



# Performance Improvement Projects

## Annual Summary Report

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## 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 second annual reports.

\*Note: As of September 2<sup>nd</sup>, 2016, Hennepin Health (HH) and Metropolitan Health Plan (MHP) have consolidated under the name "Hennepin Health", and as such, HH and MHP have consolidated their PIP efforts. For the purposes of this report, HH and MHP will be separated and asterisked in *text descriptions*, so as not to confuse counts of participating MCO's across the three year cycles (e.g. – "In 2015, eight managed care organizations..."). Please note that data reporting will reflect the consolidation of HH and MHP, and all *data reported* will be labeled under Hennepin Health (HH) from this report through the final report for this PIP cycle. Additionally, Medica Health Plans no longer held a Families and Children contract at the time of final reporting for this PIP.

## 2015-2017 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 MinnesotaCare (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

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<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

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

*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.

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 had not yet completed a full year of implementation at the time of the first report. A number of MCO’s have adjusted their baselines due to membership changes and enrollment turnover since the issuing of the first interim reports. As many of the intervention effects were not yet captured in HEDIS data due to reporting time lag, these changes are appropriate and will better reflect the nature of disparities and intervention effects in the final reports.

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.

In the second interim reports, MCO’s discussed the progress they had made in addressing barriers, new barriers they had encountered, changes to partnerships and collaborators, data errors, and baseline resets. In addition, some MCO’s reported that the AMM Withhold requirements had resulted in some effects on AMM outcome measures. In some instances, these effects resulted in overall improvements to the AMM rate, but negatively impacted disparity rates due to some populations experiencing greater improvements than others.

The Final Reports reflect the final outcomes over the 3-year PIP cycle. Some MCOs reached and/or exceeded their goals. Others identified barriers and challenges, which, while preventing them from reaching their outlined goals, allowed the MCOs to learn critical information about the MHCP enrollees they serve. Ultimately, the AMM PIP has proven exceptionally valuable, both in terms of improved treatment outcomes and better understanding the healthcare needs of the MHCP population.

**Table 2. MCO Rates and Goals for 2015-2017 PIPs**

**BluePlus**

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

HEDIS Year	White	Non-White	Disparity
2014	39.99%	31.93%	-8.06%
2015	41.59%	28.46%	-13.13%
2016	39.61%	27.77%	-11.84%
2017	43.12%	27.01%	-16.11%
2018	40.78%	27.92%	-12.86%
Change	+ 0.79	- 4.01	+4.80

### HealthPartners

*Goal: Reduce disparity in baseline AMM rates between White and Non-White members by 20%, or 3.72% percentage points – Baseline reset to 2015 due to enrollment and membership changes*

HEDIS Year	White	Non-White	Disparity
2015	43.36%	24.65%	-18.71%
2016	44.82%	24.19%	-20.63%
2017	43.46%	24.49%	-18.97%
2018	41.62%	28.83%	-12.79%
Change	-1.74	+4.18	-5.92

### 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*

HEDIS Year	White	Black	Native American	White-Black disparity	White-Native American disparity
2014	46.47%	40.54%	35.89%	-5.93%	-10.58%
2015	42.66%	38.98%	17.39%	-3.68%	-25.27%
2016	47.46%	26.71%	25.00%	-20.75%	-22.46%
2017	44.14%	23.91%	28.57%	-20.23%	-15.57%
Change	-2.33	-16.63	-7.32	+14.30	+4.99

**Medica – (No Families and Children contract during Final reporting period)**

*Goal: Reduce disparity in baseline AMM rates between White, Non-Hispanic and Non-White members by 5.38 percentage points – Baseline is an aggregate of 2014 & 2015 rates*

HEDIS Year	White	Non-White	Disparity
2014	55.20%	36.06%	-19.14%
2015	44.47%	32.56%	-11.91%
Baseline	49.83%	34.31%	-15.52%
2016	43.94%	38.60%	-5.34%
Change	-5.89	+4.29	-10.18

**MHP – 2015 ONLY: Now consolidated with Hennepin Health**

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

<b>HEDIS Year</b>	<b>White</b>	<b>Black</b>	<b>Disparity</b>
<b>2014</b>	35.13%	31.66%	-3.47%
<b>2015</b>	33.33%	33.73%	+0.04%
<b>Change</b>	-1.8	+2.07	-3.51

**UCare**

*Goal: Increase antidepressant medication adherence in the Olmsted County population by 6 percentage points, to 44.81%*

<b>HEDIS Year</b>	<b>All</b>
<b>2014</b>	<b>23.08%</b>
<b>2015</b>	<b>16.67%</b>
<b>2016</b>	<b>18.75%</b>
<b>2017</b>	<b>23.91%</b>
<b>2018</b>	<b>22.22%</b>
<b>Change</b>	<b>-1.15</b>

*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 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.

*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>
<b>2014</b>	0.0%
<b>2015</b>	25.0%
<b>2017</b>	35.0%
<b>Change</b>	+35.0

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.

In the second interim report, IMC noted that a data collection error occurred, which has since been corrected. In order to ensure accurate reporting, only the rates reported in the Final Report (due September 1, 2018) will be included in future PIP Reports. This will allow time for results to accurately appear in data and for the data collection errors to be fully corrected.

The results of the Final Report showed a final rate of improvement of 35%, far exceeding the 8% goal. Direct outreach by phone and mail proved successful. Education on the benefits of case management and offers for case management referrals were offered. Continued partnerships and outreach regarding depression and treatment will be continued to sustain this improvement.

### *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>
<b>2013</b>	34.43%
<b>2014</b>	37.43%
<b>Baseline</b>	<b>35.89%</b>
<b>2015</b>	39.63%
<b>2016</b>	37.17%
<b>2017</b>	37.92%
<b>2018</b>	40.82%
<b>Change</b>	+4.93

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.

In the second interim report, PW indicated that denominator changes and small denominators likely contributed to the change in rate for HEDIS 2016 measures.

The Final Report demonstrated that outreach attempts were successful in producing the targeted improvements. While PrimeWest Health fell 1% short of their intended goal, the ongoing successes of their interventions encourages reaching this goal with continued implementation. PrimeWest will also change their communication model, so that provider communications are sent via providers’ own quality staff, encouraging receptivity and enhanced improvement.

*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.*

<b>HEDIS Year</b>	<b>All</b>
<b>2013/2014</b>	33.6%
<b>2015</b>	37.64%
<b>2016</b>	38.84%
<b>2017</b>	40.38%
<b>Change</b>	+6.78

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.