outreach telephone calls from the member services and case management staff. **Assumptions** These interventions were developed with the following assumptions. 1. All members in Care Management will be asked about their height and weight, and a BMI will be calculated. 2. All members who are overweight or obese may request assistance from care management for help with weight management, whether or not they are in CM for any other issues. 3. This health promotion program will be provided as an adjunct to our members' health plan benefit structure. The identification, risk stratification, interventions and communications are not intended and will not be used to replace the individualized health care provided by enrolled members' primary care or other health providers **Incentives and Rewards:** Incentives and rewards cannot be used for gambling, alcohol, tobacco or drugs (except for over-the-counter drugs). The program, including incentives and rewards, is made available to all members who meet the requirements of the program. Incentives and rewards are not used to direct the member to select a certain provider. The maximum reward dollar amount on incentives and rewards does not include money spent on transportation, child care provided during delivery of services; or healthy behavior program services. Incentives and rewards may take 90 to 180 days or greater to receive. Incentives and rewards are non-transferrable to other Managed Care Plans or other programs. Members will lose access to earned incentives and rewards if they voluntarily dis-enroll from the Aetna Better Health of Florida or lose Medicaid eligibility for more than one-hundred eighty (180) days.
Description of Enrollee Identification Method	Active Referral Sources include: - Providers - Community Agencies - Member self-referral - Internal Staff [e.g. Care Management staff] - Health Risk Questionnaire/Health Risk Assessment Passive Referral Sources include: - Medical Claims—If there is a claim coded with a diagnosis of Obesity or Morbid Obesity

	• 278.0 Overweight and obesity • 278.00 Obesity, unspecified • 278.01 Morbid obesity • 278.02 Overweight • 278.03 Obesity hypoventilation syndrome - Pharmacy data [dispensing of weight reduction medications] Criteria: • Overweight (BMI of 25 to 29.9) with no current treatment for co-existing conditions • Obesity Class I (BMI 30.0–34.9) with any uncontrolled co-existing conditions ***or*** 2 or more well controlled co-existing conditions • Obesity Class II (BMI 35.0–39.9) with any uncontrolled co-existing conditions ***or*** 2 or more well controlled co-existing conditions • Obesity Class III (BMI ≥40) with Physician's written clearance
Description of Written Agreement/Program Enrollment Process (if applicable)	**<u>Care Management</u>** - Obtain written or verbal consent from member and primary care physician to participate in Healthy Behaviors Weight Management Program using Member Attestation form - Create Supportive case in CM (or add event if member already in CM) with goals, required follow up activities and Care Plan o Introductory letter to Member and provider o Coordinate with PCP o Coordinate with nutritionist, counselor or any others involved in member-centered goals and care plan o Outreach member/family per schedule: weekly first month, then every other week 2nd and 3rd month - Review Care Plan at each encounter with the member. - Establish and document SMART Individualized Member goals (loss of "X" % from % starting weight, increase in tolerance of physical activity to "X" minutes, etc.). - Refer enrolled member to nutritionist/ counselor/support group based on member's needs; coordinate with PCP if physician order needed for referral - Confirm successful completion of 6-month program requirements (Member can stay in supportive or population CM beyond this point for weight loss support but criteria will have to be developed for this extended CM support) - Provide enrollment and completion information to finance for incentive distribution.

	Providers - Approve participation of moderate or high-risk member in Weight Management program by signing the Member Attestation or approving by means of a verbal consent. - Complete initial assessment that includes ht./wt./BMI, co-morbid conditions and an exercise prescription - Member will need at least one follow up appointment with PCP at the end of the program - Additional appointment will be required within 60 days from beginning of program for those members designated as High-risk

Part II. Interventions and Incentives

Intervention	Incentive Type*	Incentive Value *	Incentive Criteria	Limitations
Care Management • Initial telephonic outreach to review the process and assess the member's readiness to change and barriers to change • Provide member with telephonic contact information and discuss scheduled follow up to coach and to assess progress and support members' skills development • Telephonic outreach performed monthly and adjusted as appropriate based on member's progress • Provide self-management support [education, tools, etc.]—KRAMES, Web based resources • Refer to Nutritionist or Weight Management group sessions in community • Telephonic outreach to member every other week for the first and 2nd months. May progress to monthly outreach, based on member's status. (e.g. progress with weight loss, adherence to program, individualized member need) • Consider additional individual specialty consultation, including behavioral health	Wearable Bluetooth Fitness Tracking Device Rewards Card	$20.00 $20.00	Complete three (3) months of weight management program; meeting weight loss goals; attending appointments with nutritionist and PCP Complete six (6) months of weight management program; meeting weight loss goals;	One (1) device per member One (1) gift card per member

• Outreach to member weekly first month, then every other week 2nd and 3rd month. May progress to monthly outreach, based on member's status • HP Care Manager to provide appropriate condition-specific disease self-management • HP Care Management Interface with PCP regularly to discuss individual care plan for the member (include member if possible), jointly identify goals for member to consider, review results and ensure ongoing physician supervision of weight loss program			attending appointments with nutritionist and PCP	
Provider • Approve participation of moderate or high-risk member in Weight Management program • Complete initial assessment that includes height/ weight/BMI, co-morbid conditions and an exercise prescription • Member will need at least one follow up appointment with PCP at the end of the program • Additional appointment will be required within 60 days from beginning of program for those members designated as High-risk	N/A	N/A	N/A	N/A
Tools & Supports **MEMBERS:** - Krames educational material - Web based resources **PROVIDERS:** - Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults from the NIH at http://www.nhlbi.nih.gov/health-pro/guidelines/current/obesity-guidelines/index.htm				

- Aim for a Healthy Weight booklet from the NIH, free to providers at http://www.nhlbi.nih.gov/health/resources/heart/obesity-lose-wt-booklet.htm				
Measures of Effectiveness Annual reporting: - Percent of enrolled members referred to and completing dietary consultations - Percent of members completing 6-month program - Change in BMI per member after 6 months enrollment (by initial obesity category/subcategory) - HEDIS: ABA Adult BMI Assessment; Data collected via claims & MRR; age: 18-74				

Part III. Milestones, Goals and Rewards

Milestone/Goal	Reward Type*	Reward Value*	Reward Criteria	Limitations
Three (3) months participation in weight management program	Wearable Bluetooth Fitness Tracking Device	$20	Member has completed three (3) months of participation in the Weight Management Program and has demonstrated a weight reduction	One (1 device) per member
Six (6) months participation in weight management program	Gift Card	$20	Member has completed six (6) months of participation in the Weight Management Program and has demonstrated a weight reduction	One (1) gift card per member

Part IV. Evidence Base

Detailed Description of Research to Support Effectiveness	Aetna Better Health of Florida uses the theory of planned behavior and strategies identified in the professional literature that are associated with healthy eating, physical activity, and achieving and maintaining a healthy weight. Evidence based guidelines used to develop interventions: 1. Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, National Health Lung and Blood Institute, US Department of Health and Human Services, Update in progress, expected release 2012, available via website: http://www.nhlbi.nih.gov/guidelines/obesity/index.htm **2.** Screening for and Management of Obesity and Overweight in Adults: Agency for Healthcare Research and Quality (US); 2011 Oct. Report No.: 11-05159-EF-1. available at: http://www.ncbi.nlm.nih.gov/books/NBK65294/pdf/TOC.pdf

Part V. Definitions

Intervention	Any measure or action that is intended to improve/restore health or alter the course of disease (e.g. – counseling sessions, educational classes, etc.)
Milestone/Goal	Meaningful step toward meeting a goal or actual goal to be attained.
Criteria	Condition(s) that must be met for the enrollee to receive the incentive/reward
Limitation(s)	Any restriction(s) that result in an enrollee not qualifying to receive the incentive/reward

APPENDIX III – Substance Use Healthy Behaviors Program Description
Program description effective 6/28/2022

Statewide Medicaid Managed Care Program
Healthy Behaviors Program Description

Part I. Program Overview

Plan Name	**Aetna Better Health of Florida**
Program Name	**Substance Use Program**
Brief Description of Program	Aetna Better Health of Florida's Healthy Behaviors programs provide specific interventions for a subset of the population within the context of Integrated Care Management. These interventions are aimed specifically at assisting members with substance use. Aetna Better Health of Florida realizes that recovery from substance use disorders is often not a linear and there are many paths to recovery. According to SAMSHA's guiding principles, "The process of recovery is highly personal and occurs via many pathways. It may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. Recovery is characterized by continual growth and improvement in one's health and wellness and managing setbacks. Because setbacks are a natural part of life, resilience becomes a key component of recovery."[1] This recovery-oriented system of care approach is reflected in this program description to consider members voice and choice. **Assumptions:** These interventions were developed with the following assumptions. 1. Members with substance use issues will be identified through claims data, health risk assessments and other methods of surveillance (i.e., provider referral). 2. Members will be stratified for intervention based on our predictive modeling tool (CORE) and will be offered assistance through our Integrated Care Management program. 3. This intervention will be provided as an adjunct to our members' health plan benefit structure. The identification, risk stratification, interventions and communications are not intended and will not be used to replace the individualized health care provided by the enrolled members' primary care or other health providers. The overarching goal is health promotion to help our members to understand the health risks of substance use and elicit changes in members' health-related behaviors that positively impact their

[1] *Recovery and recovery support*. SAMHSA. (2022, April 4). Retrieved June 17, 2022, from https://www.samhsa.gov/find-help/recovery

	current and future health and wellness. This will be done through collaboration, engagement, identification of strengths and leveraging those strengths to enhance resiliency and result in members' improved condition management and self-efficacy. The goals of the Care Management interventions are to: • Increase our members' ability to self-manage their behaviors • Increase the number of members engaged in treatment options • Reduce or delay morbidity (complications) and mortality associated with substance use • Decrease the incidence of ER and In-patient visits • Teach wellness and better overall management resulting in healthier lifestyle choices • Enlist family or other support entities as possible to aid in maintenance of wellness and condition management activities • Engage the member and members' provider(s) in following nationally recognized and evidence-based guidelines for evaluation and treatment • Assure, where possible: o Appropriate use community resources, substance use professionals, psychiatrists o Better methods of adherence, aimed at resulting in better perceived quality of life • Track outcomes to identify opportunities to improve the interventions **Incentives and Rewards:** Incentives and rewards cannot be used for gambling, alcohol, tobacco or drugs (except for over-the-counter drugs). The program, including incentives and rewards, is made available to all members who meet the requirements of the program. Incentives and rewards are not used to direct the member to select a certain provider. The maximum reward dollar amount on incentives and rewards does not include money spent on transportation, childcare provided during delivery of services; or healthy behavior program services. Incentives and rewards may take 90 to 180 days or greater to receive. Incentives and rewards are non-transferrable to other Managed Care Plans or other programs. Members will lose access to earned incentives and rewards if they voluntarily dis-enroll from the Aetna Better Health of Florida or lose Medicaid eligibility for more than one-hundred eighty (180) days.
Description of Enrollee Identification Method	**<u>Identification</u>** Any eligible members with a qualifying diagnosis who are 13 years of age or older. Active Referral Sources include: - Providers

- Community Agencies
- Member self-referral
- Internal Staff [e.g., Concurrent Review, Care Management and Utilization management staff, pharmacy]
- Health Risk Questionnaire/Health Risk Assessment/Outreach Risk Questionnaire [HRQ/HRA/ORQ]
- Caregiver/guardian
- ER/inpatient referrals

Passive Referral Sources include:
- Claims and predictive modeling (CORE)
- Pharmacy data

Participant Stratification

Low Risk
- HRQ/HRA/ ORQ
- Caregiver/guardian

High Risk
- Claims and predictive modeling (CORE)
- Pharmacy data
- Providers
- Community Agencies
- Member self-referral
- Internal Staff [e.g., Care Management and Utilization management staff, pharmacy]
- ER/Inpatient referrals

Aetna will provide an annual training for providers on the screening and identification of members with alcohol or substance related disorders. This training will assist all providers in screening enrollees for signs of alcohol and substance abuse. This evaluation may occur during: Initial contact with a new enrollee; routine physical examinations; initial prenatal contact; when the enrollee evidences serious over-utilization of medical, surgical, trauma or emergency services; and when documentation of emergency room visits suggests the need.

Description of Written Agreement/Program Enrollment Process (if applicable)	**Care Management** • Follow all standard Integrated Care Management processes for Supporting or Intensive Care Management including documentation of goals, care plan actions and appropriate follow-up by Care Management • Confirm successful completion of program or ongoing attendance to meetings and therapy sessions, medication and collaborative treatment plans are being followed • Member may remain in Care Management for other issues at this point or may be discharged with information about how to re-contact Care Management at any time in the future • Aetna recognizes that a combination of counseling and oversight by the Primary Care Physician provides an increased likelihood of successful treatment. **Providers** • Follow nationally recognized guidelines for management of substance use • See member regularly for follow-up • Collaborate with Care Managers and the member's care team as needed, including providing clinical information needed to appropriately educate and direct the member in better self-management. A built-in functionality of the Substance Use Program is securing the member's commitment to participation in the program. Upon identification of a member meeting the parameters for inclusion in the program, the member will receive information that includes, but is not limited to: • Local and community resources that can provide support and education regarding addictions, recovery communities, locations and meeting times for Alcoholics Anonymous / Narcotic Anonymous within the consumer's access area • Consents for the release of information to facilitate effective coordination of care, while safeguarding the consumer's right to privacy • A copy of the consumer's rights and responsibility as they relate to health care and treatment • A consumer attestation that the member is willingly participating in the program A designated Care Coordinator Case Manager who is assigned to the consumer's care. The designated Case Manager will be responsible to complete the case management assessment, to identify the member's readiness to participate in the program and level of functionality to facilitate the development of the care plan. The member will have direct access to the case manager to assist with appointments, coordination efforts, communication with treating practitioners, etc.

Part II. Interventions and Incentives

Intervention	Incentive Type*	Incentive Value *	Incentive Criteria	Limitations
Care Management **Supportive Care** - Describe benefits - Give community resources - Provide names of therapist or agencies **Intensive Care** - Describe benefits - Give community resources - Provide names of therapist or agencies - Coordinate appointments and transportation as needed - Provide additional education and encouragement	N/A	N/A	N/A	N/A
Tools & Supports **MEMBERS** - Educational information may include but is not limited to: o Condition-specific self-care, normal progression of a chronic condition, common complications, signs of complications, methods of condition management o Nutrition, where applicable o Importance of physical activity as recommended by member's provider(s) o Appropriate laboratory or other testing for specific conditions o Details on condition complications and risks	N/A	N/A	N/A	N/A

○ Additional educational information on specific complications and conditions, for members with special risks or complications ○ In applicable plans, information on how to use the 24-hour, nurse line (available 24 hours a day, 7 days a week) ○ The importance of working with the health practitioner in a partnership toward healthier behavior - Krames educational material - Web based resources **PROVIDERS** - Clinical practice guidelines will be linked on the plan web site - Plan CMO or Medical Director(s) will be proactive in educating providers who are not following standard guidelines				
<u>Measures of Effectiveness</u> Annual reporting: • Reductions in inpatient admissions and avoidable ED Utilization • Increase in members completing substance use program • Increase in members enrolled in treatment with community practitioners and providers	N/A	N/A	N/A	N/A

• Increase in members receiving medicated assistance treatment (if applicable)				

Part III. Milestones, Goals and Rewards

Milestone/Goal	Reward Type*	Reward Value*	Reward Criteria	Limitations
Engagement in substance use program/meaningful step toward recovery	Rewards Card	$20.00 Total	Based upon the information that not all members paths to recovery are linear and there are many paths to recovery. Members can obtain reward through participating in their choice of program as a meaningful step toward recovery. Below is a list of programs which members may engage in (but is not exhaustive), to obtain reward. • Verification of continuous attendance at AA/ NA group meetings for 90 days through	Must be 13 years or older and taking active steps to engage in treatment which has been confirmed by their care coordinator or case manager.

			member presentation of chips • CM verify attendance at psychosocial rehab, intensive outpatient program, partial hospitalization program, completion of substance use residential program as verified through claims. • Participation in Care Management for a minimum of 90 days • Verification of member obtaining medication assisted treatment as verified through pharmacy claims	
Continuous engagement in substance use program or successful completion of	Rewards Card	$20.00 Total	Members can obtain reward through	Must be 13 years or older and

program/meaningful step toward recovery			participating in their choice of program as a meaningful step toward recovery. Below is a list of programs which members may engage in (but is not exhaustive), to obtain reward. • Verification of continuous attendance at AA/ NA group meetings for 90 days through member presentation of chips • CM verify attendance at psychosocial rehab, intensive outpatient program, partial hospitalization program, completion of substance use residential program as verified through claims.	maintained engagement in substance use or has successfully completed substance use program which has been confirmed by their care coordinator or case manager.

			• Participation in Care Management for a minimum of 90 days • Verification of member obtaining medication assisted treatment as verified through pharmacy claims	

Part IV. Evidence Base

Detailed Description of Research to Support Effectiveness	Attaining and maintaining sobriety are important to an individual's ability to achieve overall health and wellness. There are 4 major dimensions that support a member's life in recovery: • Health • Home • Purpose • Community[2] Recovery can happen in many different settings and through many approaches such as the clinical setting, through faith-based organizations, medication, peer support, family support, and self-care. [3]

[2] *Recovery and recovery support*. SAMHSA. (2022, April 4). Retrieved June 17, 2022, from https://www.samhsa.gov/find-help/recovery

[3] *Recovery and recovery support.* SAMHSA. (2022, April 4). Retrieved June 17, 2022, from https://www.samhsa.gov/find-help/recovery

	Medication-assisted treatment (MAT) which is the use of medications to treat individuals with opioid and alcohol use disorders. These medications are approved by the Food and Drug Administration (FDA) and are specific to each individual. MAT in combination with therapy have been shown to successfully treat these both opioid and alcohol use disorders and has been proven through research. MAT has also shown a decrease for a need in detoxification and has also been that it can help with sustained recovery.[4] Upon identification of a member meeting the parameters for inclusion in the program and the member's consent to be a willing participant, a screening tool will be administered: ▪ Drug Abuse Screening Test – 10 (DAST-10): Used for members who have possible involvement with drugs, not including alcohol ▪ Alcohol Use Disorders Identification Test (AUDIT): Is used for early detection of individuals with risky or high-risk drinking. The AUDIT was developed by the World Health Organization (WHO) as a simple method of screening for alcohol related disorders and to facilitate a brief evaluation. It also provides a framework for intervention to help facilitate recovery and abstinence thus avoid the harmful consequences of their drinking.[5] The DAST – 10 was developed in 1982 by Harvey Skinner, PHD and was designed to provide a brief instrument for clinical screening and treatment evaluation and can be used with adults and older youth.[6] Alcoholics Anonymous and Narcotics Anonymous are both interventions to address substance use. Per both Narcotics Anonymous and Alcoholics Anonymous websites, many of the staples of AA and NA are very similar in that they are: are nonprofessional, self-supporting, multiracial, apolitical programs, they are widely available throughout the world, there are no age or education requirements, membership is open to anyone who wants to do something about his or her drinking or substance

[4] *Medication-assisted treatment (MAT)*. SAMHSA. (2022, June 10). Retrieved June 17, 2022, from https://www.samhsa.gov/medication-assisted-treatment

[5] U.S. Department of Health and Human Services. (2000, October). *Alcohol Use Disorders Identification Test (audit)*. National Institute on Alcohol Abuse and Alcoholism. Retrieved June 17, 2022, from https://pubs.niaaa.nih.gov/publications/audit.htm

[6] *Instrument: Drug abuse screening test (DAST-10)*. Instrument: Drug Abuse Screening Test (DAST-10) | NIDA CTN Common Data Elements. (n.d.). Retrieved June 17, 2022, from https://cde.drugabuse.gov/instrument/e9053390-ee9c-9140-e040-bb89ad433d69

	abuse problem.[7] [8] Membership comprises of men and women who are recovering from alcohol and substance abuse worldwide and the only requirement for membership is a desire to stop drinking or using substances. There are no dues or fees for AA or NA membership and they are supported through their own contributions. AA / NA are not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy; neither endorses nor opposes any causes. The primary purpose is to stay sober and help others achieve sobriety. They both are considered nonprofessional – they do not have clinics, doctors, counselors or psychologists and both are considered a peer model. There is no central authority controlling how the groups operate. Both groups use a Twelve Step Program model which provides a framework for self-examination and a road to recovery, free of alcohol and substances. The relative success of the AA/NA programs appears to be the therapeutic value of addicts working with other addicts.[9] [10] According to Narcotics Anonymous, the average length of time that members are drug free is 11.41 years. [11]The main difference between the two organizations is that narcotics anonymous is that the group is open to all drug addicts and does not specifically limit to only alcohol.[12] Because addiction affects many aspects of an individual's life, a comprehensive continuum of services promotes recovery and enables the consumer to integrate into society as a healthy, alcohol / substance free individual. This continuum must be designed to provide engagement in treatment and motivation, treatment at the appropriate level of care, and support services that will enable the individual to maintain long-term sobriety and recovery. Treatment should be structured to ensure

[7] Alcoholics Anonymous World Services, Inc. (2022). *Have a problem with alcohol? there is a solution.* Alcoholics Anonymous. Retrieved June 20, 2022, from https://www.aa.org/

[8] NA World Services, Inc. (2018). *Public relations handbook - na*. Information about NA. Retrieved June 20, 2022, from https://www.na.org/admin/include/spaw2/uploads/pdf/PR/PR_Handbook_2016.pdf

[9] NA World Services, Inc. (2018). *Public relations handbook - na*. Information about NA. Retrieved June 20, 2022, from https://www.na.org/admin/include/spaw2/uploads/pdf/PR/PR_Handbook_2016.pdf

[10] Alcoholics Anonymous World Services, Inc. (2022). *Have a problem with alcohol? there is a solution.* Alcoholics Anonymous. Retrieved June 20, 2022, from https://www.aa.org/

[11] NA World Services, Inc. (2018). *Public relations handbook - na*. Information about NA. Retrieved June 20, 2022, from https://www.na.org/admin/include/spaw2/uploads/pdf/PR/PR_Handbook_2016.pdf

[12] NA World Services, Inc. (2018). *Public relations handbook - na*. Information about NA. Retrieved June 20, 2022, from https://www.na.org/admin/include/spaw2/uploads/pdf/PR/PR_Handbook_2016.pdf

	smooth transitions of care across the care continuum. Case Management can facilitate all of these aspects of care that promote recovery and can assist members in accessing treatment or services to promote their recovery.

Part V. Definitions

Intervention	Any measure or action that is intended to improve/restore health or alter the course of disease (e.g. – counseling sessions, educational classes, etc.)
Milestone/Goal	Meaningful step toward meeting a goal or actual goal to be attained.
Criteria	Condition(s) that must be met for the enrollee to receive the incentive/reward
Limitation(s)	Any restriction(s) that result in an enrollee not qualifying to receive the incentive/reward