Quality Initiatives Report

Quality Program Transparency and Accountability

May 2013

Angela Kaiser, Manager
HealthPartners
Quality, Measurement and Improvement
angela.m.kaiser@[redacted]

Table of Contents

Table of Figures:

Introduction

HealthPartners was founded in 1957 as a cooperative. Today we are the largest consumer governed nonprofit health care organization in the United States. We provide medical and dental coverage to more than 1.4 million members in Minnesota and surrounding states. We employ more than 21,000 employees in our integrated health care system.

As a mission driven organization, we've always measured our progress against the spirit of our founding. We are here to improve the health of our members, our patients and the community. Today's challenges are different than they were in 1957. But our dedication to changing things for the better – from federal health care policy to the health and wellness of our newest public programs enrollee – is unchanging.

Health care is complex, but we ground our work in a very simple concept. Developed by the Institute for Healthcare Improvement, The Triple Aim calls for accomplishment of three critical objectives at once:

These three objectives are inextricable, and each influences the others. As a large, integrated health care system, we have a unique view of these relationships because we serve as both a health plan and a care provider. This allows us to understand, influence and partner with other providers to improve care, experience and financing at the same time.

We are helping to lead and pioneer this work on many fronts from the national level to our local communities. As an organization and as individual leaders representing many disciplines, we are deeply involved with organizations such as the Institute of Medicine, the Institute for Healthcare Improvement, the National Quality Forum, the National Committee for Quality Assurance, various advisory committees of the U.S. Dept. of Health and Human Services and many others.

For us, the Triple Aim isn't a theoretical aspiration or a marketing slogan. It's infused within every aspect of our organization.

We have a long history of working with the State Department of Human Services to provide health care to public program enrollees. We enrolled our first state public programs member in 1985 through the state's demonstration waiver. Since then, the number of members enrolled in our programs has steadily grown. Today we proudly serve about 83, 000 state public program enrollees.

In this report, you will read of just five of our important accomplishments in delivering on measureable, meaningful improvement for the benefit of our members and enrollees.

- Reducing avoidable admissions, readmissions and improving coordination of care
- Increasing participation in Medication Therapy Management (MTM) program
- Supporting members with behavioral health needs
- Helping members get needed care
- Reducing disparities in health

Admissions and Readmissions

Why we chose this activity.

Healthcare has many specialties and several different types of care settings. Reducing the time members spend in the hospital is an important way to meet the triple aim goals while maintaining positive experience for our members. Regions Hospital is a high volume hospital for our public program members and is an active partner with us on our hospital initiatives.

Poor coordination of care between providers and between settings can result in confusion and miscommunication of complex, detailed information. This confusion and miscommunication can result in problems with patient care and the need for a patient to return to the hospital or result in unplanned hospital readmissions, many of which are avoidable. It also contributes to reduced member satisfaction, and overall higher healthcare costs. For this reason, it is a great candidate for our Triple Aim improvement efforts.

Studies have shown that 20% of patients undergo unplanned readmissions to a hospital within 30 days of being discharged[i]. Some analysis has suggested 76% of unplanned hospital readmissions within 30 days are potentially avoidable. Avoidable readmissions resulting from the fragmented health care delivery settings are expensive and reflect low quality and poor coordination of health care services.

Goals

- To reduce avoidable hospital admissions by meeting member needs prior to the need for hospitalization.
- To reduce avoidable hospital readmissions by improving the coordination of care between providers and between care settings.
- To improve member satisfaction with the coordination of their care.

What we did to achieve these goals

HealthPartners has implemented a multi-strategy approach to reduce avoidable hospital admissions, reduce avoidable readmissions and improve coordination of care through outreach to members, care delivery changes, and community partnerships.

Outreach to Members:

- Care coordinators contact members within 48 hours of receipt of discharge notification to assist members with making an appointment if the member has not already done so.
- Care coordinators help members understand the importance of attending the follow-up visit within 15 days of discharge. For our Minnesota Senior Health Options (MSHO) members, Care Coordinators play an important role in this process, as they already have a relationship with the member and can effectively help facilitate the coordination of care.
- When a member leaves the hospital, it is important that they understand their medications, how and when to take them, and what side effects to look for. Members who are discharged from Regions to Integrated Home Care are encouraged to work with a Medication Therapy Management Pharmacist (MTMP) who can help them with this.

Care Delivery Changes

- Regions Hospital, a high volume hospital for our state public programs members made changes to their after visit summary (AVS) for patients to enable them to better understand what they are supposed to do following discharge from Regions. This information is also sent to the primary care doctor so they can follow up with the patient as well.
- Regions Hospital is enhancing transition processes including the use of technology to get information from one care setting to the next.
- HealthPartners Medical Group (HPMG) Primary Care Providers developed a standard approach to proactively manage the care and follow-up of patients who have chronic conditions. Patients are identified upon discharge from the hospital or Emergency Room (ER). The Doctor completes an initial assessment of the patient and develops a care plan which is used to teach patients about self care management. Frequent follow-up occurs with the patient and the clinic RN care coordinator.

Community Partnerships

- Regions Hospital is a collaborative participant sharing what they have learned with other health care organizations in the statewide campaign focused on Reducing Avoidable Readmissions Effectively (RARE).
- Collaborative care approaches are in place with select residences (such as Central Towers) and select nursing homes to ensure optimal follow-up care.
- HealthPartners has a Quality Improvement Project (QIP) which focuses on improving transitions of care; focused on improving coordination of medication management. The goal of this QIP is to improve medication management, which will lead to a decrease of 30 day readmissions for our MSHO and Minnesota Senior Care Plus (MSC+) Population who receive home health care.

- HealthPartners is also participating in a collaborative Performance Improvement Project (PIP) called Transitions of Care: Improved Post Discharge Follow-Up Care. The goal of this PIP is to increase the number of MSHO and MSC+ members' that complete a scheduled follow-up appointment following hospital discharge to home. The post discharge visits offer an opportunity to assess conditions and modify the treatment plan to help prevent readmissions. This project includes improvement in the discharge planning process, hand-off to ambulatory care and coordination with primary care, as well as educating the member on the importance of the follow up appointment.

Results

HealthPartners monitors our overall admission rates for all state public program members. This measure has seen steady progress over the past three years as seen in Figure 1 as a result of the overall improved coordination of care between plan and health system.

HealthPartners Health Plan Admission Monitoring	
Year	Rate
2010	48.61 admits / 1000 members
2011	48.12 admits / 1000 members
2012	47.42 admits / 1000 members

Figure 1

We utilize the national HEDIS[ii] Plan All-Cause Readmissions measure to monitor readmission rates, and the national standard CAHPS to assess member satisfaction with how well their care is coordinated**.** As you can see in Figure 2 HealthPartners All Cause Readmission rate for MSHO members is 13.2% compared to the 2012 Minnesota average of 16.22%. Use of multiple related strategies and initiatives toward this goal can be effective at reducing readmission rates.

MSHO - All Cause Readmission (PCR) HEDIS Measure	
Year	Rate
2010	15.0%
2011	15.2%
2012	13.2%
MN Average 2012	16.2%

Figure 2

Member satisfaction has been impacted in areas related to care coordination and provider communication. CAHPS is a national standard that measures member satisfaction with the services their health plan provides. As you can see in Figure 3, satisfaction with provider communication and with care coordination has shown steady increase.

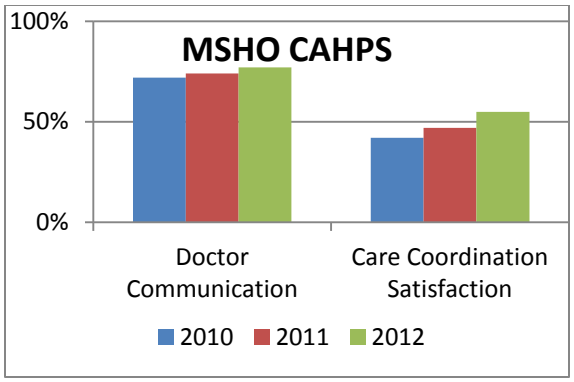

Figure 3

Conclusions / Lessons Learned

We have simultaneously achieved triple aim results on the following key dimensions of care:

- Reduced hospital admission and readmission rates benefiting health, experience and affordability
- Improved satisfaction with doctor communication and coordination of care benefiting health and enhanced member experience

We have learned that to be successful our strategies need to address the following barriers to best care:

- Limited communication between care provider information systems and community partners (other hospitals, community clinics, skilled nursing facilities, etc.) around patient care needs.
- Socioeconomic challenges that our patients face such as homelessness, poverty, stressors and lack of family support can interfere with the patient's ability to prioritize their health.
- Poor health literacy is an issue with the majority of the population, and can be amplified for elderly patients and diverse populations who have a limited understanding of the health care system. Hospital discharge instructions are detailed and confusing for patients who are compromised because they don't feel well.
- Culture and language can be barriers to a full understanding of health needs and discharge instructions.
- Availability of the complete discharge summary for primary care providers prior to the scheduled follow-up can be a barrier to enabling the primary care providers to have the information they need to accomplish a complete patient progress assessment. Clinics are promoting discharge summary completion and distribution to primary care providers prior to scheduled follow-up visits.
- Transportation barriers make it difficult for patients to get to a pharmacy to fill their prescriptions. Regions hospital pharmacy is working to fill prescriptions prior to the patients being discharged to promote patient understanding of medication regimens and to eliminate transportation issues in obtaining discharge prescriptions.

Recommendations/Sustainability

HealthPartners is committed to continuing to work with our care partners, both internally and externally to ensure that member needs are addressed during these times of great vulnerability. The transition between inpatient care and discharge to the community presents many challenges. We strongly recommend utilizing a multi-faceted approach and continued attention to this improvement work, as we believe the outcomes for members can continue to improve in this important area.

While avoiding admissions and readmissions to the hospital are measures of improved care, our attention will continue to focus on the transition between care events puts the member first and keeps their needs as the primary focus. Because we have the support of leadership at many levels of the organization, we believe we will be able to sustain these results and will continue to strive to improve disease specific outcomes and overall health outcomes for our members.

Pharmacy

Why we chose this activity

Members with high risk diseases may be on multiple medications, sometimes prescribed by different providers who may not be fully aware of all the patient's medications. Making sure each member's medications are appropriate and working for them is an important part of improving health. To that end, HealthPartners, in partnership with our pharmacy vendors and clinics, has been focused on improving the communication between members and their primary care physician, disease and case management staff, and their pharmacy as well as increasing the utilization of Medication Therapy Management (MTM) by our members. RxCheckUp, our MTM Program, is a comprehensive approach to managing the pharmacy needs of members with high risk diseases and those utilizing multiple medications.

Goals

- Increase the safety of medication management for those on multiple medications or with high risk diseases
- Improve the member experience around pharmacy issues.
- Increase utilization of Medication Therapy Management (MTM) Services.

What we did to achieve these goals

RxCheckUp, HealthPartners' MTM program, is available to all members on public health insurance. While this exceeds the DHS requirements for availability, HealthPartners believes that access to this service is a valuable benefit to members who may be at risk medically. Members can request a consultation with an RxCheckUp pharmacist by contacting the pharmacy program or member services. Providers are also well-versed on the MTM program and are encouraged to refer their patients, especially those with complex conditions.

Targeted Outreach

While the program is available to all members, high risk members are identified for outreach through medical and prescription claims data and in partnership with HealthPartners' Disease and Case Management program, specifically:

- Members with high risk coronary artery disease
- Members with high risk diabetes
- Members with high polypharmacy utilization; defined as members who are taking seven or more medications and have been hospitalized or have had no primary care in the past 12 months.

Assignment of an MTM Provider

Once a member is identified for outreach, the member is sent a letter introducing them to the program, explaining the benefits and how they can become involved. They are also assigned to an MTM site. Having a positive relationship between the member and the MTMP is one of the best predictors of member acceptance of the MTM program. In order for the program to be effective, the member must be comfortable with accessing the service, so the MTM assignment can be critical to their acceptance of the program. Considerations for the MTM assignment include:

- Has the member seen an MTM provider in the past?
- Is there an MTM provider connected to their primary care location?
- Where do they get the majority of their prescriptions filled?
- If there are no MTM providers who fulfill these connections, the member is typically connected to an MTM provider at an HPMG clinic pharmacy.

The MTM provider is expected to reach out to the member within 2 weeks to schedule a consultation. The initial consultation typically lasts approximately 60 minutes and includes a thorough review of medications the member is taking to assure that each medication is indicated, effective, safe, and convenient and that the member's understanding, expectations, and concerns about their medication therapy are addressed. These services are a highly coordinated effort to collaborate with the member and their family when needed, the pharmacist and the member's care provider(s).

Optimizing MTM Participation

RxCheckUp has implemented several strategies to maximize participation in the MTM program:

- Video conferencing is available for MTM consultation. If a member, due to medical frailty or desire, wishes to meet with an MTM provider but the service is not available at their primary clinic, a video conference can be done from their home clinic to an MTM provider at another location. This allows their primary care provider to participate in the consultation and assist in answering both pharmacist and member questions.
- Integrating and enhancing the role of pharmacists in the clinic process. The role of pharmacists in the management of some diseases, particularly diabetes, has enhanced care coordination for members. Members are encouraged to have appropriate lab tests to monitor medication levels. This is supported with reminders at various touchpoints in their care.

Results

One measure of the success of this program is the national HEDIS measure for annual monitoring of patients on persistent medications. A second, internal measure is the number of members who have utilized this program. As shown in Figure 4, gains in this measure have been modest for both Medicaid and MSHO, highlighting the challenges of effective medication management

Persistent Medication Combined HEDIS Measure			
MSHO		**MEDICAID**	
Year	Rate	Year	Rate
2010	94.0%	2010	86.49%
2011	95.2%	2011	87.36%
2012	94.6%	2012	86.63%

Figure 4

More encouraging is the increase in participation of Medicaid members in the program (Figure 5). Many of the outreach initiatives were instituted in late 2010 – 2011 in response to low utilization. Response has been dramatic with over a 200% increase in the first year.

Medicaid Participation in MTM Services	
2009	126
2010	108
2011	251

Figure 5

Member experience for those who participated in the program is very high.

- Ninety-nine percent (99%) would recommend the service to family and friends.
- While this program can be time intensive, especially at first, 85% of participants said the program was completely worth their time.
- Ninety seven percent (97%) of participants made lifestyle changes that could reduce their need for some of their medications.
- Analysis of high risk populations that utilize MTM services in our commercial population have shown improvements in chronic condition control including optimal diabetes outcomes, hypertension and lipid control. The overall program was determined to have demonstrated an 11:1 Return on Investment (ROI) in evaluation of the impact on the Total Cost of Care (TCOC).

Conclusions/Lessons Learned

We have simultaneously achieved triple aim results with the increased participation in the MTM program as evidenced by the health benefits through improved chronic condition management, by the improved affordability through a significant ROI, and to member experience as evidenced by the high rates of member satisfaction.

Limited member and provider awareness of the program can be barriers to program participation requiring the following proactive interventions:

- Communication is included in all new member materials and periodically following identification of eligibility for the services.
- The program name was changed to RxCheckUp to enhance interest in the program and engage members who may be at a more moderate risk for medication issues.
- Introduction to the program occurs through member welcome calls, targeted mailings and member communication tools such as web site and newsletter articles.
- Providers can effectively explain the benefits of working closely with an MTM pharmacist can more effectively engage their patients in this type of program. To promote effective provider reminders are included with formulary and drug safety updates.

Recommendations/Sustainability

We strongly recommend continued attention to the integration of MTM program in care processes, and continued proactive communication of the benefits of the program due to its ability to affect the triple aim:

- Member's experiences with MTM services have been extremely positive.
- Members felt empowered to make positive health changes.

The MTM programs are offered at no additional cost to members who have multiple medical conditions, who are taking many prescription drugs and who have high medication costs. We intend to sustain this service for our members, to improve medical care coordination, reduce costs and complications and ultimately improve the health of our members.

The positive outcomes related to the Triple Aim are so impactful and the effects for the members can be so pronounced, that we are committed to offering a comprehensive medication therapy management program to Medicaid members through our RxCheckUp program. Focus at this point will remain on improving access to MTM pharmacists and increasing member participation in the program.

Service Initiatives

Why we chose this activity

One arm of the Triple Aim is to improve the experience of the individual. HealthPartners has worked to communicate effectively with members and provide a customer service experience that is customized to the needs of each member. We want interactions with our members to be tailored to the needs of that particular member, achieving issue resolution and resulting in increased satisfaction for each member. To that end, we have implemented processes that have made accessing information and assistance amazingly simple and easy to use. These services have resulted in a more customized personal experience and a more 'connected' membership.

Goal

HealthPartners strives to deliver an exceptional experience to our members who look to us to support them in their use of health care services, as evidenced by improved member satisfaction results as measured by CAHPS results.

What we did to achieve the goal

HealthPartners has member services staff who are dedicated to serving our Medicaid population. These staff are called the Riverview Service Center Member Services. These staff have special training on issues related to the Medicaid contract, benefits, complaints processes and resources available to these HealthPartners members.

Loyalty Contacts

As part of our commitment to providing exceptional personal service, Riverview Service Center (RVSC) Member Services has a Loyalty Contact initiative. The purpose of a Loyalty Contact is to demonstrate our commitment to our members and our interest in their questions and concerns. We hope to maintain and improve our members' satisfaction with their interactions with us and the information we provide, and encourage their loyalty to HealthPartners by 'wowing' them with an exceptional service experience.

- RVSC Member Services began the initiative by making outbound phone calls, and has now incorporated outbound written communication such as a personal note.
- Member services representatives may identify an opportunity to follow-up to ensure the member received the resolution they expected.
- Loyalty calls are made about any topic, from following up to make sure that a requested item was received, to ensuring resolution on formulary alternatives, prior authorization requests, network options, etc.
- This level of proactive customer service and support creates an emotional connection and can result in increased satisfaction with services overall.

Decision Support

Shared Decision Making (SDM) is a formal process that supplements clinic based counseling by identifying and addressing gaps in knowledge and incorporating patient preferences into the decision making process. Often people who receive a new diagnosis are overwhelmed with new information and feel pressured to make a decision about a course of care based on other people’s experiences and expectations.

- HealthPartners provides access to Decision Support tools and resources that allow members (on their own or with health plan assistance), to make a confident, comfortable choice based on their values and personal preferences.
- Decision Support is provided at no additional cost to HealthPartners members and can be used for any health and social decision when two or more options are available. It is especially helpful for patients facing decisions about newly diagnosed conditions, patients with chronic diseases and patients and families facing end-of-life decisions.

- In health care, Decision Support helps members understand the pros and cons of each option, consider the value they place on each pro and con and use this information to participate actively with their doctors in choosing an option.

The key messages to members:

- Health care decisions can be complicated. The "right" decision for someone else may not be right for you. That's why we want to support you with free decision support resources and tools.
- Decision support resources help you make informed, personal health care choices.
- Decision support tools are simple, easy-to-use. You can use them on your own or with help from trained member advocates at HealthPartners, and you can use the results to talk with your doctor.
- The Decision Support Process does not steer members toward any particular decision. It provides help to members in making decisions that are right for them and gives them the tools to talk to family and friends about their decisions.
- Members can access decision support resources on their own via the HealthPartners web site, or they can work one on one with a trained Nurse Navigator who can guide them through the process of exploring their options and their feelings about each proposed course of treatment. Member Services staff can assist our members with referrals to the Nurse navigators.

Pharmacy Navigators

Medication or formulary issues are very common questions from members who contact member services. Member services staff have access to resources within the pharmacy area of HealthPartners to problem solve these issues.

- Pharmacy Navigators have special training in pharmacy benefits and systems that make them a valuable resource for Riverview Member Services when assisting members with complex pharmacy questions or issues.
- When a member calls member services with a pharmacy related question that is beyond the scope of the members services staff, they contact the Pharmacy Navigators, who can proactively interact with providers regarding the prior authorization process and other pharmacy administrative processes.
- Some examples of assistance that Pharmacy Navigators can provide include alternatives to non-covered medications; step therapy requirements beyond information already available; Prior Authorization denial reasons and criteria beyond information already available; and assistance in understanding and explaining pharmacy terminology

Member Outreach Calls

HealthPartners member services will perform outbound call projects when time allows or if there is a business need. These are typically completed to welcome members to the plan or to notify members of a preventive service they could take advantage of.

- Currently all new members to the plan receive an automated voice message welcoming them and giving them high level details on what they can expect as new members to HealthPartners.

- Other examples of calls which have been completed include Blood Lead test reminder calls to parents of members who are in need of a blood lead test or a follow up call to a Medication Therapy Management invitation letter.

Person Centered System (PCS)

HealthPartners provides some great opportunities for members to improve or maintain their health. Members are often unaware of these opportunities or forget to take advantage of them. The HealthPartners' Person Centered System (PCS) helps Member Services to notify and/or remind our members of opportunities to take care of their health.

- PCS campaigns are launched from an internal message system with the HealthPartners communication system. Letters or e-mails are sent to members who are identified as eligible for or in need of a given preventive service.
- If that member contacts member services for any reason, the same message is also delivered to them by the staff they speak to.
- Examples of services that are recommended via this system include: childhood or adolescent immunizations, blood lead testing, C&TC, colorectal cancer screening, cholesterol reminders, mammograms, pneumonia and influenza immunizations and MTM services.
- For members that sign up for HealthPartners electronic e-mail message, they can receive these same messages via e-mail. Currently, 19.7% of Medicaid members choose to receive notifications electronically when available.

Electronic Resources

- In 2013, HealthPartners launched a new mobile app, myHP, to help answer questions and locate needed services. MyHP can be downloaded to any smart phone and includes multiple resources for members such as: an electronic version of the membership card, CareFinder to help people find the closest clinic or urgent care to their location, '*my pharmacy'* enables members to request a prescription refill via the app, and contacts for member services.
- Some members are more comfortable accessing resources for assistance via on-line. Currently 19.7% of HealthPartners HPCare members are enrolled into an on-line '*My HealthPartners'* account.
- One significant achievement has been a redesign of the My Plan documents page on member's myHealthPartners.com account. The new My Plan documents page navigation is much simpler, with more information available for past enrollment years.

Finding Needed Care

Assisting members in accessing care is a core service of any health plan. Member service staff is available to answer questions about the network available to members and can offer them assistance in finding a clinic that is convenient for them.

- HealthPartners encourages members to seek the most appropriate level of care for their care needs, such as an urgent care, instead of the emergency room for low intensity needs.
- HealthPartners has many options to assist members in finding the best care.

- The myHP app has a clinic locator function which includes urgent care locations, as well as contact information for our 24/7 nurse line and the 24/7 on-line clinic virtuwell.
- The main page of the web site also has a clinic locator, and members can call member services for assistance in locating a clinic that is in their network and will work for them.
- The CareLine and virtuwell contact information is posted on the web as well.
- For members who utilize the emergency room for issues that could have been treated in Urgent Care, HealthPartners sends a letter via the PCS system with a reminder of options available. The letter encourages them to call CareLine, our 24 hour nurse line if they have questions about the most appropriate place to go for care. In addition, the letter is educational in nature about where to go to seek care for a variety of common illnesses.
- If members repeatedly go to the ER for low intensity issues, a nurse from the CareLine will reach out to them to assist them with locating a primary care clinic and help them feel more comfortable in utilizing the CareLine services in the future.

Customer Care Training

Staff at all levels of HealthPartners care system participated in "Connecting the Dots" trainings which emphasized the interconnectedness of all areas within HealthPartners.

- Staff learned about how all areas of the plan and system impact the Triple Aim and how they may be able to utilize other areas of HealthPartners to have a positive impact on the health of our members and patients.
- Clinical staff participated in Emotional Connections Training, designed to normalize a closer connection between clinic staff and their patients. Staff learned about the importance of 'warm transfers' within the clinic, during the visit and at the close of the visit. This practice helps ensure their patients are cared for both physically as well as emotionally and feel a stronger connection to their medical provider.

Results

Overall, the initiatives and interventions introduced have been successful, or at least partially successful, in helping HealthPartners reach our service goals. Compared to the 2012 State Average, our CAHPS results have held steady or improved. Family and Children's Medicaid, Minnesota Care and MSC+ scores are within or above the State Average.

In addition to CAHPS, another measure of member satisfaction is the number of grievances received by the plan. In 2010, there were 8.3% complaints per 1000 members. In 2011, that rate decreased to 6.5% and in 2012, continued to decrease to 6.2%.

Also in 2012, HealthPartners MSHO earned 4.5 Stars by Centers for Medicare and Medicaid Services (CMS) and increased the number of stars in five of nine CAHPS categories. This recognition is an indicator of our effectiveness in member experience.

Member satisfaction with most areas of service related to HealthPartners has been improving for the past few years. As a result of many of the initiatives implemented by Member Services, HealthPartners's CAHPS score for Customer Service improved notably for MSHO and MSC+ in 2012(Figure 6).

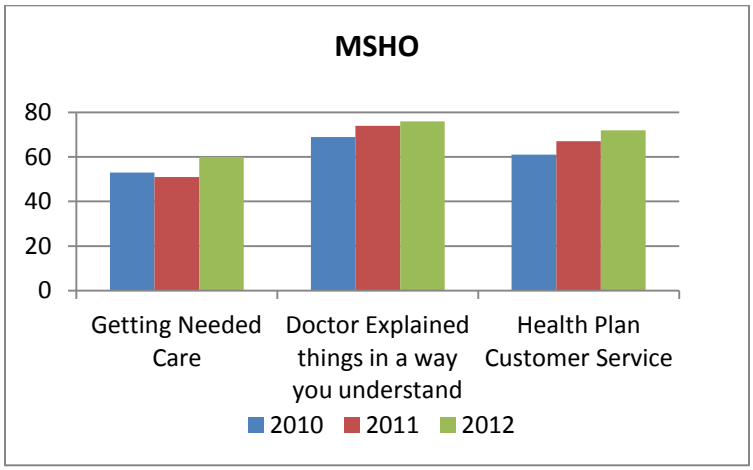

Figure 6

Although Our Medicaid and MinnesotaCare members' score declined slightly over 2011, the score was still higher than the State Average at a statistically significant level (Figure 7). For MSHO, the composite score for Getting Needed Care notably improved over 2011 to bring this composite score within the State Average.

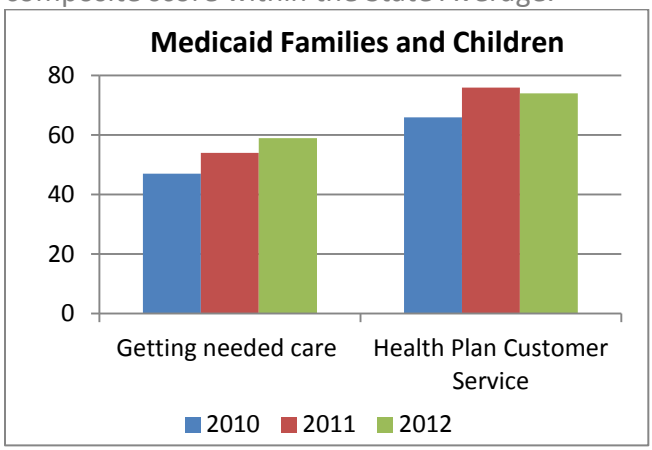

Figure 7

It was rewarding to have MinnesotaCare's score improve on knowing where to get after-hours care in 2012 after focusing improvement actions on communicating urgent care, CareLine and virtuwell® options. For Getting Needed Care, Families and Children's MA, MinnesotaCare and MSC+ scores are comparable between 2011 and 2012. We continue to focus our efforts on Customer Service and Getting Care Quickly.

Conclusions / Lessons Learned

In conclusion, our service initiatives have been successful in impacting CAHPS results:

- Improved members satisfaction with getting needed care
- Variable results on satisfaction with customer service

We have learned that many of the initiatives and interventions require more than one year to be implemented and to be experienced by members.

- Service improvements are not a 'quick fix' and impacts are often not seen immediately, but rather over a period of time.
- The infrequency of member contact with the health plan means that individual members may not see the changes immediately, if ever.
- Member's eligibility and turnover rate means shorter enrollment tenure. Not maintaining eligibility with the plan for a longer period of time can make it difficult to make a lasting positive impression.
- Changes in demographic information make it difficult to reach members during outreach and education efforts. Getting reliable enrollment data is dependent on members providing updated information to their county.

Recommendations / Sustainability

We recommend continuation of the initiatives currently in place and ongoing attention and responsiveness to additional needs identified by our members. We are committed to the Triple Aim and to improving our CAHPS score, as well as CMS Stars rating. Each year upon receipt of the CAHPS scores, initiatives are evaluated for their effectiveness based on the results and modified or enhanced to respond. Due to the long lead time needed for impact, we intend to sustain the current approaches in 2013.

Behavioral Health

Why we chose this activity

Behavioral health conditions are prevalent and highly distressing to impacted members, their families and communities. Behavioral Health conditions reduce member abilities to responsibly execute their roles and responsibilities in the family, at school or at work. Untreated or undertreated mental health conditions or chemical health conditions also exacerbate physical health diagnoses and are associated with making poorer lifestyle choices. Finally, behavioral health conditions when undiagnosed or undertreated undermine the individual's ability to experience wellbeing, satisfaction and joy.

Because of the extensive reach of behavioral health into all aspects of health, this area directly relates to Triple Aim efforts to improve overall health of this population and improve their health care experience. HealthPartners is dedicated to reducing the stigma that many feel about accessing behavioral health care, while assuring the right care is delivered in the right setting at the right time and that members are full partners in reviewing and pursuing their behavioral healthcare options.

Goals

- Improve health, experience and access of behavioral health care.

- Partner with community-wide initiatives to improve behavioral health services and outcomes for members and patients and the community and to reduce stigma regarding mental health.

What we did to achieve these goals

HealthPartners has a variety of approaches to helping members manage behavioral health issues which are customized to meet the needs of the target population and reduce common barriers to successful care. Behavioral health case management services for HealthPartners members on Medicaid are provided directly by HealthPartners health plan staff, allowing for a closer relationship with members, involved providers and organizations.

Depression Care

HealthPartners programs for members with depression strive to increase member knowledge about the diagnosis and to increase collaboration among community system, families and the health care system.

- Members who are newly diagnosed with depression and begin an antidepressant medication are mailed information to help them self-manage their care.
- HealthPartners Depression Disease and Case Management Program, *On Your Way*, continues to support members by providing educational newsletters and antidepressant refill reminders. If a member does not refill an antidepressant prescription on the expected schedule, a second refill reminder is mailed.
- Ten days after a missed refill, the member's prescriber is notified. This coordination with the provider allows optimal care and can prevent adverse outcomes resulting from poor self-management.
- In 2012, this program had a 95% engagement rate among those eligible.

Bipolar Disorder and Schizophrenia

Disease Management for bipolar disorder and for schizophrenia is delivered through the *Moving Forward* Program.

- This program utilizes telephonic case management to provide ongoing support and information.
- In 2012 a pilot was conducted to increase medication adherence for persons in the *Moving Forward* program. We identify and call members who are four to six days overdue in refilling their antipsychotic or mood stabilizer medication. We identify and resolve barriers to adherence and document in the EMR.
- The program utilizes a quarterly health information newsletter with resources and guidance on self care, refill reminders for medications and provider alerts for past due medications.
- This program is seen as very important because adherence to mood stabilizer and antipsychotic medication are associated with better clinical and functional outcomes.
- In the last measurement year available, this program had an 87% engagement rate among those eligible.

Dual Diagnosis

HealthPartners' Medicaid Dual Diagnosis program identifies Medicaid members with both a mental health and chemical health condition and seeks to improve the coordination of care for the member, improve access to resources and improve overall health outcomes.

- Members in this program are engaged in telephonic care coordination which is focused on increasing adherence to treatment and enhancing the practitioner / patient relationship.
- Members receive health coaching and a focus on personal goal setting. This program has an enhancement in that members are able to earn gift card incentives for accomplishing health goals such as attendance at psychiatry appointments or completion of a chemical dependency evaluation.

Monitoring and Improving Progression of Care

HealthPartners rounds at Regions, Fairview, Abbott and United inpatient psychiatry to offer supports to the treatment team, such as identification of network programs and practitioners, to help assure appropriate progression of care. Objective data is gathered and shared with hospital Medical Directors to support their oversight of their staff psychiatrists.

Population Health

Population Health refers to HealthPartners' Health Care Home program. In 2012, a "Population Health" clinic was set up at Regions Hospital.

- The care team at the Population Health clinic includes a part time advanced practice nurse to evaluate patients and prescribe psychiatric medications; and a part time therapist skilled in crisis stabilization skills.
- Televideo equipment was installed in the HPMG primary care clinics so they can link to the Population Health clinic. Recently we have increased the times when "walk in" patient are invited to use the Population Health clinic.

Outreach to Members

For Prepaid Medical Assistance Program (PMAP) and MinnesotaCare members with severe behavioral health conditions who tend to drop out of behavioral health treatment, we have implemented a treatment reengagement strategy.

- Our staff contacts the member by phone to encourage them to reengage with their care plan.
- We verify attendance by checking claims for behavioral health services.
- We offer the Population Health clinic (either by appointment or walk-in,) televideo at their HPMG primary care clinic or a psychiatry slot in our network.

Results

When a person with a mental health diagnosis has fragmented care, the health care system can be difficult to navigate, causing stressors and creating additional barriers to successful daily living. The HealthPartners programs are fully integrated with and accessible to our care systems which enhances the member experience by improving coordination of care and communication between the member and their family, and their care coordinators and providers.

- As shown in Figure 8, HealthPartners behavioral health programs have a high member engagement rate which speaks to the successful integration of services available to our members.

Behavioral Health Disease Management Programs	2011 Population	2010 Population	2009 Population	Engagement Goal
On Your Way: Depression DM				
Identification	9,058	8,513	8,908	
Engagement	8,521	7994	8,190	
Percent engagement	94%	94%	92%	**90%**
Moving Forward: DM for Bipolar Disorder and Schizophrenia				
Identification	1,508	1379	1,743	
Engagement	1,268	1161	1349	
Percent engagement	**84%**	**84%**	**77%**	**75%**

Figure 8

- In the *Moving Forward* Program, there were 374 instances of overdue medication refills in 2012. Forty three percent (43%) (161) of these members were contacted by phone and 43% of these (69) showed a claim for refilling the target medication within 7 days of the phone contact.
- The dual diagnosis program tracks successful completion of individual goals as a measure of member success in the program. This measure reflects progression toward the triple aim goal of improving the health of the population served. The increase in engagement and successful goal completion shows that the target areas of this program are meeting the needs of the members who participate (Figure 9).

Dual Diagnosis Program	2011	2012
Total Members Eligible	32	57
Total Members Achieved Goal	29	53
Percentage achieving goal	90%	92%

Figure 9

- Population Health Clinic results: From February 2012 to January 2013 there were 332 Population Health clinic office visits (face to face) and 34 completed televideo visits. Of the clinic visits 28 were “walk in” visits, demonstrating the need for flexible services for this population.
- Member Outreach Results: In 2012, we had 475 difficult to treat patients, who missed multiple appointments or dropped out of treatment. Our centralized service reached 54% (257) by phone to identify and resolve barriers to treatment adherence. There were 52% of those we spoke (133) with who accepted and attended at least 1 behavioral health appointment in the 30 days following the phone call. We were pleased that 28% of the entire group identified as “difficult to serve” kept a behavioral health appointment within 30 days of our call.

Conclusions / Lessons Learned

In conclusion, our customized behavioral health programs have a high engagement rate and successfully support our members to reach their goals. We have learned that when a person with a mental health diagnosis has fragmented care, the health care system can be difficult to navigate, causing stressors and creating redundancies which can be confusing to members and add to the cost of care.

The HealthPartners programs work cooperatively with our owned and our network care systems to enhance the member experience by improving coordination of care and communication between the member and their family, and their care providers.

Recommendations/Sustainability

We strongly recommend the continuation of our customized efforts to engage and support members and work collaboratively with providers and the community. We intend to sustain our attention to this very important health issue. HealthPartners continues to be a leader in behavioral health programs and outcomes. Other health plans have emulated some of our programs and approaches. HealthPartners is committed to maintaining a variety of behavioral health programs that fit the individual needs of our members.

Health Disparities

Why we chose this activity

Health disparities are widely recognized as a serious public health issue in the United States and Minnesota. Minnesota is seen as one of the healthiest states in the country; however we have a high rate of health disparity between people of color and whites. HealthPartners has made it a priority to reduce health disparities and create a culture of equitable care throughout our plan, clinics and hospital system. The EBAN Experience is an effort that integrated the community and the health care community to give health care providers the training and tools they needed to better serve diverse communities. The guiding principal is that all people have equal access to high quality health care and services regardless of race, ethnicity, language, geographic location or socio-economic status.

One area where health disparities exist is in the area of colorectal cancer. According to the American Cancer Society, the rate of colon cancer among African Americans is about 17% higher than in white men and women. Despite this, screening for the disease is lower among populations of color. HealthPartners decided to make improving the disparity within the screening rate for colorectal cancer (CRC) a priority. Colon cancer is a preventable disease, so utilizing screening is a valuable tool in meeting the triple aim goals of reducing costs and improving health of our members.

Goal

- The goal of the EBAN Project was to seek an understanding of cultural beliefs of diverse communities and how these beliefs impact the choices made related to health care decisions.

- The parallel goals of the CRC disparities screening project include
    - Decrease to less than 12.7% the percentage point difference between the colorectal cancer screening rates for white patients and patients of color.
    - Decrease to less than 25.5% the percentage point difference between the colorectal cancer screening rates for Minnesota Health Care Program covered patients and patients with all other insurance coverage.

What we did to achieve these goals

The EBAN Experience™ was launched as an ambitious effort to improve community health where there were gaps in care among ethnic groups or by race. EBAN is a symbol from the Asanti people of Ghana, Africa. It represents security, safety and trust.

- The EBAN Experience allowed health professionals and community members to learn from each other, to work as teams to understand the causes of unequal care outcomes and to make attempts to improve the health of communities.
- A series of guided discussions were held to explore cultural differences, values and beliefs about the health care system and share attitudes and thoughts about the differences between the health care system in Minnesota and participants' country of origin or cultural beliefs.
- Community members representing Hmong, Somali, African American and Latino Communities participated in the collaborative across multiple teams including pediatric immunizations, diabetes outcomes, mammography rates, colorectal cancer screening, fluoride varnish, advance directives and pain control.
- The work of the teams were a beginning of establishing long term changes in the health care system to improve care outcomes, create new leaders for future improvement initiatives and build key links with communities for further efforts to improve health and well-being. HealthPartners is now spreading the findings of the EBAN teams across the health care system.

EBAN Colon Cancer Screening Workgroup

One EBAN initiative that achieved great success over the course of the project is the colon cancer screening workgroup. Work on this initiative began at the Brooklyn Center Clinic exploring the beliefs of the Somali community related to this cancer screening process.

- Specific issues that the colorectal cancer screening (CRC) screening group identified as cultural barriers to colon cancer screening include such things as
    - attitudes toward this particular screening test
    - concern about discussing such sensitive issues with a provider or an interpreter of a different gender
    - patient gowns appeared to be used/dirty when they were laid out for the patient
    - Hmong patients may object to the removal of tissue (polyp) as part of the test
    - the lack of multilingual signage was not welcoming
- As a result of this project, the GI clinic was informed of how standard practices can be perceived differently by different groups and staff was educated to make accommodations and to raise their awareness of these barriers.

Colorectal Cancer Screening (CRC) Disparities Work Group

In addition to the work being done around CRC screening for the EBAN project, HealthPartners is participating with 3 other health plans (Medica, Blue Plus and UCare) on a CRC screening Performance Improvement Project (PIP).

- Through this project, each health plan partnered with one or more clinics to address barriers to CRC screening and to increase the screening rate at that clinic for members who are on Medicaid.
- The goal of the project is to increase the relative improvement rate (RIR) for the participating clinics by an aggregated 15% RIR in the first calendar year of the project.

HealthPartners health plan is working with HPMG Brooklyn Center Clinic and HPMG Riverside clinic on this PIP project and developed a CRC Disparities Work Group to evaluate issues across the system and implement solutions. The initiatives implemented have proven so valuable that they are being spread beyond those clinics and implemented at all HPMG clinics. Most HPMG clinics are still in the process of fully implementing these process changes as of spring of 2013, but positive results are already apparent.

Provider Role

To evaluate the potential changes that could benefit the CRC screening rate, the CRC Disparities team evaluated the work that was begun at Brooklyn Center Clinic.

- It was identified that much of the success could be translated to a particular provider who is passionate about the issue and was a driving force for change. In interviews she shared that discussion with patients is vital to the acceptance of a screening test.
- Research shows that patients are more likely to complete preventive screening when it is recommended by their own health care provider. One element of the PIP project was to ensure that all clinic staff are aware of the most current clinical guidelines related to CRC screening so they can share that information with their patients. HealthPartners conducted a clinical guidelines update as part of the routine education provided to their health care teams to increase providers comfort with this issue.

Member Education and Outreach

Colorectal cancer screening is something that many people are not familiar with, or if they are, they have heard horror stories from their friends and family. To educate our members, we presented current information, educated on the various options for the screening and followed up with members to answer any questions they may have.

- Educational prompts from both the American Cancer Society and CDC were integrated into public spaces and exam rooms to raise awareness about the disparity.
- An educational packet about CRC screening was developed to share with patients in the exam room.
- HealthPartners health plan utilizes preventive care reminders designed to reinforce messages that patients are getting from their health care provider.

Targeted outreach has been a critical element in the success of this project. HealthPartners has dedicated substantial resources to these efforts. To ensure that the outreach was targeted to the appropriate members, HPMG and HealthPartners collaborated to compare data on members who may have had a screening at a location other than HPMG.

- The plan analyzed claims and was able to identify a significant number of members on public programs who had a CRC screening at a different provider and were in fact up to date. This allowed targeted outreach to only those members who actually needed it.
- Scheduling staff in the GI clinic conduct outreach calls to members on Medicaid and people of color in an effort to reach that population and specifically reduce the disparity.
- Because people tend to trust their health care provider and are more likely to have a screening done at their recommendation, a letter from their health care provider was sent to all members identified as needing a screening.
- A trained nurse called members to discuss the options for CRC screening and was able to schedule a colonoscopy or order a FIT test if accepted.

Clinic Processes

In addition to the outreach work being done on the plan side of the CRC PIP project, we have partnered on work groups with HPMG to make significant changes in their clinic flows, Electronic Health Record (EHR) procedures and lab processes to improve CRC screening.

- Clinic processes were reviewed to identify cultural barriers to scheduling and completion of CRC screening. For example, Somali women indicated they were not comfortable discussing this screening with a male health care provider, so whenever possible, Somali women are scheduled with a female provider.
- HPMG made the decision to elevate the FIT test to equal status as the colonoscopy, recognizing that clinically, the colonoscopy is a more effective screening tool, but if members are only willing to do the FIT test, that must be respected and their care managed accordingly.
- Standardized language and tools were developed for presenting FIT and colonoscopy. If the member chose the FIT test, the nurse would escort the member to the lab to pick up the test.
- Processes were also changed for members who agree to have a colonoscopy. The front desk staff were trained to schedule the appointments so the member would leave their clinic with an appointment for their colonoscopy. This limited the risk of members lost due to contact changes.
- The EHR is a valuable tool to communicate preventive screenings. This project evaluated the steps in the EHR that could impact the touch points for communication about preventive screenings.
- Clinic staff were trained to have standardized work flow to inform patients of options and schedule screenings.
- Triggers were developed in the EHR to track patients who said they would schedule colonoscopy or FIT to ensure procedure or test was initiated.
- Nurses, providers, schedulers and others were trained to ensure uniform use of EHR for tracking of needed preventive care and to support patient follow-through. This project implemented a process to send a note via EHR to the primary care provider of patients who fail colonoscopy appointment for a follow up discussion at the patient's next appointment.

Results

EBAN

The EBAN Project lasted 12 months. At the end of the year, each team presented a summary of their projects to the collaborative, HealthPartners senior leaders and community members. The work of the teams were a beginning of establishing long term changes in the health care system to improve care outcomes, create new leaders for future improvement initiatives and build key links with communities for further efforts to improve health and well-being.

CRC Screening

There are two parallel measurements taking place related to this project at the same time. One measurement is internal HealthPartners data related to decreasing the disparity rate within our clinics. The second is the PIP measure, which included aggregate data from all four health plan and clinic partnerships.

The first measurement is internal to HealthPartners project in attempting to decrease the disparities gap related to CRC screening.

- As you can see from Figure 9 (below), there has been steady progress on meeting the goal for the disparity between CRC screening rates of white patients vs. patients of color.
- The disparity rate at the beginning of the project was 16.7%. In March 2013, this project dipped below the target goal of 12.7% to an actual point difference of 11.2%.
- The disparity rate between Minnesota Health Care Program members and commercial insurance members at the start of the project (June 2011) was 27.1%. Within six months, the rate had met the goal of 25% and has continued to decrease. In August 2012, it rested at 21.8%.

Colon Cancer Screening Disparity

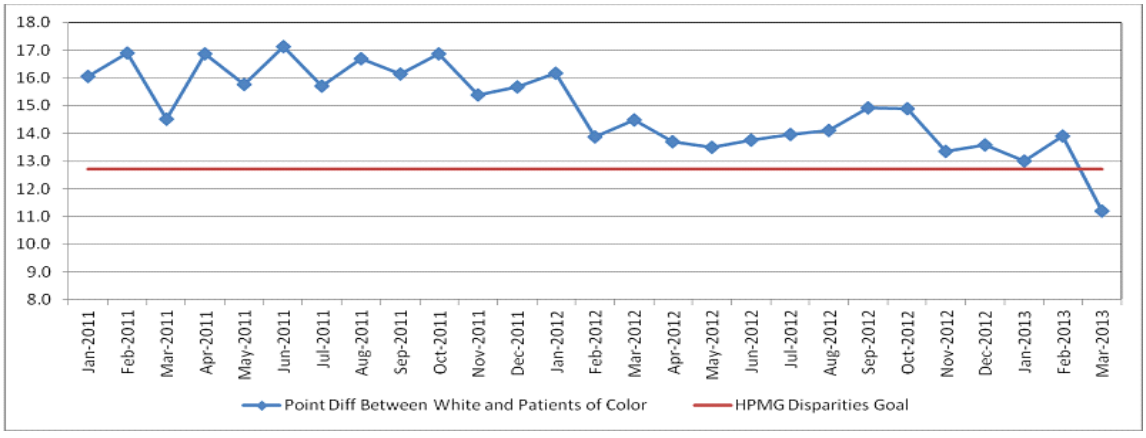

Figure 10

The second measure is the Performance Improvement Project, which aggregates the screening data from all participating health plans and clinics. HealthPartners health plan CRC screening rate of 57.32% for Medicaid members is higher than the statewide average of 54.71%.

Colorectal Cancer Screening PIP	Rate	RIR
Baseline: 7/1/2010-6/30/2011	42.53%*	N/A
Measurement Period 1: 7/1/2011-6/30/2012	50.04%	13.07%

Figure 11

The goal if the PIP CRC Screening project is to increase the Relative Improvement Rate by 15% in the first year of the project. Despite significant strides toward achieving the desired goal of 15% RIR in the first year of the PIP project, we did not achieve that goal, as shown in Figure 11. The improvement attained from aggregated data from all health plan / clinic partnerships was 13.07% RIR.

- Clinics that agreed to participate in this project accepted an immense challenge and took the responsibility to improve their colorectal cancer screening rate very seriously. As such, the clinics and health plan partners did extensive needs assessments to evaluate their internal processes and patient flow, EHR practices, patient experience and communication systems.
- Each clinic and health plan partner identified a variety of barriers and began to address potential solutions. Due to the extensive impact that changes to clinic process flows and other activities can have on the daily work of all levels of the clinic staff, clinics were deliberate about implementation of the clinic-based interventions.
- Clinics and health plan partners agreed that appropriate implementation took priority over timely implementation. As a result, many of the clinic based interventions were not fully implemented until late in the measurement year, and were not able to impact the first measurement period rate.

Conclusions / Lessons Learned

In conclusion, we learned much through our EBAN work by engaging the community. And we were able to apply those learnings to the colorectal cancer screening initiative with good success. It means an investment in outreach to both members and providers.

Throughout the process of determining barriers to CRC screening for diverse populations, there were many lessons learned with “Aha!” moments that have opened doors to our understanding of this issue, and may be able to be applied to other health disparities as well.

- Historically, there has been a lack of formal clinic processes to track members with complete CRC screening and identify those that are eligible for screening.
- Barriers in the clinic include under-utilization of EHR and information systems and poor tracking of CRC screening status in the EHR.
- Research shows that the gap between provider intent to screen for colorectal cancer and the actual practice of screening results primarily from inadequate use of office systems[iii]. This project confirmed that there are barriers in the clinic systems that can be addressed. This project used data to seek to understand who was in need of a CRC screening, and optimize the use of that information.

- Some providers may lack a clear understanding of why their patients are resistant to screenings, what are the current CRC screening guidelines, testing options, and the age at which to begin screening. This project included primary care provider education, and included other clinic staff to reinforce the messages being given to patients at various touch points in the visit.
- A common barrier to completing colonoscopy is access to timely appointments. This project attempted to manage this, but in reality, even a few weeks delay in appointment availability can be a deterrent to completing the appointment. Notifying their primary care provider of missed appointment or failed prep for the procedure was determined to be an appropriate follow-up to this situation.
- Low health literacy is a common barrier to preventive screenings for members on public health insurance programs and the public in general. There is a lack of understanding of the screenings available for colorectal cancer, and a lack of awareness of the increased need for people of color to address this issue. This project included educational strategies to mitigate the lack of knowledge. This included developing materials specific to this issue, utilizing culturally appropriate materials that are available and training staff to have a culturally sensitive discussion.

Recommendations / Sustainability

HealthPartners is very proud of the strides we have made around health disparities. We intend to sustain the efforts to close gaps in care and plan to continue to seek to understand barriers to care for diverse populations. A new EBAN 3D Collaborative™ has begun in 2013. This program has a focus on decreasing disparities in African American and Somali populations at five clinic sites across our system of care with an aim of sharing solutions, outcomes and best practices for diabetes care across our organization.

The Triple Aim includes improving the health of all members, including those in minority groups, recent immigrants and those on state public health insurance. As such, these initiatives are being implemented system-wide, and can even be replicated to address other health disparity issues. It is our recommendation that continued attention be applied to reducing disparities in care across all payers.

---

[i] Reference—Jencks, et al Rehospitalization in the Medicare fee for service program NEJM, 2009 360: 14118-1426.
[ii] The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by health plans and administered by NCQA to measure health plan performance on important dimensions of care and service
[iii] (Wei, E., Ryan, C., Dietrich, A., & Colditz, G. (2005). Improving Colorectal Cancer Screening by Targeting Office Systems in Primary Care Practices: Disseminating Research Results into Clinical Practice. Archives of Internal Medicine, 165(6), 661-666)