



Minnesota Department of **Human Services**

**Performance Improvement**

**Projects Annual Summary Report**

**January 2016**

Carly Lykes Frostman  
Quality Improvement Analyst  
Healthcare Research and Quality



For accessible formats of this publication or assistance with additional equal access to human services, write to [dhs.quality@state.mn.us](mailto:dhs.quality@state.mn.us), call 651-431-2610, or use your preferred relay service. (ADA1 [9-15])

**Table of Contents**

Introduction..... 3

2015 Performance Improvement Projects..... 3

    Reducing Racial and Ethnic Disparities in the Management of Depression: Improving Antidepressant Medication Adherence ..... 3

        1) MCO Collaboration (the Collaborative): BP, HH, HP, Medica, MHP, UCare..... 4

        2) Itasca Medical Care..... 6

        3) PrimeWest Health..... 7

        4) South Country Health Alliance ..... 7

    Reducing Racial and Ethnic Disparities in the Management of Depression: Improving Follow-up After Hospitalization for Mental Illness..... 8

        1) Collaboration: Medica and UCare ..... 8

        2) South Country Health Alliance ..... 9

# Performance Improvement Projects Annual Summary Report

## Introduction

In 2015, eight managed care organizations (MCOs)<sup>1</sup> contracted with the Minnesota Department of Human Services (DHS) to provide health insurance to Minnesota Health Care Programs (MHCP) enrollees. All MCOs that contract with DHS to provide coverage to MHCP enrollees are required to conduct ongoing performance improvement projects (PIPs) that focus on improving the care and services provided to MHCP enrollees. PIP goals must be clear, precisely defined, and address a critical issue that the MCO’s members face, in either clinical or non-clinical areas. Moreover, MCOs must select objective, measurable indicators to assess the effectiveness of the interventions.

Prior to 2015, MCOs were required to initiate a new PIP each year, while simultaneously maintaining the efforts of previous years’ PIPs. As of 2015, PIPs are now conducted on a three year cycle. MCOs submit new proposals every three years, followed by interim reports at the end of the first and second years, and a final report at the close of the third year. Whereas MCOs typically select their own topic, the State selected the topic for the 2015 – 2017 cycle: reducing racial and ethnic disparities in the management of depression.

This report summarizes the goals, interventions, and measures of the PIPs initiated in 2015, as well as updates from the first annual reports.

## 2015 Performance Improvement Projects

### **Reducing Racial and Ethnic Disparities in the Management of Depression: Improving Antidepressant Medication Adherence**

All MCOs serving Families and Children Medical Assistance (F&C-MA) and Minnesota Care (MNCare) program enrollees chose to focus on improving antidepressant medication adherence, as measured by the Healthcare Effectiveness and Data Information Set (HEDIS) Antidepressant Medication Management (AMM) Continuation Phase rate. In addition, one MCO chose this topic as the focus of their work with their Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), and Special Needs Basic Care (SNBC) populations. Due to the technical definition of the AMM measure, only members with a new depression diagnosis who were treated with antidepressant medication were included in the study population. The measurement schedule for these PIPs is outlined below in Table 1.

**Table 1. HEDIS AMM Continuation Phase Measurement Periods and PIP Intervention Years**

<b>HEDIS Reporting Year</b>	<b>HEDIS Denominator Inclusion Dates</b>	<b>HEDIS Measurement Period</b>	<b>PIP Intervention Year</b>
2014	May 2012 – April 2013	May 2012 – December 2013	Baseline
2015	May 2013 – April 2014	May 2013 – December 2014	Pre-implementation
2016	May 2014 – April 2015	May 2014 – December 2015	Year 1 (partial)
2017	May 2015 – April 2016	May 2015 – December 2016	Year 1 – 2
2018	May 2016 – April 2017	May 2016 – December 2017	Year 2 – 3
2019	May 2017 – April 2018	May 2017 – December 2018	Year 3

<sup>1</sup> BluePlus (BP), HealthPartners (HP), HennepinHealth (HH), Itasca Medical Care (IMC), Medica, Metropolitan Health Plan (MHP), PrimeWest Health (PW), South Country Health Alliance (SCHA), and UCare

**1) MCO Collaboration (the Collaborative): BP, HH, HP, Medica, MHP, UCare**

Six MCOs partnered to design a plan including a cohesive set of member, provider and community interventions. Some aimed to reduce disparities between White and Non-White members, while one concentrated on improving Non-White rates.

- Member interventions – primarily aimed to educate members regarding the importance of medication adherence, potential side effects, depression symptoms, and confidentiality:
  - Targeted telephonic outreach by care coordinators or health coaches
  - Outreach via mail, including educational materials, resources, and refill reminders
  - Antidepressant refill reminder calls
  - Referrals to case management services as needed
- Provider interventions – each MCO reached out to its provider network to promote training and educational opportunities developed by the Collaborative:
  - Cultural competency training including issues specific to depression and antidepressant medication, health literacy, and communication
  - Online “Provider Toolkit,” with patient resources, such as pharmacies with translation services and a shared-decision making tool
- Community interventions – MCOs further collaborated with community organizations, such as NAMI-MN and local religious groups, to increase awareness of depression and symptoms:
  - Share resources at local health fairs
  - Promote and attend community events during Minority Mental Health Month in July

In addition to the interventions listed above, several MCOs implemented interventions more specific to their members’ needs or their care system. For example, HP emphasized partnerships among clinics to standardize care and improve consistency, while Medica relied on its Medication Therapy Management (MTM) program to identify high-volume pharmacies to provide additional support to members.

MCOs defined their own goals, depending on their enrollment levels, member demographics, and baseline rates. Table 2 lists each MCO’s goals, baseline rates, pre-implementation rates, and the change in rates. It is important to note that due to the technical specifications of the AMM measure and project timing, the MCOs have not yet completed a full year of implementation. Thus, it is too early in to draw any conclusions regarding intervention effectiveness from current data.

In the first interim reports, MCOs shared barriers they encountered, how to address those barriers moving forward, as well as other lessons learned during the first year of implementation. The most common barriers reported by the MCOs were: unreliable contact information, inability to reach members, member reported side effects, or delays in receiving timely data. Methods MCOs used to address barriers included: calling members at alternating times, searching multiple sources for more current contact information, additional education regarding side effects and how to cope with them.

**Table 2. MCO Baseline Rates and Goals for 2015 PIPs****BluePlus**

*Goal: Reduce disparity in baseline AMM rates between White, Non-Hispanic and Non-White members by 4 percentage points*

<b>HEDIS Year</b>	<b>White</b>	<b>Non-White</b>	<b>Disparity</b>
2014	39.99%	31.93%	-8.06%
2015	41.59%	28.46%	-13.13%
Change	▲1.60	▼3.47	▲5.07

**HealthPartners**

*Goal: Reduce disparity in baseline AMM rates between White and Non-White members by 20%, or 1.84 percentage points*

<b>HEDIS Year</b>	<b>White</b>	<b>Non-White</b>	<b>Disparity</b>
2014	38.70%	29.51%	-9.19%
2015	43.36%	24.65%	-18.71%
Change	▲4.66	▼4.86	▲9.52

**Hennepin Health**

*Goal: Reduce disparity in baseline AMM rates between White, Non-Hispanic and Black members, and White, Non-Hispanic and Native American members by 20%, or 1.18 and 2.85 percentage points, respectively*

<b>HEDIS Year</b>	<b>White</b>	<b>Black</b>	<b>Native American</b>	<b>W-B Disparity</b>	<b>W-NA Disparity</b>
2014	46.47%	40.54%	35.89%	-5.93%	-10.58%
2015	42.66%	38.98%	17.39%	-3.68%	-25.27%
Change	▼3.81	▼1.56	▼18.5	▼2.25	▲14.69

**Medica**

*Goal: Reduce disparity in baseline AMM rates between White, Non-Hispanic and Non-White members by 5.38 percentage points*

<b>HEDIS Year</b>	<b>White</b>	<b>Non-White</b>	<b>Disparity</b>
2014	55.20%	36.06%	-19.14%
2015	44.47%	32.56%	-11.91%
Change	▼10.73	▼3.5	▼7.23

**MHP**

Goal: Reduce disparity in baseline AMM rates between White and Black members by 20%, or 0.69 percentage points

HEDIS Year	White	Black	Disparity
2014	35.13%	31.66%	-3.47%
2015	33.33%	33.73%	+0.04%
Change	▼1.8	▲2.07	▼3.51

**UCare**

Goal: Increase the baseline AMM rates among the Non-White population by 6 percentage points, raising it to 33.33%

HEDIS Year	Non-White
2014	27.33%
2015	27.41%
Change	▲0.08

**County-Based Health Plans**

Three county-based purchasing organizations (CBPs) serving more rural areas of Greater Minnesota have relationships with their member Counties that create a unique set of strengths and challenges. These CBPs they have lower overall enrollment numbers and lower levels of diversity among their members. Accordingly, they conducted separate PIPs to more closely tailor interventions to their members' and providers' needs. They also decided to include all members with a new depression diagnosis, regardless of race, in their study populations.

**2) Itasca Medical Care**

With only four members meeting the participation criteria, IMC has been working with the smallest study population.

- Member interventions:
  - Education outreach via the 1<sup>st</sup> quarter member newsletter
  - Telephonic outreach to those with a gap in antidepressant medication refill
  - Referrals for case management or additional assistance as needed
- Provider interventions:
  - Education outreach via the 1<sup>st</sup> quarter provider newsletter
  - Encourage collaboration between providers and pharmacies
- Pharmacy interventions:
  - Education outreach via the 1<sup>st</sup> quarter provider newsletter
  - Encourage blister-packing of member medications
  - Print prescription labels and medication instructions in members' preferred language

*IMC Goal: Increase AMM rates of all members by 8 percentage points.*

<b>HEDIS Year</b>	<b>All</b>
2014	0.0%
2015	25.0%
<b>Change</b>	<b>▲25.0</b>

In the first interim report, IMC noted that they experienced difficulty reaching members due to incorrect or missing phone numbers. In response to this challenge, IMC decided to also send customized letters to members to notify them of a missed refill and offer additional information.

### 3) PrimeWest Health

Although PW included all White and Non-White members in its study, it did include one additional intervention targeted at Non-White members.

- Member interventions:
  - Health coach calls to Non-White members filling a new antidepressant prescription
  - Weekly health coach calls and motivational interviewing for all members who are late in filling their antidepressant medication
  - Reminder letters to all members who are late in filling their antidepressant medication
- Provider interventions:
  - Electronically distributed provider toolkit
  - Provider follow-up by phone to all members who pose specific medical questions in health coach calls
  - Letters to providers when any member misses an antidepressant medication refill
- Community interventions:
  - General outreach through PSA postings, website postings, and email blasts

*PW Goal: Increase baseline AMM rate of all members by 6 percentage points. PW used the average of its 2013 and 2014 AMM rates as its baseline.*

<b>HEDIS Year</b>	<b>All</b>
2013	34.43%
2014	37.43%
<b>Baseline</b>	<b>35.89%</b>
2015	39.63%
<b>Change</b>	<b>▲3.74</b>

The only barrier PW reported in the interim report was difficulty reaching members by phone. Similar to IMC, PW also responded by sending a letter to members who could not be reached by phone.

### 4) South Country Health Alliance

In addition to including all members in the PIP, SCHA committed to monitoring the AMM rates of both White and Non-White members to ensure that disparities do not develop over time.

- Member interventions:
  - Mailings to members 1, 3, and 6 months following their first antidepressant prescription fill to offer general education, positive affirmation, and any additional support needed to adhere to their treatment plan
  - Health coach phone calls to members following the 1<sup>st</sup> mailing
  - Develop simple and engaging member communications
- Provider interventions:
  - Cultural competency training for Member Services and Health Services staff, as well as to other interested departments
  - Extend cultural competency training opportunities to County partners in Public Health and Human Services
  - Provide additional support and resources to high-volume pharmacies and inform them of interpreter services
  - Provide data and additional support to clinics with low performance scores related to depression remission
  - Partner with healthcare coordinators to provide additional support to members

*SCHA Goal: Increase baseline AMM rate of all members by 6 percentage points. PW used the average of its 2013 and 2014 AMM rates as its baseline.*

HEDIS Year	All
2014	33.6%
2015	37.64%
Change	▲4.04

Following implementation of this PIP, SCHA gave providers the option to use the AMM measure in its 2016 Pay-for-Performance program. SCHA also added a *Cultural Sensitivity Tip Sheet* to the provider toolkit. SCHA also experienced challenges when contacting members and is attempting to obtain updated information from members.

### **Reducing Racial and Ethnic Disparities in the Management of Depression: Improving Follow-up After Hospitalization for Mental Illness**

With varying eligibility requirements for MHCP programs, enrollees in each program often face a different set of issues and have different needs. In order to address the distinct needs of their MSHO, MSC+, and SNBC members, three MCOs chose to focus on improving follow-up with members who were discharged from recent hospitalizations for mental illness. The two larger MCOs collaborated on a project designed to improve their HEDIS Follow-up After Hospitalization for Mental Illness (FUH) rates at both 7 and 30 days after discharge. The third MCO, a CBP, chose to focus on improving its HEDIS Medication Reconciliation Post-Discharge (MRP) rate, which measures post-discharge follow-up specific to medication.

#### **1) Collaboration: Medica and UCare**

Medica noted a disparity in FUH rates between its SNBC and commercial product members as driving the selection of this measure. Similarly, UCare observed a disparity in FUH rates between SNBC White and Non-White members. Although both MCOs included all members, regardless of race, in the study, they emphasized SNBC population and cultural issues related to psychiatric disorders in their interventions.

- Member interventions:

- Care coordinators will call recently discharged members to schedule a follow-up visit, provide education regarding depression and antidepressant adherence, and connect members with additional resources
- Educational mailings twice per year to all members who were hospitalized within the last year
- Provider interventions:
  - Offer educational opportunities to providers regarding behavioral health conditions and the SNBC population, cultural issues related to behavioral health, and the importance of educating members regarding follow-up care
  - Post a provider toolkit with patient and provider resources on their websites, and disseminate through provider newsletters
  - Identify the hospital with the highest volume of patients enrolled in the SNBC program and provide additional support and resources
- Community interventions - MCOs further collaborated with community organizations, such as NAMI-MN and local religious groups, to increase awareness of depression and symptoms:
  - Share and disseminate resources at local health fairs
  - Promote and attend community events during Minority Mental Health Month in July

**Medica**

*Goal: Increase FUH rates by 5.40 percentage points for 7 days and 4.50 percentage points for 30 days*

<b>HEDIS</b>		
<b>Year</b>	<b>7 Days</b>	<b>30 Days</b>
2014	57.22%	75.28%
2015	62.60%	81.00%
Change	▲5.38	▲5.71

**UCare**

*Goal: Increase FUH rates by 7 percentage points for 7 days and 6 percentage points for 30 days*

<b>HEDIS</b>		
<b>Year</b>	<b>7 Days</b>	<b>30 Days</b>
2014	41.40%	43.87%
2015	61.63%	69.66%
Change	▲20.23	▲25.79

To address the challenge of reaching members, UCare will make process adjustments to improve discharge communication with members. Medica will encourage providers to personally refer members to the program in order to boost participation rates and collect updated contact information.

**2) South Country Health Alliance**

For purposes of this project, SCHA slightly modified the MRP definition to only include members who were discharged from an acute hospital setting to home and excluded those who were discharged to foster care, assisted living, or a nursing home. Furthermore, to align this PIP with

Medicare requirements, SCHA included all members, regardless of race, but distinguished between members who receive only receive Medicaid benefits (SingleCare) and those who receive both Medicaid and Medicare benefits (SharedCare).

- Member interventions:
  - RN home visits within 30 days of a member being discharged from the hospital
  - Promote awareness of project and educate through newsletters and direct mailings
- Provider interventions:
  - Conduct training prior to home visits for County care coordinators and Public Health Nurses
  - Promote awareness of project and educate through newsletters and direct mailings

**SCHA**

*Goal: Increase rate of MRP within 30 days for entire target population by 6 percentage points.*

<b>HEDIS Year</b>	<b>Single Care</b>	<b>Shared Care</b>
2014	0.00%	0.08%
2015	N/A	N/A
Change	N/A	N/A

After receiving feedback from county care coordinators, SCHA is providing additional training and guidance on how to address members’ refusals to receive home care visits. County staff feedback also informed SCHA of a data collection error, which has since been corrected.