Quality Improvement Program Evaluation
2018

May 2019
# Table of Contents

- Executive Summary .......................................................................................................................... 3
- Preventive Services .......................................................................................................................... 14
- Chronic Care ...................................................................................................................................... 21
- Stars Initiatives .................................................................................................................................. 26
- HealthPartners Pharmacy Quality and Utilization Improvement (QUI) Program .................................. 31
- Safety .................................................................................................................................................. 40
- Admissions and Readmissions Withholds .......................................................................................... 45
- Emergency Department Utilization .................................................................................................... 50
- Dental Withholds ............................................................................................................................... 57
- Colorectal Cancer Screening .............................................................................................................. 61
- Reducing New Chronic Opioid Users - PIP ......................................................................................... 66
- SNBC Dental Access Improvement and Evaluation Project .................................................................... 73
- Chronic Care Improvement Program (CCIP): H2422 MSHO Improving Antidepressant Management in Sr Population ........................................................................................................................................... 82
- Chronic Care Improvement Program (CCIP): H4882 Journey Diabetic Nephropathy .......................... 88
- Quality Improvement Program (QIP): H4882 Journey Annual Wellness Visit .................................. 91
- Medical Record Documentation ......................................................................................................... 94
- MSHO Model of Care Measureable Goals .......................................................................................... 97
- Behavioral Health .............................................................................................................................. 100
- Complex Case Management Hospital Readmission Rates .................................................................. 107
- Continuity and Coordination of Medical Care .................................................................................. 111
- Continuity and Coordination of Medical and Behavioral Health ......................................................... 129
- Hemoglobin A1c Screening for Diabetics ............................................................................................ 143
- Health Promotion ............................................................................................................................. 146
- Health Disparities .............................................................................................................................. 149
- Service Initiatives .............................................................................................................................. 177
- Complaints, Grievances and Appeals ................................................................................................. 182
- Monitoring the Utilization Management Program ............................................................................. 190
- Affordability Initiatives ....................................................................................................................... 200
- Medical Coverage Policy Development ............................................................................................. 203
- Genetics Program .............................................................................................................................. 207
- Practitioner Credentialing ................................................................................................................... 215
- Network Strategies ............................................................................................................................. 216
Executive Summary

Mission: Why We Are Here
To improve health and well-being in partnership with our members, patients and community

Vision: Where We Are Headed
Health as it could be, affordability as it must be, through relationships built on trust

Values: How We Act
- Excellence
- Compassion
- Partnership
- Integrity

Integration of Quality and Utilization Management
To support the Triple Aim values of health, experience and affordability, HealthPartners integrates our quality improvement and utilization management functions. Integration enables us to better serve our members by ensuring that quality and experience are always considered when delivering utilization management strategies and programs. To support this approach, we have consolidated our utilization management program into our Annual Health Plan Quality Evaluation. We also include our Utilization Management (UM) Program Description as an attachment to our Quality Program Description. Our Annual Evaluation includes topics demonstrating this integration with UM such as Emergency Department Utilization, Reducing Hospital Admissions and Readmissions, a report on the Experience with the Utilization Management Process and our Financial Affordability/Stewardship initiatives. All these reports articulate our Triple Aim approach towards UM program administration.

Health Improvement Outcomes
- Performance on publically reported measures
  - HealthPartners plans are one of the top-rated (commercial) health plans in Minnesota and among the highest-rated plans in the nation with a rating of 4.5 out of 5, according to the National Committee for Quality Assurance (NCQA) Private Health Insurance Plan Ratings 2018–2019. We are in the top 10 percent in the nation as one of 45 private plans that received an overall rating of 4.5 out of 5.
  - In 2018, 75 percent of our commercial HEDIS measures are in the top 25 percent in the nation, with 29 percent in the top 10 percent. This is above our local competitors.
HealthPartners Freedom (Cost) Medicare plan is the top-rated Medicare plan in Minnesota, with a score of 5 out of 5, according to the NCQA Medicare Insurance Plan Ratings 2017–2018. HealthPartners® Freedom received a 4.5-Star rating from The Centers for Medicare & Medicaid Services (CMS). Our 4.5-Star status makes us one of the top-rated plans in Minnesota. Another HealthPartners Medicare plan, Minnesota Senior Health Options (MSHO), once again received a 4.5 Star Rating for 2019 for the seventh year in a row. MSHO is a plan for people who have both Medicare and Medicaid.

**Pharmacy quality measures**

- Due to our ongoing focus on quality improvement related to pharmacy, HealthPartners achieved remarkable results in 2017:
  - HealthPartners CMS Star Rating for adherence to statins in 2018 was 5 stars for all Medicare plans.
  - The 2018 Pharmacy Partners in Excellence MTM Program yielded positive results. Awards were distributed in November 2018.
    - 3 MTM practices met target for Gold award (at least 40% of target members engaged in MTM)
    - 2 MTM practices met the target for Silver award (at least 25% of target members engaged in MTM)
  - Among HealthPartners members receiving their first fill of opioid medication (i.e., no prescriptions for opioids were filled in the preceding 120 days), there is an increasing percentage who are receiving low quantities (i.e., fewer than 20 tablets). In 1Q2017, only 56% of members were receiving low quantities; that percentage has improved to over 67% in 4Q2018.

**Behavioral Health Performance and Initiatives**

- In 2018, HealthPartners supported the Science Museum of Minnesota’s development of the Mental Health: Mind Matters exhibit. Originally developed in Finland the exhibit did not use culturally appropriate language or approaches for the United States or offer culturally-relevant resources. HealthPartners provided important financial support, subject matter expertise and content for resources, including creation of a dedicated resource area for adults and children. This resource area offers culturally-relevant resources in many languages for African American, recent refugee immigrant, Somali and Latin American communities.

- The Behavioral Health Case Management programs for members at high risk for psychiatric hospitalization educated members with key behavioral health conditions and supported them to improve their condition self-management. HealthPartners deployed 45,500 member communications which focus on education, care coordination, medication adherence and closing gaps in care with more than 7,550 members.
o Our Beating the Blues (BTB) program is now available across more platforms including desktop, laptop, tablet and new in 2018, smart phones with automatic synchronization across platforms. Preliminary analysis of BTB participants showed that the program is serving its intended function of reaching and helping those with mild to moderate stress, depression and anxiety. A three-point scale BTB participant survey revealed high satisfaction with 94% saying it has been helpful in their work life and 97% saying it has been helpful in their personal life.

o HealthPartners expanded our Building Emotional Resilience suite of services and piloted several new online learning topics with HealthPartners employees and spouses. Nearly 1,900 employees and spouses completed a Building Emotional Reliance program in 2018. Our new courses support functioning in the workplace and beyond:
  ▪ Choose Civility
  ▪ Bring Your Best Self to Work

• Focusing on Health and Wellbeing

o HealthPartners continued to invest in our Lifestyle Management Program by creating an updated and enhanced framework for well-being activities that leverages behavior change tactics. Participants get actionable bits of knowledge combined with practical tips to apply daily, and tips to help consider the impact of their environment, social support and planning for set-backs that can reinforce healthy habits.

o Expanded well-being tools and programs, including the Health Assessment and family coaching into Medicare and Medicaid product lines.

o Our health promotion programs monitor a key participant experience metric, “The activities helped to improve my overall quality-of-life (strongly agree & agree)”). Our goal is to drive towards highly personalized evidence-informed programs, and improve results year over year. From 2016 to 2017 performance rose by 2 percentage points, from 81% to 83% and we maintained our 83% result in 2018. Measures for specific programs include:
  ▪ Participants focusing on weight management lost an average of 7.9 lbs.
  ▪ Participants focusing on sleep reported sleeping an average of 6.7 hours per night
  ▪ 62% of participants who focused on nutrition reported meeting national guideline of eating at least 5 fruits and vegetables on a daily basis
  ▪ 72% of participants focusing on physical activity reported meeting physical activity guideline of 150 minutes of moderate or vigorous physical activity on a weekly basis
  ▪ 69% of participants focusing on stress management reported that their stress level has improved as a result of the program
  ▪ 86% of participants focusing on gratitude reported an increase in positive emotions such as joy, compassion and optimism
  ▪ 77% of tobacco cessation coaching participants remained tobacco-free for six months
• **Supporting our Entire Community**

  o HealthPartners has a longstanding commitment to improve the health of the diverse communities we serve. The Health Equity Sponsor Group oversees the efforts across the organization to decrease disparities.
    ▪ Colorectal cancer screening rates for patients of color have improved from 43% in 2009 to 65.8% in 2018 – reducing the screening gap from more than 26% to roughly 11%.
    ▪ Breast cancer screening rates for patients of color have improved from 69.3% in 2006 to 75.7% in 2018 – reducing the screening gap between whites and patients of color from 12.9% to 7.4%.
    ▪ New in 2018, we created a workgroup to address disparities in pediatric and adolescent immunization rates. In targeted clinic systems, we decreased the gap between commercial and government payors by 2.35% which resulted in a 3.85% overall increase in screening rates for the Adolescent Immunization Combo 2 measure.

  o HealthPartners was also one of two organizations to receive the Centers for Medicare and Medicaid Services’ 2019 CMS Equity Award. The award recognizes organizations that demonstrate an exceptional commitment to health equity by reducing disparities among minority and other underserved populations.
    ▪ HealthPartners initiatives made significant progress to reduce the disparity in antidepressant medication compliance between whites and non-whites. The goal of the project was to reduce the disparity by a 20% relative improvement rate (3.72% absolute decrease) and we exceeded this goal and decreased the disparity by 5.92% over the course of the project.

**Experience Outcomes**

HealthPartners strives to increase member and provider engagement and satisfaction. We continually monitor survey results (J.D. Power, Consumer Assessment of Healthcare Providers & Systems (CAHPS), and Member Experience Survey) and various member feedback methods (complaint reports, employer and patient council feedback and online panel results) for improvement opportunities. During 2018, we:

• Enhanced care management for transplants from beginning to end with member decision support.
• Redesigned several member submitted forms for better ease of use and created functionality to submit electronically.
• Developed a personalized message prioritization and coordination system and process to better target key communications to members.
• Built and implemented an in-network request process to ensure members in narrow and focused networks products have access to medically necessary care at the in-network benefit level.

We believe the results show that the initiatives and interventions that we implemented in 2018 were generally effective in achieving our service goals.
• The CAHPS Plan Rating for commercial members improved by one percentage point from 2017, although the increase was not statistically significant. The rating falls in the 50th percentile nationally, while other Minnesota commercial plans place in the 33rd and 25th percentiles.

• In the most recent J.D. Power member survey, HealthPartners is the highest-scoring Minnesota commercial plan by a substantial amount. We have an especially strong performance in Coverage and Benefits, Claims Processing and (out-of-pocket) Costs. We have a lot of value in using these results as a complement to CAHPS results and other feedback sources in our efforts to improve member satisfaction.

Overall, member and provider satisfaction with the health plan experience is strong:

• Satisfaction with the Medication Therapy Management (MTM) program remains high. More than 98% of patients are willing to recommend and member engagement in MTM increased from 15% of targeted members in 2017 to 18.5% in 2018.

• Of the 3,524 members engaged by Behavioral Health Case Management, satisfaction was 97% in 2018 which indicates that this program is valued and of assistance.

• HealthPartners annual behavioral health satisfaction survey showed strong results
  o 77% of members satisfied with the availability of convenient appointments
  o 70% of members are satisfied with the length of time between scheduling an initial appointment and the day of the visit
  o 77% of members are satisfied with the length of time between scheduling ongoing appointments and the day of the visit
  o 79% of members were satisfied with the outcome of their care, i.e. that they were helped
  o 88% of members would recommend their behavioral health clinic to family/friends

**Affordability Outcomes**

Each year we establish an affordability target that is based upon a projection of the upcoming year’s claims to reduce the expected Total Cost of Care (TCOC) by 1-2 percent. The 2018 TCOC goal was $61 to 122 million and we achieved $61.9 million in savings. Examples of achieved results include the following:

• Complex and Inpatient Case Management services were successful in preventing inpatient admissions and reducing readmissions that resulted in reducing health care costs by $32.9 million.

• Behavioral Health Case Management services were likewise successful in preventing inpatient admissions and reducing readmissions that resulted in reducing health care costs by $10.7 million.

• Our disease management programs that focus on the core chronic diseases of diabetes, asthma, coronary artery disease, chronic obstructive pulmonary disease and heart failure reduced costs by $13.0 million. Additionally, our cancer disease management program led to a savings of $1.8 million.

• Medication Therapy Management program resulted in a savings of $3.1 million.
As of December 2018, the laboratory genetic counselor program implemented with key care delivery partners achieved approximately $2.9M in total cost avoidance since program start (up $1.4M from 2017), with an average cost savings per test order of $1,841 in 2018 (up $1,000 per test from 2017)

**Leadership Involvement**

- The Board of Directors has final authority and ultimate responsibility for the quality of care and services provided to members of the plan and for oversight of the Quality Improvement (QI) Program.
- HealthPartners Medical and Executive Leadership are actively involved in the QI program on an ongoing basis, through the establishment of multiyear Partners for Better Health Goals 2020, addressing stretch goals across the Triple Aim of health, experience, and affordability.
  - Our plan displays commitment to our multiyear goals, through routine publication of an enterprise-wide performance scorecard.
- The Quality Committee of the Board provides oversight through review of quarterly reports about the progress specific to the QI programs.
- The Quality Council meets quarterly to actively oversee multiple committees designed to improve quality and Council agendas reflect topics of the QI Annual Plan. The following committees report up to the Quality Council:
  - Pharmacy QUI (quarterly meetings)
  - Quality Review Committee (quarterly meetings)
  - Government Programs QUI (quarterly meetings)
  - Service Quality Council (quarterly meetings)
  - Medical Directors Committee (monthly meetings)
  - Additional Enterprise Leadership Committees provide routine reports and support cross-representation on multiple initiatives
- These committees generally met as scheduled and there was sufficient committee capacity to address their annual objectives.
- Charters exist for every quality committee noted above and include goals, objectives, or purpose statements and a list of attendees. Charters are detailed in a separate Quality Program Description. Each committee reviews and updates their charter annually

**Adequacy and Realignment of Resources**

HealthPartners evaluates the adequacy of the Quality Council committee structure, practitioner participation, resources, and leadership at least yearly. Evaluating resource adequacy, staffing and technology are an ongoing part of program development. They are also key elements in the annual budgeting and Return on Investment (ROI) assessments for existing programs. During 2018, HealthPartners acted on multiple opportunities to ensure appropriate staff deployment and make strategic investments in key programs.

Staffing: The following key positions support the program:
Medical Director and Associate Medical Directors: 5.9 FTEs
Senior Director, Behavioral Health Strategy and Resilience: 1.0 FTE
HealthPartners transitioned the role of Chief Science Officer to President of HealthPartners Institute which leads our Research Foundation and medical education division.

The plan supports more than 550 FTEs across the QI program. This total includes analytical resources which support our QI initiatives. Our investment represents a strong commitment to achieving the Triple Aim.

To better utilize our resources, HealthPartners made significant program shifts or investments in the following areas:

- To meet the needs of our members we increased Disease and Case Management staffing in 2018 to address new business expansion in both our public programs product as our Medicare plans transitioned from Cost to Medicare Advantage.
- After analyzing external vended communication solutions, HealthPartners chose to build an internal communications platform to improve efficiency designing and deploying personalized member outreach campaigns.
- Ongoing refinement to our Population Health Management program to align with NCQA Standards.
- Ongoing upgrades and enhancements to our CarePartner, MedHok and Cactus applications which support our UM and care management activities.
- Significant investment in a health and care engagement platform to support health assessments and serve as a member portal for access to health and wellbeing and BH/DCM programs.
- Program evaluations resulted in modifications to resource deployment. For example,
  - Allocation of resources to develop stronger tools and reports to help our network providers effectively improve the quality of care delivered to their patients who are HealthPartners members. These enhancements will continue to be deployed in 2019.
  - Implementation of an enhanced process for assessing member and provider requests for care outside the network.
  - Results from the 2018 direct-to-member FIT program were strong. HealthPartners renegotiated our contract with our test kit vendor to improve the long term sustainability of the program for 2019 and beyond.
  - Allocation of resources to develop and deploy a CMS Star monitoring and tracking tool that enhances our ability to analyze our performance throughout the year.

**Practitioner Participation**

HealthPartners continues to have substantial practitioner participation on our governing board, advisory boards, and QI committees and adhoc provider advisory groups as needed. This represents input from across the network and a wide range of clinic sites and practitioner specialties. HealthPartners practitioners participate in the planning, design, implementation, and review of the QI Program. Their
activities ensure program alignment with evidence-based care and overall population management between the health plan, care delivery systems and community partners. Network practitioners serve on our:

- Board of Directors
- Quality Committee of the Board
- Institute for Clinical Systems Improvement
- Minnesota Community Measurement
- Quality Review Committee
- Credentials Committee
- Member Focused Behavioral Health Advisory Committee
- Pharmacy and Therapeutics Committee
- New Technology Committee and periodic advisory groups including genetic testing advisory groups

In addition, ad hoc groups and community collaboratives include provider representatives. Organizationally, we feel this robust level of practitioner participation helps us achieve exceptional results and we will continue with this level of involvement during the next plan year.

Quality Connections Forums continue to be a successful strategy to improve quality across our provider network. These Forums have been functioning for six years, growing from an initial meeting of five clinic systems, to 14 regularly attending systems in 2017 and up to 16 in 2018.

Medical Directors make multiple on-site visits to multispecialty care systems, primary care and specialty care providers to sustain engagement in improving clinical care, member experience and affordability. Beginning in 2018, HealthPartners identified clinical consultant resources to support providers in achieving quality goals. These consultations are planned to begin in 2019.

Community collaborative organizations such as the Institute for Clinical Systems Improvement (ICSI), Minnesota Community Measurement (MNCM), Safest in America and Minnesota Alliance for Patient Safety provide additional methods of obtaining practitioner input on key topics.

**Challenges/Barriers to Greater Success**

- Challenges to greater success in health improvement include:
  - Most, but not all, plans cover preventive services at 100%. Members with health saving accounts (HSA’s) and other high deductible plans have a lower completion rate for preventive services than members with low or no deductible plans.
  - Providers experience ever increasing pressure to attend to numerous health goals in limited amount of time with patients.
  - Members who do not have an established relationship with a primary care provider may experience fragmented care and lack of coordination from inconsistent providers. These “unattributed” members typically have lower rates of obtaining important preventive services such as mammograms and colorectal cancer screening. If they have a chronic condition such as diabetes, utilization of important monitoring tests such as A1c and diabetic nephropathy testing are also lower.
Inability to monitor the full impact of improvement interventions on hybrid HEDIS Source Star Measures over the course of a measurement period.

Member engagement in MTM services is improving, but a continued challenge is a lack of awareness among members about what MTM is and how it differs from the services provided by their other care team providers. A common comment heard from members is “my doctor already does this [reviews medications]”, so there is a lack of understanding about the benefits of participating in MTM.

Social and financial stressors have a strong impact on member’s ability to prioritize health care. Many of the social determinants of health are barriers to seeking appropriate care. These may include housing and food instability, lack of transportation and lack of paid time off for medical appointments.

Stigma continues to be a barrier to getting prompt mental health evaluation and treatment.

Higher health and well-being engagement rates are tied to employer based incentives, but not all employer groups offer an incentive for participation in a wellness program or completion of health assessment.

Social media misinformation about immunizations contributes to low rates.

Challenges to greater success with member experiences are related to:

- Consumer sentiment about value heavily influences perceptions of experience, particularly health plan ratings. Among the top drivers is feeling that my plan is a good value. A modest 60% of members give a Top 3 rating (% 8, 9, 10). Increased premiums and out-of-pocket costs are a significant barrier to member satisfaction.

- High deductible plans and new narrow network plans continue to be popular with employers purchasing insurance for their groups and also members who purchase insurance individually. In the case of narrow network plans, members need to adjust to obtaining care from a much smaller network. Providers are also confused, which compounds the challenge.

- CMS discontinued Medicare Cost plans in many areas of our service area. The majority of our Medicare Cost members needed to shop for and select a new Medicare plan for 2019. These members had a lot of questions about their options and how their new plan would work.

- Home addresses for State Public Program enrollees are often inaccurate resulting in important health plan information being returned by the postal service, creating a significant barrier to communicating with these enrollees.

Challenges to greater success with affordability improvement include:
o Rapid pace of new technology development, FDA approval and deployment prior to sufficient knowledge of the relative value compared to existing technologies

o Limited resource/capacity challenges and the ultra-high cost of certain medications and gene therapies were significant challenges faced by the specialty pharmacy team and required new innovative management strategies and payment methodologies.

o HealthPartners contracted with external sources of drug pipeline expertise to better forecast arrivals of new expensive therapies.

o Networking opportunities to identify new ideas related to affordability

o Continuous payment reform challenges, changes and mandated benefit requirements

o Limited comparative effectiveness research of best evidence-based care to guide plan benefits, plan coverage and provider selection.

o As new technologies and tests strive to increase market share, we see an impact on member requests for specific services, increased expectations of coverage and third party vendors appealing coverage on the member’s behalf.

o Pharmaceutical, device and testing companies increasingly target our members using direct to consumer advertising

o Multiple competing policy development priorities to meet requirements for new technologies, affordability initiatives, Medicare/Medicaid policies and revision of existing policies to better support prior authorization programs.

o Direct-to-consumer marketing of genetic tests that may not be appropriate for a patient’s particular situation.

2019 Areas of Focus

• Continue to promote ePA solutions for providers to submit prior authorization requests and receive timely response from the health plan.
• Continue implementing the process improvements identified in the Pharmacy Appeals “Lean” workgroup.
• Explore insourcing portions of our direct to member home test kit program to utilize Central Lab resources.
• Convert existing member outreach campaigns from the current platform to the newly built platform so that we can deploy more robust and nimble personalized member outreach strategies.
• Continue to use MyVoice survey/focus groups to explore member’s understanding and preferences for receiving preventive and chronic care services.
• After re-chartering our HEDIS strategy committee in 2017, to include CMS Stars initiatives, the committee will make further enhancements in 2019 to improve accountability for progress on designated measures.
• Continuously strive to improve our programs and services in support of member health through new communication methods such as social media, web, phone, or other and use of targeted, personalized messaging.

• Continue to monitor, evaluate, and institute appropriate actions to address member and practitioner experience with the UM process, including a focus on transitioning to use of plan language to ensure better member understanding.

• Implement initiatives to improve and sustain optimal CMS Star Ratings for our Medicare and MSHO products.

• Implement and report on multiple required Medicare, MSHO, and State Public Program quality improvement projects (QIPs) and performance improvement projects (PIPs).

• Develop and implement strategies to achieve Minnesota Department of Human Services (DHS) withholds and the SNBC Dental goals.

• Transition from a focus on managing genetic testing to a broader view of diagnosis and treatment, including access to genetic counseling services

• Execute on key quality initiatives to support our state public programs products
Preventive Services

Description

Obtaining appropriate preventive care improves health outcomes and can prevent disease. HealthPartners supports improving the delivery of appropriate clinical preventive services by providing tools and resources to support our members and health care providers.

HealthPartners implemented a program for preventive service reminders in 2005. This program was started in response to members’ comments regarding ‘Why can’t my health care provider send me a reminder?’ and as an additional resource to clinic systems. This program supports HealthPartners strong performance on NCQA ratings, HEDIS measures, CMS Stars and Medicaid withhold requirements.

We proactively contact members who have not received best care as defined by evidence-based clinical guidelines established by ICSI and U.S. Preventive Services Task Force (USPSTF) for select services (breast, and colorectal cancer screening; adolescent, childhood and influenza immunizations). Based on member preferences, messages are sent either via postal mail or email. Many members have access to a secure web mailbox on healthpartners.com which enables them to access messages from both the plan and select providers. In 2016, an interactive voice response (IVR) pilot for sending flu shot reminders was completed. In 2017, a colorectal cancer screening pilot was completed sending FIT kits directly to the homes of unattributed members. In 2018, in follow-up to the success of our previous year’s pilot 30,529 FIT kits were directly sent to members’ homes. Additionally, in 2018 direct mail kits were sent to Medicare members with diabetes who were not up to date on microalbumin and/or hemoglobin A1c tests. The microalbumin urine test is a test that checks kidney function and the A1c test is a finger prick blood test that checks blood sugar control over a three month period.

Goal

Our goal is to engage, empower and partner with members, patients, providers, and purchasers to achieve the best health for our members. Our objectives:

1. Educate providers and members and facilitate the delivery of preventive health care services
2. Empower members in self-care around healthy behaviors and preventive care

The member outreach population is defined by using HEDIS specifications for the appropriate measures:

- Breast cancer screening – Women between the ages of 50 - 75
- Cervical Cancer screening – Women between the ages of 21 - 64
- Colorectal cancer screening – Women and men between the ages of 50 – 75
  - For African-Americans, American Indians and Alaska Natives begin screening at age 45
- Pediatric Immunizations – children by 2 years of age
- Adolescent Immunizations – ages 11-12 years of age
**Initiatives/Interventions**

**Member Interventions:**

1. A member survey on cancer screening preventive services identified cost as a barrier for completing the screening, so HealthPartners included language in our outreach campaigns about cost. Most preventive screenings are covered with no cost sharing for most members, so this is highlighted in the reminders.

2. HealthPartners sent more than 30,000 home test kits for colorectal cancer screening to commercial members who do not have a primary care provider identified in our system and to all Medicare and MSHO members with gaps in care. The plan directly mailed a FIT test along with information on the importance of this screening and asked members to complete the screening and send it back to the lab.

3. Case Management staff are alerted to members needing preventive services in their system and so they can remind members when they are due for a preventive service.

4. Health Risk Assessments alert members to preventive services they may need.

5. Internal and external communications channels such as social media, build awareness of the importance of cancer screenings.

6. MSHO members receive an incentive for completing a mammogram, colorectal cancer screening or an osteoporosis screening.

7. Preventive screening messages for breast cancer and colorectal cancer screening are customized using predictive analytics to improve member engagement in getting screening tests.

8. Prepaid Medical Assistance Program (PMAP) members receive an incentive for completing all adolescent immunizations needed by age 13.

**Provider Interventions:**


2. Member-specific registries that identify members needing screening are updated quarterly. Providers are notified and given instructions to access the data.

3. Equitable Care champions and staff provide race/ethnicity-specific scripting for promoting cancer screening.

4. Preventive measures are included in the slate of measures for the HealthPartners provider incentive program, Partners in Excellence. In 2018, three groups received HealthPartners’ fifth annual Preventive Care Recognition Award for major process changes that resulted in persistent, sustainable improvement for preventive care screening that addressed the health of population served.

5. Network quality improvement leaders meet for the Quality Connections Forums to share the latest science and best practice methods including successes and challenges of quality improvement initiatives.

6. Consultations are available for medical groups interested in improving their quality outcomes measures.

*2018 Quality Improvement Annual Evaluation 15*
Employer Interventions:

1. Large employers have become partners in messaging to employees and providing incentives for preventive care services. HealthPartners provides presentations, employer newsletters, and performance guarantees for preventive care services.
2. HealthPartners monitors the number of employees who received preventive outreach messages and reports on this to employer groups.

Assessment of HEDIS Results

2. Colorectal cancer screening results increased slightly in the commercial population. (Note: colorectal cancer screening is not a measure for PMAP.)
3. Pediatric and adolescent immunization rates decreased in the commercial population, the decrease for adolescent immunizations was statistically significant. In the PMAP population pediatric immunization rates increased and they declined for adolescent immunizations.
4. Chlamydia screening rates increased for commercial and PMAP populations, the increase in the commercial population was statistically significant.
5. Postpartum visits improved for the commercial population and decreased for the PMAP population. PMAP members receive an incentive for completing their postpartum visit.

Barrier Analysis

1. Most, but not all, plans cover preventive services at 100%. Members with health saving accounts (HSA’s) and other high deductible plans have a lower completion rate for preventive services than members with low or no deductible plans.
2. Preventive guidelines change and it may be confusing for members to know when to start screening, the frequency of screening, and what screening to have done when there are options. This continued to be true in 2018 for cervical and breast cancer screening guidelines.
3. Medical societies publish and promote consensus-based preventive guidelines that may be inconsistent with the evidence; this causes patient and provider confusion.
4. Variation exists in the provider’s ability to collect race/ethnicity data and language data, which can affect ability to address disparities.
5. Providers have limited resources for testing proposed initiatives and the time and resources needed to make systemic change can be costly. By sharing successes and strategies via Quality Connections we support tested interventions for quality improvement.
### Opportunities for Improvement – Results/Outcomes

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<th>2015</th>
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<td>66.4%</td>
<td>66.4%</td>
</tr>
<tr>
<td>Pediatric Immunization Combo 3</td>
<td>72.5%</td>
<td>76.9%</td>
<td>75.4%</td>
<td>75.4%</td>
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<tr>
<td>Adolescent Immunization Combo 1</td>
<td>78.1%</td>
<td>89.5%</td>
<td>87.4%</td>
<td>87.4%</td>
</tr>
<tr>
<td>Chlamydia screening</td>
<td>68.4%</td>
<td>71.3%</td>
<td>67.5%</td>
<td>67.5%</td>
</tr>
<tr>
<td>Postpartum visit</td>
<td>69.6%</td>
<td>65.0%</td>
<td>72.3%</td>
<td>72.3%</td>
</tr>
</tbody>
</table>

### Member Outreach Campaigns (table of results below)

Outreach campaigns are deployed each calendar year and impact HEDIS results for the next measurement year.

We saw success with noted improvements in the following campaigns:

- Cancer screening campaigns:
  - Breast cancer screening conversions increased 1%, from 7% in 2017, to 8% in 2018.
  - The PCS cervical cancer screening campaign was paused for 2017 and 2018 due to the complexity of measurement guidelines. Development of a new campaign is planned for 2019.
  - Colorectal cancer screening conversion rates increased 3%, from 7% in 2017 to 10% in 2018.

- Pediatric immunization campaign results held consistent at 38%. We continue to send monthly letters.
• Adolescent immunization campaign - Results declined from 23% in 2017, to 8% in 2018. The decline was due to changes in the HEDIS measure which now includes a completed HPV series, whereas in the previous year this was not included.
• Flu shot campaign including IVR - We saw dramatic improvement in results for our Flu shot campaign.
  o SWM messaging conversion rates improved to 15% in 2018 compared to 12% in 2017, a 3% increase. A total of 1,080,605 SWM messages were sent.
  o IVR calls resulted in a 24% conversion rate in 2018, compared to 15% in 2017, a 9% increase. A total of 225,670 IVR calls were made.
  o In comparing SWM messages versus IVR calls, IVR performed 9% better. Results were 15% for SWM and 24% for IVR.

Assessment of 2018 Actions

• Adobe & Personalization Pipeline – In 2018 discovery work was done on Adobe, a platform for member outreach campaigns. Adobe did not provide the functionality needed for outreach campaigns and an internal platform called the Personalization Pipeline was created. The pipeline continues to match up messages to members based on the type of message that is most motivating to the individual member, such as convenience of a service or doctors recommend. In addition to mailings and secure web mail, this personalization pipeline includes additional channels of communication to match the member’s preference such as personal e-mail, notifications to their HP.com account and reminders via member services or care coordinators.
• MyVoice – These online surveys explore member’s understanding of recommendations, assess preferences and test messages about convenience and scheduling of preventive services. Three MyVoice surveys were planned for 2018 - mammogram, preventive care and diabetes and four surveys were actually completed. Additionally, the findings from a previous year were used as part of our flu campaign. For 2018, surveys were completed for:
  ▪ Mammogram
  ▪ Preventive care
  ▪ Diabetes
  ▪ FIT for colorectal cancer screening
  ▪ Flu – utilized findings from a previous MyVoice survey to create a “Shoo the Flu” message on the bag tags for prescriptions picked up at pharmacies
• Social Media – 2018 topics included adolescent immunizations, chlamydia screening, mammograms and colorectal cancer screening. Social media provided a vehicle to expand health information to members who may want more in-depth detail on a health topic. HealthPartners leveraged current social media channels and looked at ways to optimize these streams and utilized improved capabilities.
  o Blogs - Blogs and links on a member’s HealthPartners account page provide connections to experts and more personalized information.
Facebook - Facebook provides a very cost-effective means to customize messages to specific populations, e.g. women ages 50-74 for mammograms. Members are able to access HealthPartners website and detailed links.

- At Home Test Kits – In 2018, the at home test program for FIT kits for colorectal cancer screening was expanded based on the success of the pilot that was done in 2017. In 2017 the FIT kit pilot for colorectal cancer screening showed that this is a successful strategy to reach members and offers a convenient way to get screened. The 23.8% return rate is more than twice the response we have had compared with sending letters or secure web mail messages in previous years.
  - 30,529 FIT sent
  - 7,252 kits returned for a return rate of 23.8%
  - 386 positive results for a positive rate of 5.3%

- To continue our work in reducing racial and payer disparities for cancer screening we had representation on these care delivery work groups:
  - Colorectal Cancer Work Group
    - The Colorectal Cancer Work Group was a team recipient of the President’s Award for outstanding work in improving screening.
  - Breast Cancer Work Group

**Actions for 2019**

- At Home Test Kits – The sending of FIT kits to member homes was so successful that this program will be continued in 2019. A change is being made with the lab our vendor was using to improve turnaround times of results and of members and their primary provider receiving results.

- Improve Well Project – In planning ahead for FIT kits being sent to member homes in 2020, we are participating in Improve Well and exploring the opportunity to use HealthPartners’ Central Lab FIT for members who are also patients within our family of care. We believe this opportunity could provide further timeliness of completing the test, providing results and following up with members who will need a colonoscopy.

- FIT & Mail Order Pharmacy – a MyVoice Survey completed in 2018 showed that being able to order a FIT test when renewing mail order prescriptions was perceived as a convenient option for members to get their FIT kit. Further exploration with pharmacy will be continued in 2019.

- Chlamydia At Home Testing – The opportunity exists for members who are due for a chlamydia test to have the test sent to them at home. This would be another test that could be done in the privacy of a member’s home. Park Nicollet’s study of patients completing a chlamydia test in the clinic and another one at home showed the home test kit was as reliable as the test done in the clinic.

- Personalized Member Messages – Expand personalized messaging for preventive services to our members by providing messages that meet the member’s preferences. Email messages will now be able to be sent to a member’s personal email versus their having to log into their HealthPartners account. When members are in their account, they can click on the bell icon and see what screenings they are due for and have increased ease in scheduling appointments.
## Outreach Campaigns

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breast cancer screening</strong></td>
<td>73,190 (9%)</td>
<td>79,110 (8%)</td>
<td>66,739 (7%)</td>
<td>101,803 (8%)</td>
</tr>
<tr>
<td><strong>Cervical cancer screening</strong></td>
<td>116,258 (4%)</td>
<td>46,802 (5%)</td>
<td>Campaign paused</td>
<td>Campaign paused</td>
</tr>
<tr>
<td><strong>Colorectal cancer screening</strong></td>
<td>169,232 (5%)</td>
<td>178,228 (7%)</td>
<td>211,051 (7%)</td>
<td>145,353 (10%)</td>
</tr>
<tr>
<td><strong>Pediatric Immunization (Letter only)</strong></td>
<td>15,937 (32%)</td>
<td>24,573 (38%)</td>
<td>21,376 (38%)</td>
<td>26,537 (38%)</td>
</tr>
<tr>
<td><strong>Adolescent Immunization</strong></td>
<td>25,888 (1%)</td>
<td>13,979 (5%)</td>
<td>23,421 (23%)</td>
<td>27,347 (8%)*</td>
</tr>
<tr>
<td><strong>Diabetes Optimal Care</strong></td>
<td>14,966 (52%)</td>
<td>10,473 (46%)</td>
<td>11,837 (43%)</td>
<td>9,909 (50%)</td>
</tr>
<tr>
<td><strong>Annual Flu Immunizations</strong></td>
<td>293,243 (% not avail)</td>
<td>SWM 492,756 (2%)</td>
<td>SWM 770,317 (12%)</td>
<td>SWM 1,080,605 (15%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IVR 7,364 (6%)</td>
<td>IVR 188,661 (15%)</td>
<td>IVR 225,670 (24%)</td>
</tr>
</tbody>
</table>

*HEDIS measure changed, completed HPV series now required.
Chronic Care

Description
Almost half of all Americans live with a chronic condition. HealthPartners supports chronic care improvement by helping our members achieve optimal care goals and by promoting effective change in provider groups to support evidence-based clinical and quality improvement across a wide variety of health care settings.

Goals
The objective of the program is to improve the health outcomes of members with chronic diseases and to prevent or delay complications of these diseases. Goals follow HEDIS measures for chronic diseases with emphasis on diabetes – annual retinal eye exam, glycosylated hemoglobin (HbA1C) testing, nephropathy screening and blood pressure control. Success is measured by improvement in HEDIS rates and on conversion rates for members who received member outreach through postal mailings, emails and disease or case management services.

HealthPartners goal for commercial members is to achieve Band 1 performance. HealthPartners also has goals related to achieving a 5-Star rating for our Medicare Cost and MSHO plans. CMS uses these ratings to assess and rate health and drug plan quality, performance and satisfaction of members. The Star Ratings strategy is consistent with CMS’ Triple Aims (better care, healthier people/healthier communities and lower costs through improvements).

Comprehensive Diabetes Care Description
The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following:

- HbA1c testing
- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- HbA1c control (<7.0%) *selected population
- Eye exam (retinal)
- Monitoring for diabetes nephropathy
- Blood Pressure (BP) control (<140/90)

Eligible Population: Commercial, Medicaid, Medicare; ages 18-75 during the measurement year, continuously enrolled in measurement year.
Numerator: members with a claim or medical record documentation for the above services
Denominator: members with a diagnosis of diabetes, ages 18-75, in the measurement year

Initiatives/Interventions
Email messages were sent to members with diabetes who were coming due for HbA1c testing and/or dilated retinal eye exam.

- In 2018 HealthPartners sent 9,909 messages, with a conversion rate of 50% for receiving one or both services.

HealthPartners provides disease management programs for chronic conditions: asthma, CAD, COPD, diabetes, heart failure, and rare and chronic diseases for all our product lines including Commercial, Medicare, and Minnesota Health Care Program (MHCP) members.

Distribute chronic disease member registries to providers with flags for missing and overdue services and participation in a disease management program.

- Registries include race/ethnicity and language data

Staff monitors condition specific, evidence-based guidelines aligned with ICSI and USPSTF to assure programs and measures are consistent with current evidence.

Disease management member materials share condition specific information and education.

In previous years diabetes and cardiovascular measures were included in the Performance Improvement Excellence (PIE) program. The Health & Patient Experience Quality Dimensions program was created in 2017 to monitor and reward clinic progress on chronic condition measures. Measures have been grouped into categories of care, called Quality Clusters which are specific to primary care, pediatric and specialty groups. Optimal diabetes care and diabetes eye exams are included as part of Care for Chronic Conditions.

Quality Connections Forums engage HealthPartners network provider groups in quality initiatives to improve publicly reported measures.

- Hosted by HealthPartners, the group creates the agenda which includes both preventive and chronic improvement projects as well as process improvements
- Participants share the latest science and best practice methods and share successes and challenges of quality improvement initiatives

To support improvement in our performance on the osteoporosis Star measure, Clinical Quality Improvement nurses collaborate with both HealthPartners Medical Group and Park Nicollet to facilitate monthly fracture follow-up with target members and facilitate bone mineral density testing or provide prescriptions to treat/prevent osteoporosis. At the end of 2018, we began discussions about how to improve the effectiveness of this intervention (we dropped to a 1 star rating which is the lowest). After discussions with both HealthPartners medical group and Park Nicollet, a cross-functional work group was formed. This work is continuing into 2019.

HealthPartners has multiple initiatives currently in place and in development to ensure our members with chronic diseases receive the services they need to effectively manage their condition. Historically, there have been separate committees and work groups that oversee commercial and Medicare populations. To ensure effective coordination of our initiatives across product lines, HealthPartners enhanced the scope of our HEDIS oversight committee to also include oversight of CMS Stars measures. The HEDIS/CMS Stars Steering committee provides strategic direction on the many initiatives designed to improve both chronic and preventive care, especially as they relate to HEDIS and CMS Stars measures.
Barrier Analysis

- Higher member costs for health care including prescription drugs used to control diabetes and other chronic conditions
  - Out of pocket expenses for members are often increasing due to changing deductibles and co-pays
- Our ability to provide accurate outreach to members is dependent on claims information
  - Claims lag can be a barrier for timely identification of gaps in service
- Inability to identify all retinal eye exam claims for persons with diabetes due to eye benefits increasingly covered by third party benefit carve-outs
- Members who do not have an established relationship with a primary care provider may experience fragmented care and lack of coordination from inconsistent providers
- Providers experience ever increasing pressure to attend to numerous health goals in limited amount of time with patients.
- Providers have limited resources for testing proposed quality improvement initiatives, and the time and resources needed to make systemic change can be costly.
- State and federal quality improvement measures such as those related to DHS withholds and CMS Stars measures continue to change and evolve which can make targeted improvement activities challenging.
- Some member populations are very difficult to contact and engage; this is especially true with our state public programs members.

Opportunities for Improvement: Results/Outcomes

Through these initiatives, it is clear that improvement can often be incremental and slow. System and process changes at the provider level lead to the greatest, sustained improvement, and we continue to encourage our network clinics to utilize best practices in their care. Challenges remain in understanding lack of improvement or decreases in goals for chronic diseases. We believe the more we can learn about members and the more strategies we use to connect with members, the more effective we will be. Current activities will continue in the next program year with expanded collaborative efforts with Marketing and Health Informatics to identify members by micro-segments and tailor messages that resonate with member values (i.e. cost and convenience). We believe this will improve our current outreach efforts in improving the health of members with chronic diseases.

Actions for 2019

Adobe & Personalization Pipeline – In 2018, HealthPartners created a robust, internal platform called the Personalization Pipeline to deploy multi-channel member engagement campaigns. In addition to postal mailings the personalization pipeline includes additional channels of communication to match the member’s preference such as personal e-mail, notifications to their HP.com account and reminders via Member Services or care coordinators. Diabetes messaging from the pipeline began going to members November 2018. The new campaign includes two forms of digital outreach:
1. A generic teaser email in a member’s personal inbox prompting them to log in to their online account for authenticated content
2. Authenticated content presented to a member who’s logged in to their online account

Mobile users who have opted in to receive push notifications will also receive a message through this channel. The brief push notification will open the myHP app where member will be able to see the complete message personalized to them.

- **At Home Test Kits –** In 2018, HealthPartners launched a program to send home test kits to members with diabetes. The two tests were an A1c blood test which tests blood sugar control over a 3-month period and a microalbumin urine test that tests for protein in the urine which can indicate kidney damage. This strategy offers a convenient way for members to get tested and will be continued in 2019.
  - 209 A1c tests sent and 12% returned the test
  - 1,279 microalbumin tests sent and 17.8% returned the test

- **MyVoice -** We will continue to utilize MyVoice surveys to solicit input from our members to inform our outreach initiatives. These surveys explore member’s understanding of recommendations, assess preferences and test messages about convenience and scheduling of preventive services.

- **Social Media -** Social media provides a vehicle to expand health information to members who may want more in-depth detail on a health topic.
  - Blogs and links on a member’s HealthPartners account page provide connections to experts and more personalized information,
  - Facebook provides a very cost-effective means to customize messages to specific populations. Members are able to access the HealthPartners website and detailed links

- **Real Men Wear Gowns**
  - In 2017 and 2018 HealthPartners teamed up with KARE11 news station and will do so again in 2019 to bring awareness to the importance of men’s health. Men are 24% less likely to go to the doctor than women. This campaign highlights the importance for men to see a doctor on a regular basis to be screened and monitored for chronic diseases such as heart disease, hypertension, diabetes, as well as preventive care such as immunizations and cancer screening.

- **Network quality improvement leaders meet for the Quality Connections Forums to share the latest science and best practice methods including successes and challenges of quality improvement initiatives.**
### Diabetes HEDIS Results

<table>
<thead>
<tr>
<th>HEDIS Measure</th>
<th>HEDIS 2015</th>
<th>HEDIS 2016</th>
<th>HEDIS 2017</th>
<th>HEDIS 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Testing</td>
<td>NA</td>
<td>95.6%</td>
<td>94.3%</td>
<td>94.0%</td>
</tr>
<tr>
<td>HbA1c Poor Control &gt;9%*</td>
<td>NA</td>
<td>19.5%</td>
<td>23.5%</td>
<td>22.6%</td>
</tr>
<tr>
<td>HbA1c &lt;8%</td>
<td>67.5%</td>
<td>67.5%</td>
<td>63.9%</td>
<td>65.0%</td>
</tr>
<tr>
<td>HbA1c &lt;7%</td>
<td>NA</td>
<td>44.7%</td>
<td>37.7%</td>
<td>39.1%</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>59.9%</td>
<td>56.9%</td>
<td>63.0%</td>
<td>59.9%</td>
</tr>
<tr>
<td>Nephropathy Screen</td>
<td>88.8%</td>
<td>90.3%</td>
<td>90.1%</td>
<td>89.8%</td>
</tr>
<tr>
<td>Blood Pressure &lt;140/90</td>
<td>83.9%</td>
<td>82.5%</td>
<td>79.6%</td>
<td>76.6%</td>
</tr>
</tbody>
</table>

* = Lower is better

### PMAP

<table>
<thead>
<tr>
<th>HEDIS Measure</th>
<th>HEDIS 2015</th>
<th>HEDIS 2016</th>
<th>HEDIS 2017</th>
<th>HEDIS 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Testing</td>
<td>93.2%</td>
<td>92.7%</td>
<td>94.5%</td>
<td>93.1%</td>
</tr>
<tr>
<td>HbA1c Poor Control &gt;9%*</td>
<td>25.9%</td>
<td>25.2%</td>
<td>21.9%</td>
<td>26.8%</td>
</tr>
<tr>
<td>HbA1c &lt;8%</td>
<td>61.7%</td>
<td>63.0%</td>
<td>63.1%</td>
<td>57.8%</td>
</tr>
<tr>
<td>HbA1c &lt;7%</td>
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<td>42.3%</td>
<td>41.6%</td>
<td>37.3%</td>
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<tr>
<td>Eye Exam</td>
<td>63.1%</td>
<td>62.8%</td>
<td>65.0%</td>
<td>68.8%</td>
</tr>
<tr>
<td>Nephropathy Screen</td>
<td>86.9%</td>
<td>89.8%</td>
<td>89.1%</td>
<td>88.7%</td>
</tr>
<tr>
<td>Blood Pressure &lt;140/90</td>
<td>79.6%</td>
<td>79.2%</td>
<td>78.1%</td>
<td>79.4%</td>
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</tbody>
</table>

* = Lower is better

### Medicare Cost

<table>
<thead>
<tr>
<th>HEDIS Measure</th>
<th>HEDIS 2015</th>
<th>HEDIS 2016</th>
<th>HEDIS 2017</th>
<th>HEDIS 2018</th>
</tr>
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<tbody>
<tr>
<td>HbA1c Testing</td>
<td>NA</td>
<td>97.0%</td>
<td>97.0%</td>
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</tr>
<tr>
<td>HbA1c Poor Control &gt;9%*</td>
<td>NA</td>
<td>8.5%</td>
<td>8.5%</td>
<td>11.2%</td>
</tr>
<tr>
<td>HbA1c &lt;8%</td>
<td>84.0%</td>
<td>81.1%</td>
<td>82.6%</td>
<td>79.8%</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>80.8%</td>
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<td>82.2%</td>
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<tr>
<td>Nephropathy Screen</td>
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<td>93.9%</td>
</tr>
<tr>
<td>Blood Pressure &lt;140/90</td>
<td>84.0%</td>
<td>80.0%</td>
<td>85.6%</td>
<td>75.9%</td>
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* = Lower is better

### MSHO

<table>
<thead>
<tr>
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<th>HEDIS 2016</th>
<th>HEDIS 2017</th>
<th>HEDIS 2018</th>
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</thead>
<tbody>
<tr>
<td>HbA1c Testing</td>
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<td>97.1%</td>
<td>95.5%</td>
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</tr>
<tr>
<td>HbA1c Poor Control &gt;9%*</td>
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<td>75.7%</td>
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<td>71.8%</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>76.0%</td>
<td>79.6%</td>
<td>79.2%</td>
<td>80.5%</td>
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<tr>
<td>Nephropathy Screen</td>
<td>91.3%</td>
<td>93.0%</td>
<td>93.9%</td>
<td>96.1%</td>
</tr>
<tr>
<td>Blood Pressure &lt;140/90</td>
<td>79.8%</td>
<td>76.7%</td>
<td>77.7%</td>
<td>76.6%</td>
</tr>
</tbody>
</table>

* = Lower is better
Stars Initiatives

Description

CMS uses a 5-Star rating system to assess health and drug plan quality, performance and member satisfaction. Higher star ratings can lead to the improvement in the quality of care and general health of the Medicare Beneficiaries. It supports the effort of CMS to improve the level of accountability for the care provided by physicians, hospitals and other providers, which drives quality improvements. The contracts for the stars initiatives are as follows: H2462 (Cost-MN, WI, ND, SD), H2422 (MSHO) and H4882 (Journey).

CMS publishes the Star Ratings each year to assist beneficiaries in finding the best plan for them. Reviews are published online in the Medicare Plan Finder.

Star ratings impact the Medicare Advantage quality bonus payments. Plans with higher star ratings may be able to offer increased benefits and lower premiums. There is a strong correlation between higher rated plans and enrollment which further perpetuates performance.

The significance of maintaining a higher star rating:

- It supports the Triple Aim
  - Member experience
  - Member health
  - Affordability through improvement
- Ability to retain membership and attract new membership and enroll year-round
- Higher CMS payment for Medicare Advantage Plans
- Market differentiator – HealthPartners is a top, high quality plan

Goals

The mission of the CMS Star Ratings Workgroup is to maintain 5 Star Ratings or improve measures from current levels that are lower than 5 Stars. Our objectives:

1. Establish year round strategies to ensure 5 Star Ratings or improvement to next star.
2. Identify Priority measures with key partners to determine strategies for improvement in these measures.

Initiatives/Interventions
The CMS Star Ratings Workgroup analyzed health plan performance to identify 2018 priority areas based on current rates, gap to goal and ability to effect a positive change in rates.

**Member Interventions:**

1. 2018 focus on Annual Wellness Visits. The Quality Improvement Program (QIP)-Optimize Participation and Engagement with Medicare Welcome and Annual Wellness Visits. Members received a mailing to schedule the Annual Wellness Visit to address health concerns, chronic conditions, obtain needed preventive care and an opportunity to discuss topics like those listed below.
   a. Improving or maintaining physical and mental health
   b. Staying physically active
   c. Reducing risk of falls


3. Silver and Fit benefit promoted with fall flyer.

4. Member blogs identifying preparation for appointments, prescriptions and preventing falls.

5. Prescription claims monitoring of prior authorization/STEP activity.

6. MSHO supplemental benefits include health education classes, weight management programs.

7. Members received plan health assessment mailings.

8. Maintaining Mental Health-Beating the Blues, Chronic Care Improvement Program (CCIP)-Improving Antidepressant Management in Senior Population.

9. In 2018 HealthPartners enhanced social media utilizing a new platform where communication was customized with links to blogs and customer education.
   a. Member HEDIS specific interventions
      i. Breast Cancer Screening-screen letters sent in Q1 2018, member blog posts, Q4 communication with new system
      ii. Colorectal Cancer Screening-preventive care reminder letter, continue rolling person centered system campaign, preventive care reminders on mobile and blogs, MSHO member incentive, Direct mail to member FIT kit campaign to eligible members
      iii. Osteoporosis Management in Women with a Fracture-supported the HealthPartners care group members who received follow up communication and interventions regarding the fracture
      iv. Diabetes Care-Kidney Disease Monitoring-microalbumin kits sent to eligible members, Chronic Care Improvement Program (CCIP)-Diabetic Nephropathy

**Provider Interventions:**

1. Fast Facts and Hot Sheets article highlighting annual wellness visit and the importance of falls and physical activity discussions

2. Breast Cancer Screening-HealthPartners Care Group reviewed needed screenings in the Care model process and provided outreach, Park Nicollet Flu clinic offered breast cancer screening for eligible members
3. Colorectal Cancer Screening- HealthPartners Care Group reviewed needed screenings in the Care model process and provided outreach, FIT Kit campaign coordination with HealthPartners Care Group as they also identified eligible members for FIT kits, Park Nicollet Flu clinic offered FIT kits for eligible members.
4. Osteoporosis Management in Women with a Fracture-Health Partners Care group conducted fracture follow up to facilitate bone density testing or medication prescriptions to treat or prevent osteoporosis within the 6 month timeframe.
5. Contracted provider collaboration initiated with Network and Provider Relations.

2018 Priority Measure Results

<table>
<thead>
<tr>
<th>Priority Measures</th>
<th>Cost Results</th>
<th>MSHO Results</th>
<th>Journey Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving or Maintaining Physical Health</td>
<td>69% 3</td>
<td>66% 2</td>
<td>69% 3</td>
</tr>
<tr>
<td>Improving or Maintaining Mental Health</td>
<td>88% 5</td>
<td>86% 4</td>
<td>78% 2</td>
</tr>
<tr>
<td>Monitoring Physical Activity</td>
<td>55% 4</td>
<td>53% 4</td>
<td>56% 4</td>
</tr>
<tr>
<td>Reducing the Risk of Falling</td>
<td>49% 1</td>
<td>53% 2</td>
<td>50% 2</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>83% 5</td>
<td>83% 4</td>
<td>83% 5</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>82% 5</td>
<td>83% 4</td>
<td>82% 5</td>
</tr>
<tr>
<td>Osteoporosis Management in Women Who Had a Fracture</td>
<td>22% 2</td>
<td>24% 4</td>
<td>26% 2</td>
</tr>
<tr>
<td>Diabetes Care - Kidney Disease Monitoring</td>
<td>97% 4</td>
<td>93% 2</td>
<td>94% 3</td>
</tr>
</tbody>
</table>

Color Legend: 1 Star, 2 Star, 3 Star, 4 Star, 5 Star

Health Plan Interventions:

1. HealthPartners has submitted comments to CMS regarding the member perception surveys and how they are weighted.

Assessment of Results

1. Improving or Maintaining Physical Health remained low performing for both Cost and MSHO
2. Improving or Maintaining Mental Health decreased to a 2 Star for Cost and maintained a 4 Star for MSHO
3. Monitoring Physical Activity maintained 4 Star Rating for both Cost and MSHO
4. Reducing the Risk of Falling continued 2 Star Rating for Cost but MSHO has maintained a strong 5 Star performance year over year
5. Breast Cancer Screening obtained a 5 Star for Cost and a 4 Star for MSHO
6. Colorectal Cancer Screening obtained a 5 Star for Cost and a 4 Star for MSHO
7. Osteoporosis Management in Women with a Fracture-Cost performance dropped to 1 Star, however, the rate increased but due to threshold changes there was a decrease in Star rating, MSHO population not enough data to report
8. Diabetes Care-Kidney Disease Monitoring increased to 3 Stars for Cost and 4 Stars for MSHO, this measure has a very high band threshold and due to small numbers is challenging to reach 5 Stars
   a. CAHPS and HOS Workgroup addressing the Health Outcome Survey (HOS) measures, benchmarked activities against another high performing plan on how to improve performance
   b. Direct Mail FIT Kit and Microalbumin Kit Campaign

**Barrier Analysis**

- Inability to monitor the full impact of improvement interventions on hybrid HEDIS Source Star Measures over the course of a measurement period.
- Inability to monitor impacts of improvement interventions for Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcomes Survey (HOS) Source Star Measures over the course of a measurement period.
- Difficult to focus improvement efforts for members who are not attributed to a specific care delivery system.
- Improvement targets need to be flexible as measure technical specifications and star rating cut points are updated annually.

**Opportunities for Improvement: Results/Outcomes**

<table>
<thead>
<tr>
<th>Product</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost</td>
<td>5</td>
<td>4.5</td>
<td>4.5</td>
</tr>
<tr>
<td>MSHO</td>
<td>4.5</td>
<td>4.5</td>
<td>4.5</td>
</tr>
<tr>
<td>Journey</td>
<td>NA</td>
<td>Plan too new</td>
<td>4.5 (use Cost Score)</td>
</tr>
</tbody>
</table>

**Follow-up of 2018 Actions**

- Direct mail update-approximately 31% of the unattributed Medicare population returned FIT kits
- Successful collaboration between Network Management and Provider Relations and Quality Improvement in which internal meetings established a 2019 Work Plan and Strategies to maximize incentives.
- Continued discussions with a high performing health plan regarding increasing physical activity/falls prevention

Actions for 2019 (2021 Star Ratings)
• Evaluate new Annual Wellness Visit Campaign

• HEDIS Actions
  o Continue successful member communication outreach campaigns associated with breast cancer and colorectal cancer screening
  o Continue and enhance direct to member test kit program for colorectal cancer screening, A1c and microalbumin testing
  o Collaborate with HealthPartners family of care on initiatives designed to improve performance on the Osteoporosis Management in Women with a Fracture Measure. Deploy both short and long term strategies to impact this population, develop outreach campaign for eligible members

• Health Outcome Surveys – member outreach campaign

• Contracted Provider Incentive Program – develop collaborative partnership to focus on increasing or maintaining the health of the members through Annual Wellness Visit completion and select HEDIS measure incentives

• Community Actions
  o Minnesota Community Measures will begin reporting on Osteoporosis Management in Women with a Fracture

The Stars Work Group will continue to monitor progress on efforts to positively impact Stars Measures.
HealthPartners Pharmacy Quality and Utilization Improvement (QUI) Program

Description
The HealthPartners Pharmacy Quality and Utilization Improvement Program seeks to fulfill HealthPartners mission and vision by monitoring, promoting and supporting the appropriate, safe and efficient use of high-quality and cost-effective medications by our members.

Goals
HealthPartners Pharmacy’s goals (as detailed in the 2018 QI Annual Plan) included:
- Continue innovative intervention strategies that optimize medication use
- Promote and expand Medication Therapy Management (MTM) through alternative payment models
- Continue to enhance our opioid safe use program
- Broaden collaboration with retail pharmacies to result in better quality and pharmacy results
- Support appropriate prescribing and cost management through development of de-prescribing efforts
- Support member affordability and experience through expansion of our new Rx Shopping Tool to include healthcare value information beyond medication cost
- Continue to streamline the electronic prior authorization process to improve compliance, efficiency and member/provider experience
- Develop an integrated pharmacy and health/wellness program to promote holistic care and reduce reliance on medications.
- Expand specialty pharmacy management and our specialty coupon program

Initiatives/Interventions

Medication Optimization
- Medication Optimization team which includes MTM pharmacists and Pharmacy Navigators supported our highest risk members through effective outreach and co-management with providers and other programs.
- Developed and launched an initiative to improve medication adherence in the MSHO population
- Piloted an opioid management program targeting members who filled at least two short-term opioid prescriptions in an effort to educate members about the dangers of moving from short-term to chronic opioid use

Medication Therapy Management
- MTM program continues to be active for all commercial, Medicaid and Medicare members, and continues to be fully integrated with Disease and Case Management.
- Continued the Pharmacy Partners in Excellence MTM Program which rewards pharmacy practices with high patient engagement in MTM services
- Added 4 new MTM practices to our MTM network which expanded access to services
Opioid Safe Use Program
- Added safety protocols on 7/1/2018 for commercial and Medicaid lines of business:
  - Implemented a 7-day duration limit
  - Members starting therapy with opioid medications are limited to a 14-day supply per episode. This 14-day limit is intended to allow one refill before prior authorization is needed.
  - Limited the cumulative daily dose of opioids to a maximum of 90mg MED with higher doses requiring prior authorization.
  - Added a prior authorization requirement for members newly prescribed long-acting opioid medications.
  - Removed codeine and tramadol from the formulary for children age 11 years and younger.
  - Removed codeine cough syrups from the formulary for children age 17 years and younger.

Rx Shopping Tool
- Updated Rx Shopping Tool to ensure search results are fully relevant, and initiated direct member outreach for refill reminders and savings opportunities
- Improved messaging and information in Rx Shopping Tool to enhance experience and clarity
- Added a total cost display to the tool and implemented an admin view for HealthPartners staff to support member calls

ePA
- Collaborated with PBM and electronic PA (ePA) vendors to improve ePA process, increase the percentage of PAs received electronically and develop capabilities for auto-effectuation

Pharmacy and Health/Wellness
- Conducted an intensive development process to create an integrated pharmacy wellness psoriasis program
- Research included multidisciplinary workshops, interviews with pharmaceutical manufacturers, surveying dermatologists, analysis of internal data and reviewing treatment guidelines and published literature
- Used a disciplined User Experience Research Process to create the research plan and inform program strategy development
  - Phase 1: Framing the Opportunity
    - RACI / Stakeholder Map
    - Stakeholder Interviews
    - Hypothesis Journey Map Workshop
    - Touchpoint Mapping Workshop
  - Phase 2: Patient Discovery
    - Patient interviews
  - Phases 3 & 4: Ideation and Piloting
    - Design Sprint using a Human-Centered Design Process
- Launched Facebook Campaign in third quarter to drive readers HealthPartners educational content regarding psoriasis

Specialty Pharmacy Management
• Launched and expanded a program at several key specialty pharmacy partners to ensure that member accumulators accurately reflect the true out-of-pocket costs paid by members
• Developed and implemented new oncology drug therapy peer-review program in partnership with key providers in HealthPartners’ network to ensure consistency in the care provided to HealthPartners members and to improve member experience
• Added additional high-cost specialty medications to the site of care program to ensure medication use occurs at the most appropriate and cost-effective level of care
• Continued the Hepatitis C Medication Optimization Outreach Program in which Pharmacy Navigators and MTM Pharmacists provide outreach to all members undergoing hepatitis C treatment so that the health plan can address and remove any barrier(s) to compliance and provide support with coordination of care to ensure the best result possible

**Barrier Analysis**

• Member engagement in MTM services is improving, but a continued challenge is a lack of awareness among members about what MTM is and how it differs from the services provided by their other care team providers. A common comment heard from members is “my doctor already does this [reviews medications]”, so there is a lack of understanding about the benefits of participating in MTM.

• Development of baseline and target rates for the updated MTM Partners in Excellence Program was difficult due to lack of data submitted by network providers in the past and unclear forecast for how data submission rates might change in the first year of the updated program.

• The partner pharmacy with whom HealthPartners collaborated for the pay-for-performance program found that members were uninterested in and/or unwilling to take their blood pressure in the pharmacy.
  o Low engagement in monitoring blood pressure is a nationwide issue, and HealthPartners will continue to include this as a component to future pay-for-performance pharmacy programs to incentivize innovation and member engagement.

• In the ambulatory setting, pharmacists face challenges regarding stereotypes and expectations about what a pharmacist should do and how much they should or can be involved in caring for patients in partnership with the rest of the care team.

• Improvement on the MSHO CMS Star Rating for ACEI/ARB adherence was difficult due to small denominator (few members) and a significant portion of members residing in long-term care facilities where hypertension medications are started and stopped based on renal function, leading to seemingly low adherence.

• Volume of Prior Authorization requests for opioid medications increased following implementation of the new limits
  o Temporary mandatory overtime for some employees was used to ensure timely review of all requests.

• Complaints were received from both members and providers regarding the new opioid limits.
  o Members and providers with complaints were educated about the rationale for the new limits – to improve safety via reduction in amount of opioids dispensed into the community.
• Pain clinic providers felt the new opioid limits should not apply to them.

• Resource/capacity challenges and the ultra-high cost of certain medications and gene therapies were significant challenges faced by the Specialty Pharmacy team and required new innovative management strategies and payment methodologies.

• HealthPartners contracted with external sources of drug pipeline expertise to better forecast arrivals of new expensive therapies.

• An interdepartmental process was developed to manage newly-launched expensive medications.

• Contract language was modified to provide better clarity to members and to direct to key opinion leaders.

Gaps in Care

Opioid prescriptions written by oncology providers required manual approval from HealthPartners due to lack of an automated way to approve such claims

• An automated method is being developed with goal implementation on 4/1/2019

Multiple members with previously-undiagnosed hypertension were identified in our pharmacy pay-for-performance partnership, highlighting the need for regular health screenings to identify members who may have a health concern about which they are unaware

Adherence issues with Hepatitis C medications

• The Hepatitis C Medication Optimization Outreach Program continues to work to address this issue with each member on Hepatitis C medications

Previous lack of input from oncology professionals in the implementation of utilization management criteria for oncology medications

• This was addressed by HealthPartners new oncology drug therapy peer-review program

Opportunities for Improvement: Results/Outcomes

Medication Optimization

• The initiative to improve adherence in the MSHO population showed only modest success due to reasons described in the “Barrier Analysis” section above. Preliminary data shows an adherence rate of 85% in 2018 compared to the final rate of 84% in 2017.

• HealthPartners CMS Star Rating for adherence to statins in 2018 was 5 stars for all Medicare plans.

<table>
<thead>
<tr>
<th>Plan</th>
<th>2017 Rate</th>
<th>2018 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freedom</td>
<td>88%</td>
<td>89%</td>
</tr>
<tr>
<td>MSHO</td>
<td>84%</td>
<td>85%</td>
</tr>
<tr>
<td>PDP</td>
<td>87%</td>
<td>87%</td>
</tr>
<tr>
<td>Journey</td>
<td>n/a</td>
<td>89%</td>
</tr>
<tr>
<td>HPUPH</td>
<td>84%</td>
<td>84%</td>
</tr>
</tbody>
</table>

• Antidepressant and Cholesterol 6-month persistency rates for all lines of business:
Adherence to Asthma Controller Medications and Oral Hypoglycemic (diabetes) Medications for all lines of business:

- The 2018 Pharmacy Partners in Excellence MTM Program yielded positive results. Awards were distributed in November 2018.
  - 3 MTM practices met target for Gold award (at least 40% of target members engaged in MTM)
  - 2 MTM practices met the target for Silver award (at least 25% of target members engaged in MTM)
- CMS Star Ratings “MTM Program Completion Rate for CMR” remained high at 75% for Cost and 86% for MSHO
- HealthPartners-employed MTM pharmacists had 7,867 visits in 2018
- Health plan MTM visits increased from 11,351 visits in 2017 to 14,709 visits in 2018, an increase greater than 29%
- MTM visits provided by MTM network providers increased from 4,650 in 2017 to 6,842 in 2018, a 47% increase
- Member engagement in MTM increased from 15% of targeted members in 2017 to 18.5% in 2018
- Satisfaction with MTM program remains high: over 98% of patients are willing to recommend

Medication Therapy Management

Opioid Safe Use Program
• From 1Q2016 through 4Q2018, the rate of chronic high dose (>= 120 mg MED) opioid use among HealthPartners members has decreased 45% for all lines of business combined (52% decrease for commercial only).

• Through 2018, the rate of chronic high dose (>= 90 mg MED) opioid use has decreased significantly, from 0.8 per 1,000 members in first quarter to 0.61 per 1,000 members in fourth quarter. Rates are broken out by line of business below:

![Rate of Chronic High Dose Opioid (>= 90 mg MED) - Mbr per 1000 mbrs](image)

• Among HealthPartners members receiving their first fill of opioid medication (i.e., no prescriptions for opioids were filled in the preceding 120 days), there is an increasing percentage who are receiving low quantities (i.e., fewer than 20 tablets). In 1Q2017, only 56% of members were receiving low quantities; that percentage has improved to over 67% in 4Q2018.

![Percent of Members whose First Opioid Fill Quantity was < 20 Units](image)

**Retail Pharmacy Collaboration**

• The 2018 Pharmacy Partners in Excellence Program yielded positive results. Awards were distributed in November 2018.
  
  o Antidepressant Medication Persistency:
    ▪ 2 pharmacies met the target for Gold award (at least 70% of members persistent)
    ▪ 3 pharmacies met the target for Silver award (at least 65% of members persistent)
  
  o Asthma Medication Adherence:
    ▪ 4 pharmacies achieved Gold award (at least 65% of members adherent)
    ▪ 2 pharmacies achieved Silver award (at least 55% of members adherent)
  
  o Diabetes Medication Adherence:
    ▪ 3 pharmacies achieved Gold aware (at least 90% of members adherent)
- 3 pharmacies achieved Silver award (at least 86% of members adherent)
  - Cholesterol Medication Persistency:
    - 4 pharmacies achieved Silver award (at least 62% of members persistent)
- The collaborative pay-for-performance program between HealthPartners and a mid-size regional pharmacy chain resulted in impressive outcomes for quality and affordability:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline Rate</th>
<th>End Rate</th>
<th>% Change</th>
<th>Target rate to achieve payment</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Dispensing Rate</td>
<td>91.9%</td>
<td>92.7%</td>
<td>0.7%</td>
<td>92.4% (0.5% increase)</td>
<td>Target MET &amp; Exceeded – pharmacy achieved payment</td>
</tr>
<tr>
<td>Formulary Adherence Rate</td>
<td>85.4%</td>
<td>88.6%</td>
<td>3.2%</td>
<td>86.4% (1.0% increase)</td>
<td>Target MET &amp; Exceeded – pharmacy achieved payment</td>
</tr>
<tr>
<td>Statin Use in Persons with Diabetes</td>
<td>75.2%</td>
<td>79.8%</td>
<td>4.6%</td>
<td>77.2% (2.0% increase)</td>
<td>Target MET &amp; Exceeded – pharmacy achieved payment</td>
</tr>
<tr>
<td>Blood Pressure Engagement</td>
<td>n/a</td>
<td>14%</td>
<td>14%</td>
<td>10%</td>
<td>Target MET &amp; Exceeded – pharmacy achieved payment</td>
</tr>
</tbody>
</table>

**ePA**
- The electronic submission of prior authorizations was high throughout 2018, and the percent of all PA requests that were received by electronic means was significantly greater than 2017. See below for approximate volumes of ePA requests and approximate percentage of PA requests that were received via electronic submission in 2017 and 2018:
Pharmacy and Health/Wellness

- At least 8 stakeholder interviews were conducted
- At least 14 participants from at least 7 different departments for Hypothesis Journey Mapping Workshop
- At least 13 participants from at least 9 different departments for Touchpoint Mapping Workshop
- At least 6 interviews were conducted with psoriasis patients
- Prototype developed during design sprint was tested by 10 psoriasis patients

Specialty Pharmacy Management

- The Site of Care Program resulted in $13.7 million in savings with an average of $7,837.71 per impacted member. Savings were achieved via:
  - Movement of 623 members to a more appropriate and cost-effective site for medication administration, saving $2.6 million
  - Re-contracting with hospitals, impacting 410 members and saving $7.2 million
  - Re-contracting with professionals, impacting 1235 members and saving $3.8 million
- The Hepatitis C Medication Optimization Outreach Program engaged 295 members engaged, with 93.9% completing their course of therapy and 96% achieving a sustained virologic response (SVR).
- An example of the new oncology drug therapy peer review program:
  - Rather than denying coverage and/or requiring that the health plan directly connect with the provider in order to make the coverage decision, HealthPartners followed the oncology specialist’s recommendation and approved a 1 month supply of medication for a member with aggressive breast cancer. Compassionate care for the drug (coverage
from the manufacturer) was then sought. This new process improved care for the patient and provided value to the patient and prescriber.

- In 2018, there were 8,942 specialty pharmacy claims which processed through the new program for improving member accumulator accuracy. This program led to changes in member accumulator calculations which improved accuracy for 625 members.

**Sustaining our Improvement: Actions for 2019**

To sustain and improve upon current results, Pharmacy Administration has the following activities planned for 2019.

- Pilot a plan to improve MTM participation
- Enhance MTM Partners in Excellence pay-for-performance program with a new focus on clinical outcomes
- Implement a processes to enhance opioid management for Medicare members starting 1/1/19:
  - Remove OxyContin / oxycodone ER from formulary
  - Implement a safety alert for new opioid users which limits therapy to a 7-days supply. Safety alerts stop the pharmacy claim at the pharmacy, allow the pharmacist to assess the member and medication, and can be overridden if/when the pharmacist provides additional information.
  - Implement a safety alert addressing a member’s concurrent use of opioids and benzodiazepines when prescribed by multiple providers. These safety alerts can be overridden if/when the pharmacist provides additional information.
- Finalize development of a case management and member restriction program for select Medicare members using opioids.
Safety

Description

HealthPartners is committed to eliminating harm due to error in the delivery of medical care. Hospital safety is addressed by many organizations such as The Leapfrog Group, The Agency for Healthcare Research and Quality, and The Joint Commission. However, less research has focused on patient safety in the ambulatory setting, including group practices, yet members are receiving the greatest proportion of their care in these settings.

Safe patient care is a very important issue for our organization. We recognize that errors occur during medical care of patients, and that these are a source of significant suffering, illness, cost, and death. A “culture of patient safety” is an essential ingredient of the safe health care organization.

Goals

HealthPartners will demonstrate its commitment to reducing errors for our members and patients wherever they receive care by:

- Enhancing the knowledge base about safety through our experience and by formal research
- Supporting care delivery systems by establishing standards and expectations related to safety
- Working collaboratively with government and private groups to improve safety
- Establishing safety measures and reporting results to members physicians and practitioners
- Training health care professionals to be competent in health care practices that improve patient safety

Initiatives/Interventions

- The Ambulatory Patient Safety Toolkit was revised and updated with current materials. It is available at healthpartners.com
- Completed an annual assessment of member safety, communication of safety improvement opportunities to providers and updates to safety improvement tools
- Implemented a comprehensive approach to pain management
- A voluntary safety survey was sent to 54 primary and obstetrics (OB) provider groups to assess the status of safety initiatives within the clinic setting
  - 23 groups responded
- Safety indicators are incorporated in the measures that define the tiered provider networks for member informed decisions about network selection
- The MTM program was expanded to include Park Nicollet Health Services clinics; this improves coordination of care and medication safety
- Improve strategies to minimize the use of drugs of abuse, including a continued focus on pain management
- Distributed Agency for Healthcare Research and Quality (AHRQ) Patient Safety indicator comparative results to hospitals
- Sent alerts to providers whose prescribing dosages appeared to be outside of safe limits
- Identified and initiated interventions for overprescribed medications and diversion, such as quantity limits and enhanced prior authorization review requirements
- Identified high-risk medications in the elderly and initiated interventions through the MTM program
- Identified members using medications newly identified with Food and Drug Administration (FDA) safety concerns and sent safety alerts
- Provided incentives and structural strategies to encourage generic use and appropriate antibiotic prescribing
- Addressed e-prescribing and pharmacy integration with EMR through questions on the Health Information Technology (HIT) survey, with results included in the 2018 Clinical Indicator Report
- Worked to improve patient understanding of health information by reviewing and simplifying patient education materials, letters, and forms across care delivery clinics and hospitals
- Regions & Methodist Hospitals continue to use the “teach-back” technique to confirm patient understanding
- Continue to utilize “Keep It Simple” - a glossary of preferred terms to use in member and patient communications
- Prioritized key communications for updates to improve member understanding
  - Successfully revised about half of the communications on our prioritized list to date.

**Barrier Analysis**

HealthPartners identified three key barriers to patient safety; member awareness and knowledge of best safety practices, practitioner knowledge and use of improved systems to ensure safe care is delivered.

**Member knowledge:**

- Physicians and practitioners are encouraged to use the ICSI guidelines and other health plan endorsed guidelines as a resource and encouraged to recommend the clinical guidelines for patients to review, which can be accessed on the ICSI web site
- Safety tools are available through the Drug Interaction Checker and the Health Information Library online at healthpartners.com

**Practitioner knowledge:**

- New and revised ICSI guidelines, pharmacy alerts and Clinical Indicators Report are shared with practitioners via electronic provider communications
Electronic prescribing prompts are used whenever possible to steer practitioners to safe and effective first-line medications

**Systems issues in the organization:**

- Quality of care issues involving safety are shared with involved physicians and practitioners and, if warranted, an action plan is requested
  - Tracking/trending of quality of care concerns is routinely done to identify areas requiring follow-up
- HealthPartners has been a key partner in the development and support of the Minnesota Health Information Exchange; resulting in a statewide source of translated documents providing information on patient medications, easing the task of medication reconciliation and improving information availability across different care systems
- HealthPartners has worked to assure clear communications through support and delivery of interpreter services and programs to address low health literacy

**Opportunities for Improvement: Results/Outcomes**

HealthPartners’ MTM Program continues to show a high level of patient satisfaction with 98% willing to recommend (agree and strongly agree) our MTM pharmacists in 2018.

HealthPartners members use their pharmacy benefits more often than any other benefit offered by the health plan. HealthPartners has multiple programs to ensure appropriate prescribing. As such, pharmacy measures represent comprehensive and broad-based measure of overall patient safety. Pharmacy measures help the plan monitor efforts to reduce inappropriate care (treatment for children with upper respiratory infection), ensure best treatment practices are followed (antidepressant medication management) and reduce the potential for harm (harmful drug/disease interactions).

### HEDIS Results

<table>
<thead>
<tr>
<th>Commercial</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment for Children with Upper Respiratory Infection</td>
<td>91.6%</td>
<td>90.4%</td>
<td>No results</td>
</tr>
<tr>
<td>Appropriate Treatment for Children with Pharyngitis</td>
<td>94.3%</td>
<td>94.5%</td>
<td>96.2%</td>
</tr>
<tr>
<td>High-Risk Medications in Elderly (one drug)* – lower rate is better</td>
<td>No results</td>
<td>No results</td>
<td>No results</td>
</tr>
<tr>
<td>Harmful Drug-Disease Interactions in Elderly (total)* – lower rate is better</td>
<td>No results</td>
<td>No results</td>
<td>No results</td>
</tr>
<tr>
<td>Monitoring Patients on Persistent Medications (total)*</td>
<td>84.0%</td>
<td>83.5%</td>
<td>84.3%</td>
</tr>
</tbody>
</table>
### HEDIS Results

**PMAP**

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Treatment for Children with Upper Respiratory Infection</strong></td>
<td>96.1%</td>
<td>95.3%</td>
<td>95.3%</td>
</tr>
<tr>
<td><strong>Persistence of Beta-Blocker Treatment after a Heart Attack</strong></td>
<td>82.1%</td>
<td>NA</td>
<td>85.7%</td>
</tr>
<tr>
<td><strong>Antidepressant Medication Management (Effective acute phase)</strong></td>
<td>51.7%</td>
<td>49.8%</td>
<td>52.5%</td>
</tr>
</tbody>
</table>

**Medicare Cost**

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Persistence of Beta-Blocker Treatment after a Heart Attack</strong></td>
<td>94.7%</td>
<td>No Results</td>
<td>No Results</td>
</tr>
<tr>
<td><strong>Antidepressant Medication Management (Effective acute phase)</strong></td>
<td>83.2%</td>
<td>81.0%</td>
<td>81.6%</td>
</tr>
</tbody>
</table>

**MSHO**

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Persistence of Beta-Blocker Treatment after a Heart Attack</strong></td>
<td>90.0%</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td><strong>Antidepressant Medication Management (Effective acute phase)</strong></td>
<td>71.9%</td>
<td>79.5%</td>
<td>74.3%</td>
</tr>
<tr>
<td><strong>High risk meds one drug:</strong></td>
<td>12.7%</td>
<td>19.1%</td>
<td>18.7%</td>
</tr>
<tr>
<td><strong>Harmful drug disease interaction</strong></td>
<td>40.8%</td>
<td>43%</td>
<td>45.7%</td>
</tr>
<tr>
<td><strong>Annual monitoring of persistent meds:</strong></td>
<td>96.4%</td>
<td>95.3%</td>
<td>96.4%</td>
</tr>
</tbody>
</table>

*NA Insufficient sample size

### Patient Experience – Medication Safety (2016 – 2018 Member Surveys)

- How satisfied were you with your clinic on explanations you received about the reason for any prescribed medicines?
- How satisfied were you with your clinic on information you received about any side effects of your medicines?
### Member Survey Results Regarding Prescribed Medications:

<table>
<thead>
<tr>
<th></th>
<th>Consumer Choice (Primary Care)</th>
<th>Cardiology</th>
<th>ENT</th>
<th>OB/GYN</th>
<th>Orthopedics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
<td>2016</td>
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<td>2017</td>
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<tr>
<td></td>
<td>2018 Retired</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Percent Very Satisfied</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>2016</td>
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<td>2017</td>
<td>2018</td>
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</tr>
<tr>
<td></td>
<td>2018 Retired</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explanations about Reason for</td>
<td>47.2%</td>
<td>60%</td>
<td>57%</td>
<td>70%</td>
<td>61%</td>
</tr>
<tr>
<td>Prescribed Medication</td>
<td>39%</td>
<td>64%</td>
<td>63%</td>
<td>74%</td>
<td>66%</td>
</tr>
<tr>
<td>Information about Side Effects</td>
<td>34.5%</td>
<td>54%</td>
<td>48%</td>
<td>60%</td>
<td>56%</td>
</tr>
<tr>
<td></td>
<td>33%</td>
<td>56%</td>
<td>58%</td>
<td>67%</td>
<td>60%</td>
</tr>
</tbody>
</table>

The above results vary across specialties with OB/GYN providers achieving the highest results and primary care providers the lowest. This indicates an opportunity for the health plan to focus efforts on assisting select types of providers with best practice communications.
Admissions and Readmissions Withholds

Description

Avoidable hospital admissions and readmissions are a leading driver of health care costs. These rates remain higher in the Medicaid population compared to the Commercial population. HealthPartners closely monitors these measures and builds them into our provider reimbursement methodologies, including our total cost of care model. Since 2012, the Department of Human Services (DHS), per state legislation, has identified these as improvement measures for the managed care organizations that provide Medicaid and MinnesotaCare services, and they are contractual financial withholds. HealthPartners has implemented numerous initiatives designed to reduce avoidable hospital admissions and readmissions and thus achieve our withhold, but more importantly, to improve the health of the members we serve.

Goals

HealthPartners analyzes our performance to understand the trends and drivers behind our hospital admission and readmission rates and identifies strategies to reduce these rates. To receive a full return on the withhold for 2018, we needed to achieve a five percent reduction from our 2017 rates. DHS will provide 2018 withhold performance in July 2019. DHS will conclude the financial withhold when we achieve a 25 percent reduction from our 2011 baseline rates.

<table>
<thead>
<tr>
<th>Withhold</th>
<th>2011 Baseline</th>
<th>2013 Rate</th>
<th>2014 Rate</th>
<th>2015 Rate</th>
<th>2016 Rate</th>
<th>2017 Goal</th>
<th>2017 Rate</th>
<th>2018 Rate*</th>
<th>25% Reduction Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admission Rate/1000</td>
<td>3.33</td>
<td>3.2</td>
<td>3.19</td>
<td>3.81</td>
<td>2.82</td>
<td>2.68</td>
<td>2.96</td>
<td>2.87</td>
<td>2.50</td>
</tr>
<tr>
<td>30-Day Readmission Percentage</td>
<td>9.44</td>
<td>10.22</td>
<td>11.46</td>
<td>10.27</td>
<td>11.76</td>
<td>11.17</td>
<td>11.53</td>
<td>11.77</td>
<td>7.08</td>
</tr>
</tbody>
</table>

*January 2019 DHS preview data.

HealthPartners Health Informatics department tracks admission rates monthly through the Hospital Services Monitoring Report which attempts to replicate the measure based on the DHS Technical Specifications. DHS provides us with preliminary data quarterly, and we receive our final data in June of the following year, in this case June 2019.

Initiatives/Interventions

Efforts to decrease hospital admissions and readmissions continue to be a challenge for HealthPartners. HealthPartners senior leadership established a workgroup to examine admission and readmission trends, conduct root cause analysis, identify opportunities for improvement and determine next steps.
Our findings show that the social determinants of health directly impact utilization of services, including admissions and readmissions. There has been significant research in this area and the workgroup felt it is important to note that impact, especially among our Medicaid membership. In addition, as a health plan, we under-utilize our own internal member support resources such as care coordination and MTM services.

Overall, the collaboration between the health plan and our care system to identify high risk members who may be at risk for hospitalization or re-hospitalization is an opportunity to impact this measure. The group examined all current initiatives and made recommendations for additions or enhancements as appropriate.

- **Disease & Case Management (DCM) Services:** Members identified for DCM services include those with complex medical conditions or poorly managed chronic conditions that are at high risk of future hospitalization. Our goal is to improve member self-management of their complex or chronic conditions, thereby reducing risk of future admissions including readmissions. Toward that end, DCM uses the following targeted interventions:
  
  - Post-discharge support for all members participating in DCM services who experience a hospital admission
  - Connection to Medication Therapy Management (MTM) services for members with complex medication regimens or medication adherence concerns
  - Assessment and care planning with interventions tailored to address the member's unique needs, barriers, and identified clinical gaps in care
  - Close collaboration with care team members including PCPs and health care home nurses, home care providers, MTM/pharmacy resources, and community based providers
  - Collaboration with Regions Care Management to facilitate identification and engagement of members hospitalized at Regions Hospital.
  - Inpatient Case Management services to support real time identification and engagement of high risk members to ensure milestones and care plans are implemented before discharge.
  - Hospital Case Managers refer members to MTM for medication review when appropriate following discharge to ensure medication reconciliation and patient understanding of any medication changes. The Regions Case Management department increased referral goals for HealthPartners Medicaid members to a goal of 60 referrals per month. They met this goal in 9 months in 2018.

- **Total Cost of Care (TCOC) Arrangements:** HealthPartners long-term strategic initiatives are based on the three dimensions of the Triple Aim; health, experience, and affordability as measured by the TCOC. HealthPartners trend management approach is built on a strong foundation of programs that are designed to reduce overuse and misuse of resources and to improve the value of the services provided to our members. We are continuously working to identify new opportunities to capture TCOC savings.

2018 Quality Improvement Annual Evaluation 46
• **Provider Interventions**: HealthPartners Medical Group (HPMG) and Park Nicollet Clinics receive daily discharge notifications from hospitals. They have implemented outreach processes for post-discharge calls with patients. Care delivery uses an algorithm to identify those who may be at especially high risk for readmission to prioritize patient calls and ensure they are scheduled for follow-up with their clinic in a timely manner. Engagement with the highest risk members continues to be a challenge.

• Park Nicollet care system implemented a text-first communication approach to reach patients following discharge. A text message is sent via a texting platform and asks a series of automated questions to help assess a patient’s risk for readmission. Based on the patient’s answers, the platform automatically notifies the care team of their responses and nurses prioritize those who need attention.

• The HPMG/Park Nicollet care system embedded a predictive analytics tool into Epic in May of 2018. Risk of Unplanned Readmission alerts assist in identifying patients who are at risk of readmission by looking at the following components: age, demographics, diagnosis, medications, order type lookback, lab lookback and utilization. Inpatient case managers document readmission risk in a note prior to discharge for access by the clinic team.

• Network clinics and hospitals are using Community Paramedics (CPs) and EMTs to conduct home visits to support the member after discharge and reduce the likelihood of readmission. CPs are experienced 911 paramedics with additional education to provide non-emergency care to patients and help manage chronic conditions. At Regions and Lakeview hospitals, orders for the CP program are made through the EPIC system. The current diagnoses that can be referred to the CP Program include CHF, COPD, AMI, pneumonia and stroke. As the benefits of these visits are recognized, the diagnoses that are targeted for visits continue to expand. Partnerships with Community Health Workers allow additional needs to be addressed. Priority is given to HealthPartners insured members. **CP Home visits** include:

  o Measurement of vital signs
  o Performing physical exams
  o Reviewing upcoming appointments or assistance with scheduling follow up
  o Medication reconciliation, education, and compliance checks
  o Connecting patients to community resources
  o Conducting home safety assessments
  o Reinforcement of dietary recommendations

Methodist Hospital’s “Good to be Home” program partners with several local fire departments for a one-time post-discharge visit by an EMT.

  o Perform blood pressure check, and ask you basic questions about health
  o Review medications and physician instructions
  o Reviewing upcoming appointments or assistance with scheduling follow up
  o Ensure access to food and transportation
  o Conducting home safety assessments
  o Replace smoke alarms or batteries as needed
• HealthPartners Community Senior Care program offers care for seniors where the patient is located – in their home, a nursing home, transitional care center or assisted living center.
  o Care at Home sends medical teams to the home of MSHO and Medicare Advantage patients at risk of readmission. The care team includes both an advance practice nurse as well as MDs.
  o To reduce readmissions due to symptom management, care teams ensure that comfort care is provided after discharge at the location the member is going to reduce the likelihood they will be readmitted for symptom or pain management. The medical team works with the staff at the TCU or nursing home to provide the appropriate level of symptom management.

**Barrier Analysis**

A multi-departmental work group reviewed and analyzed HealthPartners member admission and readmission data. This included review of reports that analyzed utilization, intensity, and top conditions. The work group met to review the data, each time with more robust data analytics. Overall, the inpatient utilization trend and top conditions affecting this trend change each year, and sometimes quarterly, so it is difficult to implement policy changes, outreach or interventions designed to impact specific conditions which may be driving trend.

- Member access, preference, and education are barriers to engaging in care. Members may avoid preventive or chronic care maintenance until a health issue has escalated to the point of hospitalization. HealthPartners continues to conduct member education and outreach regarding preventive care and appropriate ED use.

- We review every admission for members involved in complex case management to identify if there was a point when we could have taken action to improve the outcome and avoid the admission. Case Managers also work with members who are having planned admissions to ensure that transitions into the hospital and home again go as smoothly as possible. This transition planning includes medication reconciliation, communicating with the primary care provider or other specialists and assisting with accessing and coordinating additional home resources.

- A chart review of members involved in complex case management who experienced a readmission were examined for missed opportunities. Limited trends were apparent, and the review confirmed that missing a primary care follow-up visit did not appear to be a driver of readmissions for these members.

**Gaps in Care**

Post-discharge follow-up and care is crucial to reduce the 30-day readmission rate. This is a focus for members participating in DCM services. Additionally, for the broader population work is already being done with community paramedics, fire fighters, and Population Health nurses at the clinics and hospitals. Inpatient Case Managers work to increase the coordination between the health plan and our hospital providers to ensure a smooth transition from inpatient to home to decrease potential readmissions. In addition, to improve care coordination, our hospital case managers can access risk-stratified patient data.

**Opportunities for Improvement: Results/Outcomes**
Our DHS preliminary results as of January 2019 [for 2018] show our admissions rate at 2.87/1,000 and our 30-day readmission rate at 11.77%. We will continue our internal monthly monitoring of 2018 results with claims run out. We will receive the final report in June of 2019 from DHS which will include full claims run out.

**Admissions Data:**
Our internal monitoring report shows our Medicaid admissions trend at 41.87 for 2018. This is a 5% decrease from the 2017 rate of 44.08 and we are optimistic about the return of a significant portion of this withhold.

<table>
<thead>
<tr>
<th>Admissions / 1,000 members</th>
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</thead>
<tbody>
<tr>
<td>Admit Ty.</td>
</tr>
<tr>
<td>Total admits</td>
</tr>
<tr>
<td>2016</td>
</tr>
<tr>
<td>2017</td>
</tr>
<tr>
<td>2018</td>
</tr>
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</table>

**Readmissions Data**
In 2018, 509 Medicaid members participating in DCM services were hospitalized for a total of 322 admissions. 78 of the 322 admissions were readmissions within 30 days (all cause) yielding a readmission rate of 24.22%, an increase in the 30 Day All Cause Readmission rate from 2017 of 21.2% for members engaged with our DCM services.

Members participating in DCM services are at high risk of readmission due to their complex medical needs. DCM nurses report high rates of scheduled readmissions for follow-up procedures within this population. At this time, we are unable to reliably distinguish scheduled versus unscheduled readmissions in our data.

In addition to providing post discharge support to members, DCM nurses collaborate with the care team members and the DCM Medical Director for all members experiencing readmissions. DCM nurses review and update each member's care plan to address any gaps or barriers.

**Sustainability of the Activity**
Our internal monthly hospital services report provides ongoing results and analysis. More detailed analysis will occur as triggered by these reports. The work groups will continue to monitor trends in admissions and readmissions and adapt interventions to respond as needed.
Emergency Department Utilization

Description

Non-urgent use of ED services is a recognized problem, driving high health care costs and preventing continuous primary care. The lack of coordination and continuity of care between EDs and PCPs can lead to lack of follow-up care, redundant testing, and even medical errors. HealthPartners data suggests that 70% of all ED visits fit the categories of either non-urgent or primary care treatable. In addition, some members have a pattern of repeat ED use for non-urgent care.

Ensuring that members use a site of care that is appropriate for their condition is directly related to all three objectives of the Triple Aim. Coordination of care and access to the right care at the right time will promote health and improve the member’s quality experience. By providing the best care in the most appropriate site, costs reflect care received.

To address this issue, HealthPartners implemented a multi-pronged approach that addresses the key drivers of avoidable ED visits, while encouraging members’ use of services in an appropriate setting and developing a relationship with a PCP.

Goals

The goal of this project is to decrease non-urgent ED use among all populations with additional emphasis on public programs members

- Reduce avoidable ED visits, to achieve an overall 25% reduction in ED visits to meet the DHS withhold
- Educate members about where to go for care
- Improve access and availability of alternative services
- Create care strategies to reduce avoidable ED visits

Initiatives/Interventions

HealthPartners initiatives focus on three key areas: member education, improving access to primary care, and initiating innovative care strategies.

Member Education

In 2012, our CAHPS scores showed that over 25 percent of Medicaid members did not know where they should go for after-hours care. To address this lack of awareness, HealthPartners launched a member education and communication campaign in partnership our clinics and community organizations. Using an algorithm developed by New York University (NYU), we identified members with low intensity ED claims or were related to problems that could have been treated in primary or urgent care settings. Members who had two or more low-intensity visits received an outreach call from a nurse. This program continued until late in 2017, when we changed from this reactive approach to educating members about the best location of care to a more proactive approach.
Currently HealthPartners utilizes micro-segmentation analysis to identify members who are at high risk of potentially using the ED and develops personalized messages to educate them prior to ED use.

- In 2018, we deployed two micro segmented communication strategies to members who are likely to use the emergency room – one to members who are more likely to choose the urgent care and one to members who are more likely to try virtuwell as a replacement to the ED. A total of 178,203 households received one of these mailings.

- The Urgent Care message includes information about the closest Urgent Care to their home address and is tailored with a sample condition that they are likely to seek care for – such as an ear infection or back pain.

HealthPartners offers the book, *What To Do When Your Child Gets Sick* to local public health partners. They distribute it to clients at home visits and provide education on how the book can help them make appropriate decisions about their child’s care.

- CareLine is HealthPartners’ 24 hour a day, seven days a week nurse advice line. Many members are unaware of CareLine services or that CareLine nurses will help them make decisions about the best place to go for care.

  - HealthPartners developed multiple CareLine promotions to educate members about the support provided and how to access it. For example, we send new mothers a postcard introducing them to a CareLine nurse specially trained about the needs of new parents and encouraging parents to contact the nurse with questions.

  - Sometimes CareLine nurses encourage members to visit the ED as the most appropriate option for their care needs. Following these ED referrals, nurses contact the family to understand the outcome of the visit and assist with any needed follow-up.

  - We utilized CareLine nurses to call members who have more than one low-intensity visit to the ED within three months. The goal of the nurse calls was to offer advice on alternatives to ED care, educate the member on the importance of establishing a primary care relationship and answer questions. Analysis of the effectiveness of this program could not be validated based on the measures identified, so this intervention was discontinued at the end of 2017.

- Community education is a valuable component when working to change behaviors that have been normalized over a long period of time or when a member is new to the healthcare system and unsure how to get the care they need. HealthPartners has collaborated with community organizations to share key messages and reach those who are connected to those organizations.

  - Medicaid members have unique social and cultural-specific needs. Community Health Navigators (CHNs) are a proven strategy to effectively address various socioeconomic determinants of health of Medicaid and other hard-to-reach populations. Located onsite at Midway and Maplewood clinics, HealthPartners two CHNs provide face-to-face visits - both onsite and in the home - to members attributed to St. Paul, Midway, Center for International Health and Maplewood clinics. With an emphasis on improving connections between Medicaid members and their Primary Care Provider, this program aims to decrease avoidable ER use, increase use of Primary Care Clinics, and increase adherence to
Primary Care follow-up. The CHW received training on the *What to Do* book and shares the information with the families she works with.

- HealthPartners distributes a “Resources at Your Fingertips” guide that includes Member Services, CareLine and virtuwell contact information so members can easily seek advice. We share the guide at health fairs, clinics and in the Regions ER.

**Improve Access**

- HealthPartners recognizes that many people choose the ED at times when clinics are open because it is more convenient not having to schedule an appointment. To address this behavior, HealthPartners worked to make clinic visits easier to access.
  - A Nurse Practitioner at the HealthPartners Medical Group St. Paul Clinic offers walk-in care. The clinician treats a wide range of common conditions that patients would want same day access for, but do not rise to the level of needing an ED. We initially promoted this option by mail to all Medicaid members in the surrounding area. ED case managers, our Children’s Hospital partners, as well as other HPMG clinics also helped spread the message.
  - In 2018, thirteen HPMG clinics extended their hours to create more unscheduled access.

- virtuwell is HealthPartners’ on-line care provider, available 24 hours a day, seven days a week. Members can access virtuwell instantly without an appointment and certified nurse practitioners typically provide treatment plans within just 30 minutes. We promote this care delivery option in member materials and in a variety of plan communications and have seen steady increases in usage.

**Care Strategies**

Minimizing the dangers of fragmented care communication between our partner EDs and our network clinics is a health plan priority.

- Regions Hospital, Children’s Hospitals and Clinics and Methodist Hospital have implemented communication between their ED and HPMG and Park Nicollet Clinics. The hospitals electronically share ED visit summaries including the reason the member sought care and the ED discharge instructions with the patient’s PCP. Each clinic proactively contacts the member to schedule appropriate follow-up care.

- Regions Hospital expanded this discharge notification to include select community clinics and more are being added to expand this initiative.

- The health plan created an educational tool for residents at Regions on the efforts around appropriate ER use, education on PMAP and Restricted Recipients so residents.

**Barrier Analysis**

- EDs offer “fast track” care to low-intensity patients, making the wait times shorter for those members and limiting the inconvenience factor. These disparate priorities between segments of the health care system send mixed messages to members.
- Member perception that care received in the ED is higher quality than care received in a primary care clinic
- Lack of convenient appointments and keeping scheduled appointments can be a barrier for some members – particularly younger members who seek immediate results
- Lack of member knowledge concerning the kinds of services urgent care clinics and convenience clinics offer
- Lack of member knowledge of locations of urgent care and hours of operation
- Lack of knowledge on when it is appropriate to seek care in the ED and when to seek other options for care
- Members are not asked for payment at the ED, making the cost of care a non-issue

**Opportunities for Improvement: Results/Outcomes**

By targeting interventions to those areas where the greatest impact can be seen, we have achieved a reduction in our low-intensity ED use as well as the overall rate of ED use.

The raw number of ED visits for all products has fluctuated over the past several years due to membership growth. However, the percentage of all ED visits that are considered non-emergent has consistently decreased across all products. This has a positive effect on our members as they receive care in the most appropriate setting and costs for unnecessary care is limited.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>PRODUCT</th>
<th>Emergent Visits</th>
<th>Non-emergent Visits</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>COMMERCIAL</td>
<td>88,965</td>
<td>35,702</td>
<td>124,667</td>
<td>28.6%</td>
</tr>
<tr>
<td>2017</td>
<td>COMMERCIAL</td>
<td>91,293</td>
<td>34,905</td>
<td>126,198</td>
<td>27.7%</td>
</tr>
<tr>
<td>2018</td>
<td>COMMERCIAL</td>
<td>94,932</td>
<td>36,171</td>
<td>131,103</td>
<td>27.6%</td>
</tr>
<tr>
<td>2016</td>
<td>MEDICAID</td>
<td>28,312</td>
<td>16,607</td>
<td>44,919</td>
<td>37.0%</td>
</tr>
<tr>
<td>2017</td>
<td>MEDICAID</td>
<td>41,470</td>
<td>22,752</td>
<td>64,222</td>
<td>35.4%</td>
</tr>
<tr>
<td>2018</td>
<td>MEDICAID</td>
<td>49,665</td>
<td>27,178</td>
<td>76,843</td>
<td>35.4%</td>
</tr>
<tr>
<td>2016</td>
<td>MEDICARE</td>
<td>10,761</td>
<td>4,194</td>
<td>14,955</td>
<td>28.0%</td>
</tr>
<tr>
<td>2017</td>
<td>MEDICARE</td>
<td>12,267</td>
<td>4,745</td>
<td>17,012</td>
<td>27.9%</td>
</tr>
<tr>
<td>2018</td>
<td>MEDICARE</td>
<td>13,016</td>
<td>5,006</td>
<td>18,022</td>
<td>27.8%</td>
</tr>
</tbody>
</table>

Another measure that demonstrates the success of our multi-faceted interventions is the decrease in the overall rate of ED visits over the past five years. Since 2009, we have seen a 43.97% decrease in ED use among our Medicaid population. While reductions have been more modest in the commercial population, the commercial rate is also much lower overall.
HealthPartners Emergency Room Monitoring
PMAP/MNCare rate = visits per 1000 Member Months

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>55.21 DHS Baseline Rate</td>
</tr>
<tr>
<td>2013*</td>
<td>46.73</td>
</tr>
<tr>
<td>2014*</td>
<td>43.22</td>
</tr>
<tr>
<td>2015*</td>
<td>36.49</td>
</tr>
<tr>
<td>2016*</td>
<td>34.26</td>
</tr>
<tr>
<td>2017*</td>
<td>33.99</td>
</tr>
<tr>
<td>2018*</td>
<td>33.49</td>
</tr>
</tbody>
</table>

*HealthPartners internal monitoring

Emergency Room Monitoring Medicaid

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>55.21</td>
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<tr>
<td>2018*</td>
<td>33.49</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual ER visits/1,000</td>
<td>437.9</td>
<td>411.1</td>
<td>407.9</td>
<td>401.9</td>
</tr>
<tr>
<td>Total visits</td>
<td>44,081</td>
<td>38,913</td>
<td>52,747</td>
<td>62,822</td>
</tr>
</tbody>
</table>

Click on the “Home” icon or “Revert” button to return to original view.
Due to initial success, in 2018, HealthPartners focused their efforts on model improvements based on lessons learned from the 2016 CHN pilot and 2017 CHN expansion to Maplewood Clinic. Program monitoring in 2018 revealed a 68% enrollment rate and an increase in education interventions and community resource connections completed for members.

**virtuwell Usage**

The value of virtuwell is demonstrated in the higher utilization rates for our DHS state public programs members. Making access to care convenient is the hallmark of this benefit.

**virtuwell Usage by HealthPartners Members**

<table>
<thead>
<tr>
<th>Year</th>
<th>DHS</th>
<th>Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>59</td>
<td>6,067</td>
</tr>
<tr>
<td>2012</td>
<td>645</td>
<td>12,941</td>
</tr>
<tr>
<td>2013</td>
<td>876</td>
<td>13,905</td>
</tr>
<tr>
<td>2014</td>
<td>1,222</td>
<td>17,494</td>
</tr>
<tr>
<td>2015</td>
<td>1,364</td>
<td>23,667</td>
</tr>
<tr>
<td>2016</td>
<td>1,404</td>
<td>29,351</td>
</tr>
<tr>
<td>2017</td>
<td>2,466</td>
<td>36,623</td>
</tr>
<tr>
<td>2018</td>
<td>4,015</td>
<td>41,607</td>
</tr>
</tbody>
</table>
Conclusions/Lessons Learned
We have learned that some people who utilize the ED for low intensity reasons are open to more appropriate alternatives. However, there are some patients who use the ED for non-urgent care, and prefer to continue to use the ED in this way. Based on conversations with the CareLine nurses, many members have indicated that the ED fits their needs and they will continue to use it for care as they choose.

Partnerships between hospitals and PCPs enhance communication and improve continuity of care by enabling clinics to contact their patients and coordinate follow-up care.

Personalizing educational messages about alternatives to the ED in a way targeted to member beliefs and motivations effectively changes behavior.

Sustainability of the Activity
HealthPartners is committed to building on these efforts to ensure that members are receiving care in the most appropriate setting. We will continue to implement creative strategies such as virtuwell and walk-in clinics to improve easy access to care. We will also support and engage members in decision making that leads to the best health outcomes for themselves and their families.
Dental Withholds

Annual Dental Visit

Dental Service Utilization

Description

Oral health is an important part of overall health and wellbeing. According to the Academy of General Dentistry, there is a relationship between oral health and health complications such as stroke and heart disease as well as prenatal issues.

The Annual Dental Visit (MSHO, MSC+ and SNBC) and Dental Service Utilization (PMAP and MNCare) measures and quality improvement project are part of reaching contractual withholds for our Families and Children (F&C) and Seniors Contracts with DHS. DHS identified dental measures as a priority for the Medicaid population as many members do not receive their annual dental visit which could impact their overall health. In 2018, DHS increased the importance of the dental withhold for the F&C contract by assigning it 95 out of 1100 possible points.

Goals

The specifications for both withholds correspond to the NCQA HEDIS 2017 Technical Specifications for Annual Dental Visit, with expanded ages to include adults 19-64 years of age and seniors 65+.

For each contract year, our goal for SNBC and Seniors is to increase the percentage of members in each age group who receive an annual dental visit by a 10% relative improvement from our baseline rate toward the ultimate goal of 80% of members receiving an annual dental visit.

<table>
<thead>
<tr>
<th>ANNUAL DENTAL VISIT WITHHOLD PERFORMANCE MEASURE</th>
<th>BASELINE (2016)</th>
<th>2018 GOAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>19-64 YEARS OF AGE (SNBC)</td>
<td>45.75%</td>
<td>49.18%</td>
</tr>
<tr>
<td>65+ (MSHO/MSC+)</td>
<td>43.8%</td>
<td>47.42%</td>
</tr>
</tbody>
</table>

For PMAP/MNCare, the goal for 2018 is to increase the percentage of members who seek dental care by 10% over the baseline year.

<table>
<thead>
<tr>
<th>Dental Service Utilization Withhold</th>
<th>Baseline (2016)</th>
<th>2018 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-20 years of age</td>
<td>48.26%</td>
<td>58.26%</td>
</tr>
<tr>
<td>21-64 years of age</td>
<td>35.91%</td>
<td>44.91%</td>
</tr>
</tbody>
</table>

We monitor our rates monthly through internal reports from HealthPartners Health Informatics Department and quarterly with the data provided by DHS in July and October of 2018 and January and April of 2019. DHS provides our final performance in July of 2019.
Initiatives/Interventions

- Access to dental providers has been identified as an ongoing issue for Medicaid members in MN. To assist members to locate a dentist who is accepting new patients, HealthPartners created a State Public Programs Navigator role within Member Services. Member Services representatives can look to this navigator for assistance with dental support on complex benefits, provider access and as a resource for community services when non-plan benefits are needed.
- HealthPartners Dental Group (HPDG) has a Patient Dental Call Center to respond to incoming requests for dental care and to conduct follow-up for needed services for HPGD patients.
  - Staff contacts parents of 1-6 year old PMAP members who have not had a dental appointment in the last year, in an effort to schedule a pediatric exam appointment. This project will continue to connect with 20-25 families per week with a goal of scheduling at least 50% with New Patient Exams.
  - In 2018, the Dental Call Center was expanded to add two additional staff to accommodate additional outreach for the DHS Dental withhold. Protocols for scheduling Medicaid members within the HPGD clinics was updated to maximize access opportunities and call center staff received training to schedule accordingly.
- HPGD strategically recruited and hired additional dental staff to serve members at high-Medicaid dental clinics to increase access to appointment times. In addition to the call center, HPGD added more than 12 FTEs including dentists, dual license ADT/hygienists and hygienists to create improve appointment availability.
- HealthPartners dental staff attended a meeting of staff interpreters to share information on the importance of dental care and the need for members to get preventive care. This will assist them in encouraging their clients to seek dental care. Information was shared on how to schedule dental visits. Some interpreters work at clinics where medical and dental services are co-located which allows them to further assist members to make appointments.
- A member outreach campaign was initiated to contact members who have not had a dental appointment in the past 12 months.
  - HealthPartners deployed 13,921 e-mails in July encouraging members to schedule dental care. Of those 11,873 were directed to the dental call center for assistance and 2,048 were directed to their own dental clinic. In November, we sent a follow-up e-mail to 6,299 members who had not responded or were newly eligible.
  - In addition to fielding inbound calls from members, call center staff conducted outbound calls to members who have not had a dental visit in the past 12 months.
- HealthPartners dental plan sponsored a year’s supply of toothbrushes to the care delivery system to facilitate discussion about the need for the patient to see a dentist for the first time and/or get fluoride varnish.
- HealthPartners dental plan supported the Reach Out and Read program through the purchase of age appropriate books for nine month olds with a dental theme to encourage parents to start their child with dental care at first eruption of teeth.
- SNBC Care Coordinators discuss the importance of dental care during their interactions with members and assist the member to find a dentist or schedule an appointment when needed.

Barrier Analysis

Barriers to Medicaid members receiving dental care are well documented. In many areas of the state, there are limited dental clinics, and the clinics may not be accepting new Medicaid members. Dental clinics identify low payment rates and high appointment fail rates as reasons they limit the number of
Medicaid members they serve. Providing the Dental Navigator service lessens the burden on the member to make repeated calls to multiple clinics to find an open clinic.

In analysis of our own dental clinics service of Medicaid members, we identified that the volume of Medicaid patient visits increased, but the number of unique members did not increase at the same rate. As more members received preventive care and issues were identified, more visit slots were taken up by restorative care, potentially causing the unintended consequence of limiting access to more new patients.

Dental clinics have long identified high ‘fail rates’ among Medicaid patients as a reason to limit appointment access to that population. If the patient does not complete a scheduled appointment, that is an appointment lost to another patient and lost revenue to the dental clinic. HPDG conducted an analysis of the fail rate at a primarily commercial practice and compared it to a high Medicaid-patient population clinic. The fail rate at the Medicaid clinic was 18% compared to 7% at the commercial clinic for a 12 month period. This data reinforces the concern of failed appointments to this population for dental clinics and combined with the issue of low reimbursement rates helps to explain why they may limit access to Medicaid members.

While outreach to Medicaid to members results in success in scheduling appointments, staff has identified lack of correct phone numbers as a barrier. Claims lag means that the report we generate each month to identify members for outreach may be out of date. Call Center staff often find that when they are able to reach a member, the child was recently in for a preventive appointment.

Dental care is often a low priority for seniors; especially those who have dentures. Many believe that they do not need to see dentist regularly if they do not have their own teeth and only seek treatment if they experience problems.

Transportation is often a barrier to care for Medicaid members. If the closest dental clinic with availability is not in their community, Ride Care will approve transportation outside of the typical distance parameters so they can get to the dental clinic available to them.

Language and cultural issues can play a role in member understanding the need for dental care. Even among English-speaking populations, low health literacy related to preventive care is common.

Social and financial stressors have a strong impact on a person’s ability to prioritize health care. Members enrolled in Medicaid are by definition low-income and may experience many of the social determinants of health that are barriers to seeking dental care. These may include housing and food instability, lack of transportation, lack of paid time off for appointments, etc.

**Opportunities for Improvement: Results/Outcomes**

Internal monitoring shows that we are unlikely to meet the full withhold for either of these measures. Below is the most recent data we have received from DHS on our Annual Dental Visit rate. We expect further results in April and final results in July.

<table>
<thead>
<tr>
<th>ANNUAL DENTAL VISIT WITHHOLD PERFORMANCE MEASURE</th>
<th>BASELINE (2016)</th>
<th>JANUARY PREVIEW</th>
<th>2018 GOAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>19-64 YEARS OF AGE (SNBC)</td>
<td>45.75%</td>
<td>47.04%</td>
<td>49.18%</td>
</tr>
<tr>
<td>65+ (MSHO/MSC+)</td>
<td>43.8%</td>
<td>41.41%</td>
<td>47.42%</td>
</tr>
</tbody>
</table>

2018 Quality Improvement Annual Evaluation 59
<table>
<thead>
<tr>
<th>DENTAL SERVICE UTILIZATION WITHHOLD</th>
<th>Baseline (2016)</th>
<th>January Preview</th>
<th>2018 Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-20 years of age</td>
<td>48.26%</td>
<td>44.06%</td>
<td>58.26%</td>
</tr>
<tr>
<td>21-64 years of age</td>
<td>35.91%</td>
<td>33.72%</td>
<td>44.91%</td>
</tr>
</tbody>
</table>

**Sustainability**

HealthPartners is committed to assisting our members receive the dental care they need. We continue to work with dental providers to increase our network of available dentists, and with members to access the care they need. We will continue to explore innovative ways to reach out to our members through targeted e-mails and/or mailings and direct phone outreach.
Colorectal Cancer Screening

Focus Study

Description
HealthPartners Health Plan analyzed our member colorectal screening rates and learned that our “unattributed” members (members who do not have a primary care relationship) had lower screening rates than members who are attributed to a primary care provider. In addition, the screening rate for our Medicare members had been flat for several years. Our key challenges were:
1. Engaging our unattributed members in getting screened.
2. Increasing screening rates for our Medicare population

Goal
The goal of this project was to increase the number and percentage of adults up to date on colorectal cancer screening by focusing on “unattributed” members (members who do not have a primary care relationship). The member outreach population is defined by using HEDIS codes and ICSI guidelines for the appropriate measures:
- Colorectal cancer screening – Women and men between the ages of 50 – 75
  - For African-Americans, American Indians and Alaska Natives begin screening at age 45

Initiatives/Interventions
HealthPartners identified home testing as a viable option for improving colorectal cancer screenings by offering FIT tests to members in their homes. HealthPartners worked with BioIQ, a biometric screening vendor to send FIT kits directly to member homes via US mail. Clinics often send FIT kits to their patients and some health plans have begun sending FIT kits to their Medicare members. However, engaging Medicare members and focusing on unattributed members is a unique approach to this issue. Also novel, HealthPartners offered this program at no additional cost to both members and the employer group purchasers.

The program involved:
- We used claims data to identify members who were overdue for colon cancer screening
- We developed and deployed a full suite of member communications including postal letters and IVR messages to encourage program participation
- Introductory letters were mailed to members’ homes followed by FIT kits unless a member opted out of the mailing
- Registered Nurses fielded more than 2,700 member calls and responded to questions regarding the program overall, how to complete the actual test, how to interpret results and appropriate follow-up care after a positive result.
- Nurses worked with BioIQ to communicate test results to both the member and the member’s primary clinic (if known)
- Messages to members following a positive test emphasized the need to get follow-up care after a positive test result
- Members who did not have a primary care provider were educated on the importance of having a primary care provider and offered assistance to find one when needed.
• Customized Messages -
  o The American Cancer Society (ACS) created messages shown to successfully motivate people to complete a cancer screening based on guidelines and market research. HealthPartners augmented ACS data with additional marketing data to further identify types of messages that are most effective for different groups of men and women. [DELETE?]
  o Working with our marketing department, customized messages were created and delivered to members through mailed letters or secure web mail (SWM) based on the member’s preference.
  o Customized messages to members not up to date on screening based on their micro-segment identification
    o Fearful Procrastinator message: Colon cancer is the second leading cause of cancer deaths in the U.S., but if caught early, it’s 90 percent curable. That’s why screening is so important.
    o Aware and Able message: I have good news: there are quick and easy alternatives to a colonoscopy. One option is the FIT, a simple stool test you do at home with no special diet to prepare for it.
    o Member messages noted when members had 100% coverage for colorectal cancer screening. This was in response to a recent member survey on cancer screening which identified cost as a barrier for completing the screening.
    o Employer specific phone numbers and web addressed were included for a large employer group for ease in contacting Member Services
    o Ease in scheduling was included in the message
      ▪ Log onto your myHealthPartners account
      ▪ Make an appointment directly at a clinic
      ▪ Download the myHP mobile app and make an appointment directly from your Smartphone

Colorectal cancer screening promotion is an enterprise-wide focus. In addition to the initiatives detailed above, colorectal cancer screening was promoted in the following ways by the health plan:
  o Plan and Provider
    • Shared the ACS Best Practices Toolkit for Plans
    • Quality Connections Forums included repeated discussions of efforts around CRC screenings with our clinic partners.
    • CRC screening is included in the slate of measures for the Partners In Excellence provider incentive program.
  o Public Awareness
    • HealthPartners developed an internal campaign to promote Colorectal Cancer Awareness Month in March to our employees.
    • We participated with the American Cancer Society Blue Lights in March to promote awareness of CRC screening.
    • Collaborated with Kare 11 on Real Men Wear Gowns which promotes men’s health including CRC screening.
    • Spread messages about the importance of CRC screening through social Media including multiple Facebook posts and blogs.
Barrier Analysis
The FIT home test kit project had some unique challenges than we typically see when promoting colorectal cancer screenings with more traditional strategies.

- Some members are suspicious of releasing personal information and getting test data through a third party like their health plan. They prefer to work directly with their personal care physician.
- For older adults, using the test kit can be challenging from a mobility and dexterity perspective.
- Some members find the test process distasteful.
- We have seen a range of barriers to promoting colorectal cancer screenings with both members and providers.
- Most, but not all, plans cover preventive services at 100%. Members with HSA’s and other high deductible plans have a lower completion rate for preventive services than members with low or no deductible plans.
- Members are dissatisfied if a screening test becomes a diagnostic test when the exam results in an abnormal finding.
- Preventive guidelines change and although these are available to members through the website, in newsletters, and in targeted outreach it may be confusing when to start screening and to know the frequency of screening.
- Medical societies publish and promote consensus-based preventive guidelines that may be inconsistent with the evidence; this causes patient and provider confusion.
- Variation exists in the provider’s ability to collect race/ethnicity data and language data, which can affect ability to address disparities.
- Providers have limited resources for testing proposed initiatives and the time and resources needed to make systemic change can be costly. By sharing successes and strategies staff are able to utilize tested interventions for quality improvement.
- Challenges exist in ensuring consistent preventive messaging throughout the enterprise. HealthPartners supports evidence-based clinical guidelines from ICSI and USPSTF. A centralized resource has been made available to support both care delivery and health plan initiatives.

Opportunities for Improvement – Results/Outcomes
Overall, HealthPartners sent FIT kits to 30,529 members. As of early January, we achieved an overall response rate of 24.1%. Medicare members responded in greater numbers than the commercial unattributed population with a response rate of more than 31.2% compared to 19% returned for commercial members.

<table>
<thead>
<tr>
<th>FIT Kits Returned</th>
<th>Negative Results</th>
<th>Positive Results</th>
<th>Inconclusive Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>7365</td>
<td>6516</td>
<td>391</td>
<td>450</td>
</tr>
</tbody>
</table>

Although we have not completed a full program analysis, we have observed that sending the FIT kit prompts some members to contact their clinic and obtain needed preventive care even if the member declines to participate in the health plan FIT program. This enables the clinic to address all the member’s health care needs.

Many members are thankful for the program and have commented to our program nurses:
“I would like to give you and HealthPartners a positive comment to let them know this is a good thing you are doing ... This is so much easier and convenient for the person. I was very pleased when I received the kit from you ... Thank you again for taking the initiative to send the test kit to me."

“When I got the kit, I thought this is a good thing to do and put it in my to-do pile. I forgot about it. Then when I got the reminder call and later the letter from you, it reminded me to do the test. The 3rd reminder was the charm. That is a good tactic you have to remind us, thank you. People have a tendency to put off what they think is unpleasant. Doing this test is good, it will keep costs down and you sending it to me got me to do it.”

**Actions for 2019**

- **At Home Test Kits** – Sending FIT kits to member homes was so successful that this program will be continued in 2019. We are working with the lab our vendor was using to improve result turnaround times ensuring members and their primary provider receive results.

- **Improve Well Project** – In planning ahead for FIT home test kits being sent to member homes in 2020, we are participating in Improve Well and exploring the opportunity to use HealthPartners’s Central Lab for members who are also patients of HPMG clinics. We believe this opportunity could provide further timeliness of completing the test, providing results and following up with members who will need a colonoscopy.

- **FIT & Mail Order Pharmacy** – a MyVoice Survey completed in 2018 showed that being able to order a FIT test when renewing mail order prescriptions was perceived as a convenient option for members to get their FIT kit. Further exploration with pharmacy will be continued in 2019.

- **Personalized Member Messages** – Expand personalized messaging for preventive services to our members by providing messages that meet the member’s preferences. Email messages will now be sent to a member’s personal email versus having to log into their HealthPartners account. When members are in their account, they can click on the bell icon and see what screenings they are due for and have increased ease in scheduling appointments.

- **Social media** provides a vehicle to expand health information to members who may want more in-depth detail on a health topic.
  - Blogs and links on a member’s HealthPartners account page provide connections to experts and more personalized information, e.g. Real Men Wear Gowns
  - Facebook provides a very cost-effective means to customize messages to specific populations. Members are able to access HealthPartners website and detailed links

- **Real Men Wear Gowns** - HealthPartners teamed up with KARE11 news station in 2018 and is doing so again in 2019 to bring awareness to the importance of men’s health. Men are 24% less likely to go to the doctor than women. This campaign highlights the importance for men to see a doctor on a regular basis including screening for colorectal cancer.
Quality Connections is a strategy to implement quality improvement initiatives across our provider network. Representatives from clinics meet for relationship building and to share successes.

To continue our work in reducing racial and payer disparities for cancer screening, we have an active Colorectal Cancer Work Group
- The Colorectal Cancer Work Group was a team recipient of the President’s Award for outstanding work in improving screening in 2018.
- The Colorectal Cancer Work Group Received the Organization of the Year award for colorectal cancer screening from the American Cancer Society – MN in 2018.

<table>
<thead>
<tr>
<th>PCS Campaigns</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. messages &amp; conversion rates</td>
<td>No. messages &amp; conversion rates</td>
<td>No. messages &amp; conversion rates</td>
<td>No. messages &amp; conversion rates</td>
</tr>
<tr>
<td>Colorectal cancer screening (Total)</td>
<td>169,232 5%</td>
<td>178,228 7%</td>
<td>211,051 7%</td>
<td>145,353 (10%)</td>
</tr>
<tr>
<td>SWM</td>
<td>5%</td>
<td>7%</td>
<td>8%</td>
<td>10%</td>
</tr>
<tr>
<td>Letters</td>
<td>3%</td>
<td>7%</td>
<td>6%</td>
<td>8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FIT</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>No. FIT kits sent and % returned for testing</td>
<td>No. FIT kits sent and % returned for testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pilot Unattributed members</td>
<td>NA</td>
<td>NA</td>
<td>496 (16%)</td>
<td>NA</td>
</tr>
<tr>
<td>Unattributed members</td>
<td>30,529</td>
<td>23.8%</td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>HEDIS Measures</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal cancer screening (Commercial)</td>
<td>74.9%</td>
<td>69.2%</td>
<td>69.2%</td>
<td>69.3%</td>
</tr>
<tr>
<td>Colorectal cancer screening (Medicare Cost)</td>
<td>81.7%</td>
<td>82.3%</td>
<td>82.8%</td>
<td>82.2%</td>
</tr>
<tr>
<td>HEDIS Trend Report (Unattributed)</td>
<td>31%</td>
<td>39%</td>
<td></td>
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</table>
Reducing New Chronic Opioid Users - PIP

Description

The surge in opioid use and misuse in the US is well known and highly publicized. Since 2010, as the opioid problem has come to the attention of the medical community and the public, clinical guidance has been slowly disseminated from a variety of sources including the American Medical Association (AMA) and the Centers for Disease Control and Prevention (CDC). In addition, state legislatures have issued directives to address the issue. Much of the early guidance was focused on managing chronic opioid use.

This PIP focuses on decreasing the rate/number of Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare) and Special Needs Basic Care (SNBC) enrollees that are new chronic users of opioid pain relievers. The New Chronic User (NCU) measure, developed by the Minnesota Department of Human Services (DHS) supports quality improvement efforts in preventing chronic opioid use.

DHS has identified 45 days of opioid use as a critical timeline for patients as continued use beyond 45 days can result in long-term/chronic use or addiction. This project will work to decrease the number of PMAP, MNCare and SNBC members who reach that 45 day threshold.

Goals

The goal of this project is to decrease the rate of members in the PMAP, MNCare, MSHO, MSC+ and SNBC populations who become new chronic opioid users as defined by the NCU of Opioid Pain Relievers (OPR) measure developed by the MN DHS.

DHS provided plans with baseline data and rates during the project development stage and will update data annually for the duration of the project. HealthPartners will monitor our rates internally throughout the year.

Denominator Details

The Denominator (D) is the number of enrollees that were continuously enrolled in the measurement year. To be included in the denominator, enrollees must meet the specific criteria:
- Age: Enrollees aged 12 and older.
- Continuous Enrollment: Enrollees must be continuously enrolled in public programs for the measurement year.

Numerator Details

The Numerator (N) is the number of new chronic users of opioid pain relievers, as defined by:
- OPR naiveté: No OPR claims for 90 days prior to the index event.
- Chronic use: Greater than or equal to a 45 days supply of OPR during the 90 days following index event, with no more than 45 days’ gap in supply between the end of a supply and the next fill.

Baseline

<table>
<thead>
<tr>
<th>CY 2016</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMAP/MNCare</td>
<td>262</td>
<td>8874</td>
<td>3.0</td>
</tr>
<tr>
<td>SNBC</td>
<td>14</td>
<td>246</td>
<td>5.7</td>
</tr>
<tr>
<td></td>
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<td></td>
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</tr>
<tr>
<td>----------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Seniors</td>
<td>104</td>
<td>592</td>
<td>17.6</td>
</tr>
<tr>
<td>Total</td>
<td>380</td>
<td>9712</td>
<td>3.9</td>
</tr>
</tbody>
</table>

**Data Limitations**

1. Due to the small denominator size, only 1 or 2 members could influence our goal rate positively or negatively.
2. MCOs identify members on an ongoing basis who have been issued more than one Plan Member Identification (PMI) number by DHS within the calendar or measurement year. Members may have been continuously enrolled during the measurement year, however because they have been issued a different PMI number they do not meet the enrollment criteria compounding the issue of small numbers in the denominator.

**Initiatives/Interventions**

The interventions for this project are a combination of outreach to HealthPartners members and offering tools for our HealthPartners family of providers and contracted providers available to HealthPartners membership to support improved prescribing practices.

HealthPartners collaborates with the other not-for-profit health plans in MN serving Minnesota Health Care Program members. Where appropriate, HealthPartners collaborated with the other PMAP health plans (the Collaborative) to bring resources and education to the provider community to diminish duplicative messaging to providers, and to increase buy-in.

**Member Interventions**

1. Studies have shown that competing interests in a clinic visit can result in clinicians spending limited time during a pain visit discussing issues related to the drug being prescribed. This can leave patients with knowledge gaps on the risks and benefits of opioids.

   HealthPartners identifies members who were previously opioid naïve who have received a new prescription of opioids and subsequently get a refill of that opioid. The goal of this outreach is to deter any further refills and to encourage members to explore alternative therapies. The communication contains information explaining why they are receiving the letter, the risks of opioids and suggestions for talking to their doctor about alternative treatment options.

2. HealthPartners SNBC members have a wide range of physical and/or mental disabilities and are often medically complex. Multiple issues may mean they are utilizing multiple levels and types of prescription medication. On average, HealthPartners SNBC members fill 63 prescriptions each year, compared to HealthPartners Medicaid members overall average of 11 prescriptions per year. The addition of opioids into that mix may result in adverse medication issues.

   a. To address potential medication issues as quickly as possible, HealthPartners implemented a pilot project for our SNBC membership to test the effectiveness of a direct intervention from an MTM pharmacist. MTM Pharmacists contacted SNBC members who refilled their initial opioid prescription. These calls were broadly accepted by SNBC members and resulted in quality conversations. However the nature of the outreach is very time consuming and we determined
that it was a more effective use of resources to utilize a nurse for the outreach, and this function was transferred to the SNBC Care Coordination area.

The SNBC Care Coordination nurse completing the outreach calls reports that members are open to these conversations. She has made referrals to MTM when appropriate and provided additional resources. She sends members additional information and Deterra medication disposal pouches when appropriate as well.

3. Consistent messaging – According to a study published by the American Public Health Association, healthcare organizations can improve awareness about the risks of opioid use by implementing community and provider education on mental health, alternative non-opioid pain treatment options, substance abuse and overdose prevention. The Collaborative created a member brochure for participating health plans in our outreach efforts. This brochure is used by the SNBC Care Coordinator conducting outreach and can be used at health fairs and other community activities.

4. Unsafe disposal of unused opioids is a major concern; according to a National Survey on Drug Use and Health, 75% of all opioid misuse starts with individuals using medication that wasn’t prescribed for them, but instead obtained from a friend, family member or dealer. Many HealthPartners pharmacies offer prescription drop-boxes to collect unused medication.

Network clinics and hospitals use Community Paramedics (CPs) and EMTs to conduct home visits to support the member after discharge and reduce the likelihood of readmission. CPs are experienced paramedics with additional education to provide non-emergency care to patients and help manage chronic conditions. Medication reconciliation, education and compliance are often a part of the CP home visit. The project created an HP-branded educational postcard for CPs which discusses safe storage and disposal of medications. CPs also offer Deterra medication disposal pouches to their patients.

Provider Interventions

1. Quality Connections

HealthPartners works closely with our care systems on improvement efforts for our members. One way that we engage provider groups in discussion around quality initiatives is to host a Quality Connections forum three times each year. The stated purpose of the group is to share and learn so that we can take action to benefit our patients and our organizations as we mutually strive to achieve high performance on publicly reported measures.

We invite quality improvement staff from our key clinic groups to share information on improvement of publicly reported quality measures and learn from each other to impact work on those measures. The Quality Connections forum held on February 13, 2018, focused on opioids. Guests included ICSI and members of the ICSI Opioid Work Group who shared information about the project, best practices and current recommendations as well as improvement efforts that are already occurring in Minnesota.

2. Provider toolkit
The Collaborative developed a provider toolkit containing a collection of tools and resources to enhance clinical skills around partnering with patients to determine the best approach to pain management. The toolkit includes:

- Opioid Prescribing Guidelines
- Screening for Risk Factors
- Shared Decision Making Tools
- Clinical Education Opportunities
- Patient Education tools
- Pharmacy Resources

The Collaborative has promoted the toolkit through our provider newsletters, and presentations at conferences and webinars.

3. The Collaborative offered webinars to present information to the clinical and care coordination community who work with Medicaid members who may be prescribed opioids. The webinars offered in 2018 were:
   - Meeting the Challenges of Opioids and Pain – Introduces participants to the new MN Opioid Prescribing Guidelines and the Opioid Toolkit.
   - Opioids and Behavioral Health – Discussed the intersection of Substance Use Disorder (SUD) and mental health issues.
   - Meeting the Opioid Challenge: Tools and Information for Care Coordinators – presented information and strategies for SNBC and MSHO Care Coordinators working with members who may be prescribed opioids.

4. The Collaborative presented information about the project, the Provider Toolkit and other opioid related issues at the Minnesota Rural Health Conference, the Many Faces of Community Health conference and the Mankato SUD Summit in 2018.

5. HealthPartners posts a monitoring report on our Provider Portal to inform clinics of their rates of opioid measures related to HealthPartners Medicaid members. The report is updated quarterly. The measures included in the report are:
   - # of opioid naïve members (who receive a prescription) attributed to that care system
   - # who become New Chronic Users (NCU) as defined by the DHS measure
   - Rate of NCU (%)
   - Total attributed members
   - Average number of pills per first opioid prescription
   - Average number of days per first prescription
   - Average Morphine Equivalent (MME) of first prescription

Community Awareness

Raising public awareness is an important part of solving the opioid issue. We used our website, social media and local media stories to educate the public about the dangers of opioids, proper disposal and pain.

1. The "Treating Pain Without Pills" report provides a comprehensive overview of the work HealthPartners has done around the opioid epidemic.
2. In April, we launched a new pain management webpage—www.healthpartners.com/pain.

3. Our Corporate Communications team has promoted four opioid-related bog posts over the past few months on our social channels:
   - Understanding opioid addiction
   - 7 steps for treating pain that will get you feeling better
   - Why opioids make pain worse
   - How to get rid of extra medicine.

4. HealthPartners experts have been featured in news stories talking about our work to fight the opioid epidemic. We’ve shared this content via our social channels including Facebook, Twitter and LinkedIn.
   - KARE 11: HealthPartners pharmacies distribute medication to prevent opioid overdoses
   - Star Tribune: Coon Rapids clinic is innovative in helping opioid-addicted patients
   - Star Tribune: Health plans report progress in limiting opioid use
   - MinnPost: To treat chronic pain, focus on the patient rather than the pain
   - KARE 11: Pharmacist weighs in on opioid epidemic

**Barrier Analysis**

Overall, Minnesota is making significant progress in many metrics associated with the opioid crisis such as reducing the number of pills dispensed to patients and the average MME. The implementation of uniform prescribing guidelines has contributed greatly to these measures. However, there are still providers who have not fully embraced the MN opioid prescribing guidelines.

The evaluations of the webinars associated with this project have been overwhelmingly positive, however, it is difficult to reach the prescribing clinicians with this information. We will continue to promote the webinars and the recorded content and encourage clinicians view these materials.

Individual member outreach has proven difficult. Phone outreach is challenging due to lack of correct phone numbers, phones that do not accept incoming calls and calls not being returned. Mailings are also impacted by incorrect mailing addresses as well as messaging that may be difficult to understand depending on a member's reading level and health literacy.

**Opportunities for Improvement: Results/Outcomes**

**Member Outreach**

Letters were sent to members who received a refill of a new prescription beginning in September 2018. As such the data below does not reflect a full year of the intervention. The NCU rate for those members is significantly higher than the overall HealthPartners Medicaid membership.

<table>
<thead>
<tr>
<th></th>
<th>Baseline 2016 NCU Rate</th>
<th># letters mailed 9/17 – 12/31/18</th>
<th># NCU of outreach population</th>
<th>% NCU of outreach population</th>
<th>Significance?</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMAP/MNCare</td>
<td>3.0</td>
<td>1,285</td>
<td>68</td>
<td>5.29%</td>
<td>Significant:</td>
</tr>
</tbody>
</table>
These results show that a member outreach mailing may not be an impactful approach to deter members from continuing opioids use. In 2019, we are reevaluating the approach and revisiting the content of the letter to see if a stronger message will have more impact.

### Alternative Therapies Baseline

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>% of members who become chronic users (45 days) who utilize alternative therapies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: Q1 2017</td>
<td>29.8%</td>
</tr>
</tbody>
</table>

### Member Outreach Process Measures

1. Number of members who received the Opioid Refill Outreach Communication
2. Of those receiving the communication, the percent of those who did not receive any additional refills within 45 days
3. Change in the percent of members within the NCU denominator who are accessing alternative therapies as covered by Medicaid (such as PT, acupuncture, chiropractic or behavior therapy)

### SNBC Member Outreach

SNBC members often have multiple medications and can have very complicated health conditions. For this reason, we targeted this population for MTM Pharmacist outreach when they refilled their initial opioid prescription.

- Of the 47 members referred to this pilot, at least 10 were not appropriate for the referral as they had a cancer or other disqualifying diagnosis.
- The MTM pharmacists contacted 34% of members but outreach was labor intensive due to blocked numbers, no voicemail or other phone outreach barriers. Calls also were not returned after leaving repeated messages.
- Overall, the outreach was deemed to be valuable, but not an efficient use of the MTM pharmacist resource. This task was redirected to SNBC Care Coordination in late 2018 to have the initial calls made by a nurse who could refer to MTM when appropriate.

### SNBC Provider Outreach

Because of potential interactions between opioids and many common medications, HealthPartners notifies SNBC members’ primary care physicians whenever their patient fills a new opioid prescription. In 2018, we notified 141 providers. An additional 25 members received a new prescription but were not attributed to a primary care provider.
**Provider Monitoring**

Since the MN Opioid Prescribing Guidelines were published in 2018, it appears that our Medicaid network providers have been aligning their prescribing practices with them. Our provider monitoring shows that while the total number of members who received an opioid prescription in 2018 increased over the previous year, the measures of significance decreased. The average number of pills for the first prescription, the average MME of the first prescription and the overall percent of members who became new chronic users all decreased.

<table>
<thead>
<tr>
<th># Opioid Naive Members</th>
<th># who become NCUsers</th>
<th>Pct of NCUsers</th>
<th>Total Attributed Mbrs</th>
<th>Avg # pills per first Rx</th>
<th>Avg # of days first Rx</th>
<th>Avg MME first Rx</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Year 2017</td>
<td>5,973</td>
<td>180</td>
<td>3.01%</td>
<td>46,955</td>
<td>27.68</td>
<td>5.13</td>
</tr>
<tr>
<td>Full Year 2018</td>
<td>8,542</td>
<td>164</td>
<td>1.92%</td>
<td>76,373</td>
<td>22.67</td>
<td>4.15</td>
</tr>
</tbody>
</table>

While the number of clinics who prescribed opioids to our members increased. The percentage of clinic systems averaging more than 20 pills per first prescription remained fairly stable. The baseline number was limited to the first quarter of 2017 so the full year shows a more accurate picture over time. This suggests there is still work to educate providers about the amount of opioids prescribed for acute needs.

<table>
<thead>
<tr>
<th>Time frame</th>
<th>Average quantity per 1st prescription HP Medicaid Avg</th>
<th># of clinics &gt;20 Avg Qty / Rx</th>
<th>Total Number of clinics with Medicaid Opioid Naïve members</th>
<th>% of clinics with Avg Qty &gt; 20/Rx</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: Q1 2017</td>
<td>31.05 pills</td>
<td>78</td>
<td>108</td>
<td>72%</td>
</tr>
<tr>
<td>Full Year 2017</td>
<td>27.68 pills</td>
<td>91</td>
<td>175</td>
<td>52%</td>
</tr>
<tr>
<td>Full year 2018</td>
<td>22.67 pills</td>
<td>93</td>
<td>183</td>
<td>51%</td>
</tr>
</tbody>
</table>

**Sustainability of the Activity**

HealthPartners is committed to improving the situation around opioid prescribing for all Minnesotans. We have implemented many additional interventions in our clinic system, through our pharmacy policies and we are educating members about the risks through our clinics, social and traditional media. As part of the MN Health Collaborative, we will continue to work on this issue for all members and patients.
**SNBC Dental Access Improvement and Evaluation Project**

**Description**

In Minnesota, less than half (46%) of Special Needs Basic Care (SNBC) members have one or more dental visits during a calendar year. In July 2016, the MN Department of Human Services notified the health plans serving SNBC members of a new project to improve access to dental care for SNBC members in an effort to improve this rate statewide.

SNBC is a program for people with disabilities, ages 18-64, who have Medical Assistance. These members may also qualify for Medicare. This population must have a certified disability through the Social Security Administration or the State Medical Review Team, or have been determined by the county to have a developmental disability. Because of their disabilities, these members may require additional supports to access dental care, and dental providers who are unfamiliar with the needs of this population may be reluctant to see them.

This project takes a collaborative approach to interventions identified by DHS to impact this issue. All of the health plans with SNBC contracts are participating in the work groups for this project. In addition to HealthPartners, the plans involved are Hennepin Health, Medica, Prime West Health, South Country Health Alliance and UCare.

**Goals**

The goal of this project is to improve dental access for SNBC members through collaborative interventions and efforts between Managed Care Organizations (MCO’s), Minnesota Department of Human Services (DHS), DHS Direct Care and Treatment Dental Clinics (DCT-DC), and other applicable stakeholders.

Baseline rates, as indicated in the table, that in 2015, 45.89% of SNBC members one or more dental visit in 2015.

**Overall Measure of Success**

Improve the HEDIS Annual Dental Visit from the 2015 baseline rate of 45.89% and sustain this over two measurement periods.

![SNBC Baseline Annual Dental Visit Rates](image)

- In 2015, 45.89% of SNBC members had one or more dental visits.
- By 2016, the rate improved to 47.06%.
- The goal is to reach 60% by 2018 and sustain over two measurement periods.

show had measure to 60% periods
Monitoring/Additional Objectives

1. Improve the Dental Quality Alliance (DQA)/HEDIS Use of Emergency Room for Non-Traumatic Dental Related Reasons over the baseline rate of 1.84 in 2014
2. Improve the DQA/HEDIS Follow-up after ED Visit measure over the baseline rate of 36.12% in 2014
3. Participate in two DHS sponsored dental surveys (one for providers, one for members) to collect information regarding this population and their dental needs

Initiatives/Interventions

Each SNBC member has the opportunity to work with a care coordinator to help them access services and support them to meet their needs. A primary intervention for this project includes leveraging the relationship of the care coordinators to encourage members to access dental care. Other interventions include the development of a mentoring program to develop more expertise in special needs dentistry in Minnesota and a teledentistry pilot in conjunction with the DHS Direct Care and Treatment Dental clinics.

Care Coordinator Intervention - SNBC members who have not accessed dental care in the previous 12 months are identified for dental case management outreach using dental claims reports. Outreach by the care coordinator may include: education on the importance of routine preventive dental care and the link to overall health; support and encouragement; education on available dental benefits, how to locate a dentist; identification of any barriers to accessing dental services, assistance with connecting to a dentist for an appointment and transportation needs; and education on the importance of keeping scheduled dental appointments and the impacts of no show appointments. The level of assistance provided will depend on the individual member needs and wants.

- HealthPartners developed tools to support the care coordinators in this outreach including a summary of dental benefits for SNBC members, scripting for outreach calls, an Oral Care Tip Sheet and other documents to support the care coordinator. These tools were shared with our care coordinators and delegates using webinars. Care Coordinators are encouraged to work with HealthPartners Member Services to access the dental navigators to assist in securing a dental appointment if the member is experiencing difficulty finding a provider in their area with available appointments.
CM/CM Support Staff Annual Survey - In March 2018, the MCOs conducted a survey of care coordinators across all health plans to identify barriers to dental care and training opportunities that the Care Coordinators would like to see offered. The survey yielded 229 respondents, who provided key insight on barriers members face in seeking dental care and best practices and trends in working with members to access dental care.

While reviewing qualitative feedback from staff conducting member engagement calls with those who had utilized the ED for non-traumatic dental care, various trends were identified. Often talking to members, they are highly engaged due to their recent ED dental concern. When asking members about follow-up dental care, many experience dental access issues that create barriers to treating urgent dental problems such as pain, abscess, etc.

Barriers identified include needing dental care beyond the Medicaid benefit set, cost, transportation, and other social determinants of health. Another barrier identified by some CMs is the ongoing frustration with the lack of timely and convenient dental appointments available in their area. This feedback is most often heard from those CMs working outside of the metro area. Ensuring consideration of these barriers has been identified as a best practice while setting realistic action steps for the member. For example, providers often add Medicaid members to their clinic cancellation list when they are not taking new patients for these programs. These members are notified of an available appointment with little time to set up necessary arrangements such as transportation, interpreter services, employment leave, conflicting medical appointments, etc. Presenting another path that will set the member up for success in getting dental care is a key goal of this intervention.

The following best practices have been identified to help resolve member needs:

- Encourage and assist members with scheduling preventive dental appointments as far in advance as possible so that an appointment that is both geographically convenient and at a convenient time, can be secured.
- Ensure members are assisted with transportation arrangements and setting up interpreting services.
- Providing members with dental clinic information, member resources on dental and send reminders to support showing up for their scheduled appointments.
- Promote the importance of preventive care and its value in reducing ED incidents, medical cost, adverse health risks, etc.
- Assist members to find a provider they can call their dental home and provide the necessary follow-up care post-ED visit.
- Educate the member on proper usage of the ED and how to appropriately navigate the system if an urgent dental need occurs.

- The MCOs conducted a webinar for Care Coordinators on November 1, 2018 to share the results of the survey and to respond to the training needs requested.
  - Survey results included a summary of the barriers identified by members and the primary reasons members do not accept dental services.
  - Training included the importance of oral health to overall health, an overview of SNBC dental benefits and best practices identified by a plan Member Engagement Specialist.

- ER Outreach – In addition to the routine outreach around dental care, HealthPartners notifies the care coordinator if a member utilizes the ER for non-traumatic dental care. The Care Coordinator
contacts the member to see if there are outstanding needs related to the visit and offer assistance to schedule a dental visit if needed.

Special Needs Community Dentist and Staff Mentoring Program - Lack of access to dental providers with expertise in special care dentistry has been identified as a barrier to access to dental care for SNBC members. The collaborative convened an Expert Panel of clinicians with expertise in special needs dental care in October 2017. The group discussed the barriers to engaging clinicians to serve this population, reviewed current successful models in Minnesota and brainstormed potential next steps.

Expert Panel Interviews - After the initial Mentoring Expert Panel meeting, the group offered their expertise as needed throughout the project. To maximize their insight, the project utilized a Master of Public Health (MPH) intern and conducted personal interviews with members of the Expert Panel, their staff and other critical partners. The purpose of the interviews was to better understand both their needs from the health plans and to identify best practices that are already being employed in the field for SNBC members.

Thirty-four current SNBC dental providers were invited to participate. A total of 18 clinics were represented in the final interviews. These numbers reflect the total number of clinics/organizations although in some cases multiple people from the same organization were interviewed. During the initial Expert Panel meeting, the front desk and other auxiliary staff were identified as vital contacts so specific questions related to administrative staff were included in the interviews.

Themes of the questions asked included:
- Logistical information – How timely appointments can be scheduled for patients specific needs; challenges to scheduling special needs patients; time allowed for appointments; coordination or assistance with health plan information; authorizations.
- Considerations for special needs patients – How to identify level of care of the patient; support staff to accompany; transportation or other services; coordination with medical care; dental education for both the patient and their caregivers.
- Special training provided – Screening for behavioral health concerns; behavioral modification training for staff; other training to accommodate special needs.
- Special needs dental skills – Training provided to staff around serving patients with special needs; identifying gaps in knowledge in serving special needs; advice to new dentists who may want to see patients with special needs.

The results of the interviews have been transcribed and consolidated by theme into useful information. Administrative and health plan information has been integrated into the health plan grid. The results on approaches to scheduling, staff training and special needs dentistry will be incorporated into the Special Needs Dentistry Toolkit being developed by the MCOs in 2019. Preliminary information from the interviews was shared as part of the update given to the DHS Stakeholder meeting on September 10, 2018 and they will be updated on future activities developed as a result of the Expert Panel interviews.

The themes of the feedback from the experts include:
- How patients with special dental needs are similar/different from other patients
- Communication strategies to understand patient’s special needs and additional supports that may be needed
- Conducting behavioral health screenings to understand special needs
Practical strategies for making the visit go smoothly

Collaboration and training with the DCT-DC – The Expert Panel identified a need to offer information and assistance to front desk and other business office staff on issues related to Medicaid covered members. The Medical Director from the DCT-DC in Brainerd arranged a meeting with his staff to discuss how to better serve SNBC members.

- The health plans created a training for the DCT-DC clinic staff about health plan operations, steps to take to get authorizations, health plan resources and contact information. This will be used as the basis for future trainings with additional dental clinics.
- The plans also created a Medicaid Dental Services Grid which is a reference guide for clinics with up to date information on benefits, transportation and incentives by health plan.
- In addition to the DCT-DC clinics, this grid has been distributed to participants at the Oral Health Coalition meeting, county public health staff and is posted on health plan websites. It will be updated annually to reflect current benefits and contacts.

Dental Survey – In 2018, the MCO collaborative partnered with DHS to conduct a survey of dental providers to inform this project. The survey was sent to contracted dental providers of all SNBC MCOs to learn about any access barriers for people with disabilities and to identify areas for further action as part of the SNBC Dental Access and Improvement Project.

The survey was conducted using an online survey tool and was sent to the MCOs’ dental provider networks. The survey link was sent with a cover letter in September 2018, with the survey remaining active until October 31, 2018. A summary of the results is listed below.

Survey Respondents - 39.6% of survey respondents were from a dental clinic located within the Twin Cities metro area, and 56.4% of respondents were from the northern or southern area of Minnesota.

Qualitative Analysis - After reviewing the survey results, many common themes emerged. While many of the providers surveyed are currently serving Medicaid patients that are managed by a MCO, they are unwilling to see new Medicaid patients. This limits access for members trying to establish a new dental home. Inadequate reimbursement and a limited benefit set, which impact treatment, are some of the reasons cited for not accepting new Medicaid patients.

It was consistently noted this population has more extensive needs than the general population and that the current benefit set does not support these needs. For example, providers indicated that the lack of coverage for periodontal services and the restrictive sedation benefits is a barrier to appropriate care. Other responses focused on preventive care; some stating that the one cleaning per year for the standard Minnesota Health Care Programs (MHCP) benefit set is not adequate for this population. Of the providers who reported the limited benefit set has a negative impact on their ability to see patients, almost one-fourth cited reimbursement as the reason they must limit Medicaid patients.

Another barrier noted by providers was caring for patients when their personal care giver is not present. A few providers expressed difficulties in treating patients with physical disabilities due to their special needs. One provider expressed the challenges of performing patient transfers at their facility. For example, transferring to use the restroom when they are not accompanied by a caregiver can be challenging and a task they are not equipped to assist with. Another provider suggested that funding for transfer equipment along with training in transferring these patients safely may be helpful.

Communication barriers were also observed when patients present to the clinic with a lack of assistance

2018 Quality Improvement Annual Evaluation 77
and support. Some expressed having difficulty helping the patients to understand what the provider is trying to convey to them. Lastly, some providers simply noted that their staff were not equipped to serve these patients but did not provide further detail to the specific concerns the staff have with this population.

Providers stated that they are interested in additional training to help them to better serve patients with a special healthcare need. Resources that providers felt would be helpful are toolkits, webinars and educational topics in SNBC program benefits, and best practices in working with SNBC members.

**Post-Survey Follow-up**

The results of this survey helped the MCO collaborative identify action items to further the goals of the SNBC Dental Project during 2019. Responders clearly identified educational opportunities that would enhance their ability to successfully serve the SNBC population.

The majority of those who responded are not aware of the case management role (also referred to as care coordination) that SNBC members have access to. Educating the dental clinics about the availability of case management, and how this role could be optimized for some of their patients would enable dental clinics to include the case manager/care coordinator in the clinic visit process to increase the likelihood of a successful visit. This education could be completed via a combination of MCO provider newsletter articles and/or webinars to introduce this resource. In addition, there appears to be an opportunity to educate both providers and case managers about the benefit of having caregivers attending the dental appointment with members. For example, if member is approved for Personal Care Attendant (PCA) services, the PCA can be authorized to attend the appointment with the member. Educating care coordinators to ensure that the PCA is scheduled to attend with the member as well as educating providers of this option may help members have a better experience at their dental appointments.

In addition to the case managers, providers indicated a desire for education on health plan operations and resources such as filing claims, updates to State regulations, benefit set information and reasoning for low reimbursement. While the reimbursement rate is outside the scope of this project, the other topics are applicable for future educational opportunities. The plans can utilize the MCO grid developed in 2018 as a teaching tool for building these educational opportunities and offering a webinar on health plan resources.

Providers also clearly identified a desire for more information on best practices in working with the SNBC population. This aligns with the MCO mentoring group activities related to best practices. Interviews of experts in special needs dentistry in Minnesota were conducted in 2018. This information is being compiled into a usable format for educating clinicians and will be dispersed in 2019. Clinicians indicated that a toolkit format and/or a webinar series would be the most useful way for us to share this information.

**Barrier Analysis**

The SNBC population requires a set of structural and supportive service features to facilitate access to routine dental preventive and restorative care. Unfortunately, without these special features community dentists find it challenging to serve SNBC enrollees. Accommodations to address these features may range from simply accommodating a service animal, to a specialized dental chair, or the need for specialized dental procedures such as sedation.
The 2017 CAHPS dental survey results showed that a previous bad experience with a dentist and fear are among the top reported concerns by members. Because of many other socio-economic pressures, dental care may not be a high priority for members. If a member fails an appointment many providers have no show policies and will not reschedule the appointment.

The 2018 Care Coordinator survey identified member-identified reasons for not accepting dental care. They include:

- Member wears dentures therefore don’t feel dental care is important
- Dental care may not be a priority for the member as they are dealing with other social service needs and emotional issues
- Psychological issues (anxiety/depression)
- Fear (pain, loss of teeth, embarrassment, etc.)
- Needing dental work not covered by benefit set
- The member had a previous negative experience and does not wish to repeat it
- They feel that the severity of their dental issues is overwhelming

Some areas of the state have a shortage of dental providers who are contracted with HealthPartners, or who are accepting new Medicaid patients of any kind. Members who live in those areas can work with our dental navigators to find a dentist and with our RideCare program for transportation.

The benefit set for adults on Medicaid products (including SNBC) is very limited. Members may be reluctant to seek care knowing that the treatment they need is not covered and they cannot afford the costs.

The reimbursement rate for dental services for the Medicaid population is a well-known barrier that impacts provider willingness to serve this population. While this is not a focus of this project, the issue has been raised repeatedly in many venues and must be acknowledged to fully understand the issue.

Teledentistry – A required element of the SNBC Dental Access Project is for the MCO partners to collaborate with the DHS Direct Care and Treatment Dental Clinics (DCT-DC) to develop a teledentistry program. In 2018, DCT-CD informed the health plans that due to technical barriers, privacy concerns and funding issues, the DCT-DC clinic is unable to implement this intervention at this time.

Opportunities for Improvement: Results/Outcomes

The Overall Measure of Success for this project is to improve the HEDIS Annual Dental Visit measure from the 2015 baseline rate of 45.89% to 60%. This baseline rate is an aggregate rate for all SNBC dental plans for 2015.

During the first year of outreach for this project (November 1, 2017 and October 31, 2018) HealthPartners identified 2,899 members for Care Coordinator Outreach. Of these, 809 had a subsequent dental visit for a success rate of 28%.

DHS has provided the health plans with aggregate rates of SNBC members who had at least one dental visit during the year through 2018. As shown in the chart, the rate has improved since the project began in 2016 and as a collaborative, the rate has returned to the high point in our available data from 2014.
Percent of Members who had one or more regular (not ED) dental visits during the calendar year.

<table>
<thead>
<tr>
<th>Year</th>
<th>Program</th>
<th>N</th>
<th>D</th>
<th>Rate%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>SNBC</td>
<td>17,594</td>
<td>38,186</td>
<td>46.1%</td>
</tr>
<tr>
<td></td>
<td>FFS MA</td>
<td>22,176</td>
<td>45,310</td>
<td>48.9%</td>
</tr>
<tr>
<td>2015</td>
<td>SNBC</td>
<td>19,841</td>
<td>43,376</td>
<td>45.7%</td>
</tr>
<tr>
<td></td>
<td>FFS MA</td>
<td>21,319</td>
<td>43,243</td>
<td>49.3%</td>
</tr>
<tr>
<td>2016</td>
<td>SNBC</td>
<td>20,782</td>
<td>45,596</td>
<td>45.60%</td>
</tr>
<tr>
<td></td>
<td>FFS MA</td>
<td>20,219</td>
<td>40,876</td>
<td>49.50%</td>
</tr>
<tr>
<td>2017</td>
<td>SNBC</td>
<td>20,358</td>
<td>45,104</td>
<td>45.10%</td>
</tr>
<tr>
<td></td>
<td>FFS MA</td>
<td>19,128</td>
<td>39,080</td>
<td>48.90%</td>
</tr>
<tr>
<td>2018</td>
<td>SNBC</td>
<td>21,749</td>
<td>47,162</td>
<td>46.10%</td>
</tr>
<tr>
<td></td>
<td>FFS MA</td>
<td>18,025</td>
<td>37,190</td>
<td>48.50%</td>
</tr>
</tbody>
</table>

In addition to the aggregate data provided by DHS, HealthPartners monitors our own internal data to track our progress on this measure. The data for 2018 showed an increase in dental visits for SNBC members of 2.43% over 2017 dates.

<table>
<thead>
<tr>
<th>SNBC Annul Dental Rate Ages 18-64</th>
<th>2017</th>
<th>2018</th>
<th>DHS Goal for Project</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>44.10%</td>
<td>46.53%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Care Coordinators reach out to members following a visit to the ER for a non-traumatic dental reason. In the first measurement year of the project (November 1, 2017 and October 31, 2018) HealthPartners identified 216 SNBC members who received care in the ED for a non-traumatic dental reason. Of those, 29.2% were able to receive follow-up care in a dental office within 60 days.

Percentage of SNBC Members with a Dental Visit Following a Dental ER Visit

<table>
<thead>
<tr>
<th>SNBC Plan</th>
<th>Total # ER visits</th>
<th>Visit 1-15 days</th>
<th>Visit 16-30 days</th>
<th>Visit 31-60 days</th>
<th>% of visits within 60 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>HealthPartners</td>
<td>216</td>
<td>20.4%</td>
<td>5.6%</td>
<td>4.2%</td>
<td>29.2%</td>
</tr>
<tr>
<td>All Plan Totals</td>
<td>1,733</td>
<td>26.3%</td>
<td>12.9%</td>
<td>8.9%</td>
<td>48.1%</td>
</tr>
</tbody>
</table>

Percentage of SNBC Members with a Dental Visit Following a Dental ER Visit (DHS Data – all SNBC MCOs)
Conclusions/Lessons Learned

Dental access for SNBC members is a complex issue which will require a multi-faceted approach to see improvement. However, there is a need for dental clinics to better understand both the health plan logistics of serving the Medicaid population, as well as the stated desire to better serve the SNBC population in particular. Both of these areas continue to be a focus of this project as we go forward.

Care Coordinators are in a unique position to support SNBC members in acquiring dental care. The project will continue to offer care coordinators support and resources to continue to reach out to members to encourage use of dental coverage.

Sustainability of the Activity

HealthPartners actively works to contract with additional providers for government programs patients. This is an ongoing effort that will continue beyond the scope of this project as we have a commitment to providing and improving access for our members in our service areas. We contract with any willing provider agreeing to the contract terms while meeting credentialing criteria. We will continue to evaluate our networks to identify gaps and those areas of need are the first priority.

The length of this project is somewhat open-ended, with a 3-5 years’ timeline identified in the project guidelines. During that time interventions will be evaluated and issues identified will be addressed as appropriate.
Chronic Care Improvement Program (CCIP): H2422 MSHO Improving Antidepressant Management in Senior Population

Description

**Timeframe**
This project, Improving Antidepressant Management in the Senior Population initially began 1/1/2016 as a QIP. Per CMS guidance, in the letter dated 10/10/2018, this project transitioned to a CCIP on 1/1/18 and formally concluded 12/31/2018, however the member outreach initiatives remain in effect, and all tools developed during the project are available for continued use.

**Project Summary**
Upon initial diagnosis of depression and starting an antidepressant, a patient may see results in a few weeks, but most people need to remain on the medication for at least 6 months to ensure adequate response to symptoms. The Antidepressant Medication Management (AMM) HEDIS measure, continuation phase, looks at the percentage of members who remained on an antidepressant for at least 180 days (6 months).

This project aims to increase the rate of MSHO members who remain compliant with their antidepressant medication for 6 months. We also hope to impact barriers in member and provider knowledge and understanding of disease and pharmacotherapy treatment complexity of depression.

Prevalence of depression continues to rise as 1 in 10 adults report experiencing depression (Centers for Disease Control & Prevention, 2012). Anti-depressant medication adherence is a challenge for both providers and members. The complexity of the disease and pharmacotherapy treatment in elderly populations creates barriers in member and provider knowledge and understanding. The interventions executed in this project addressed those barriers with provider training and a provider toolkit. Additional interventions included outreach activities to reduce stigma associated with depression and its treatment in culturally diverse communities and efforts by HealthPartners and our behavioral health staff to educate and remind members of the importance of continuing their antidepressant medications.

**Goals**
The goal of the QIP project is to improve performance of HEDIS Antidepressant Medication Management (AMM Measure 6 month rate to 70% from baseline of 65.7%).

**AMM QIP Baseline Data – 2015 HEDIS**

2018 Quality Improvement Annual Evaluation 82
Measurement

The source of measurement for this project will be the HEDIS measure, Antidepressant Medication Management (AMM) – Effective Continuation Phase Treatment: The percentage of MSHO members 65 years of age and older with a diagnosis of major depression and were treated with antidepressant medication, and who remained on an antidepressant medication for at least 180 days (6 months).

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Numerator</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>70</td>
<td>46</td>
<td>65.7%</td>
</tr>
</tbody>
</table>

Initiatives/Interventions

The interventions for this project are a combination of outreach to HealthPartners members by our Behavioral Health area and collaborative activities for providers and others working with diverse populations on issues related to mental health and depression, including adherence.

Member Interventions

Care Coordinators and clinics worked with members to ensure that the member made a follow-up appointment after their initial anti-depressant medication prescription order.

First Fill Outreach

HealthPartners calls all MSHO members when they start a new antidepressant medication. The goal of these calls is to supplement the provider’s instructions and enhance understanding of the importance of the medication. Upon notification that a member has newly started an antidepressant medication, an independently licensed Behavioral Health professional from the HealthPartners Behavioral Health team contacts the member to educate them about the medication. Part of this conversation includes education about how long it can take to see benefits of taking the antidepressant medication and that it is recommended to continue an antidepressant medication for at least six months to see the maximum benefits.

During the call, the member is given an opportunity to discuss any questions or barriers they may have regarding medication adherence including barriers such as side effects or difficulty remembering to take their medication. The goal is to help remove any barriers and answer any questions or concerns that might be identified.
Refill reminders

HealthPartners Behavioral Health Program utilizes a refill reminder program for our Medicaid and MSHO population. We mail members a reminder letter when their medication is due to be filled. If the prescription is not filled, we send the member a more specific letter and call the member. Additionally, we send the prescriber a letter to alert them that their patient has not refilled their medication.

Provider and Staff Interventions

HealthPartners offered educational opportunities to our staff on specific areas to enhance their understanding of member’s complex medical and aging issues.

Provider Toolkit

HealthPartners worked with the other MSHO health plans to develop Antidepressant Medication Management: A Provider Toolkit in the first year of this project. The toolkit (available on the Stratis Health website for this project) provides relevant resources and tools for providers working with culturally diverse Medicaid patients who have depression. The toolkit focuses on issues related to medication adherence with an emphasis on racial and cultural perspectives. In 2016, the collaborative reviewed toolkit materials, updated links and added new resources such as tools for seniors and patients in rural areas.

The toolkit includes the following topics:

- Best Practices in Depression Care, including screening, medication adherence and follow-up after hospitalization
- Emerging Best Practice: Integration of Behavioral Health into the Primary Care Setting
- Cultural and Age Awareness and Treating Depression
- Shared Decision Making for Depression Treatment
- Mental Health Resources for providers, patients and caregivers
- Health Plan Resources and contacts

The Collaborative promoted the toolkit through multiple channels. Feedback on the toolkit has been positive and analysis of the web hits suggests that promotion of the toolkit through provider communications, newsletter articles, social media, webinars and conferences has driven interest.

2018 Webinar- In November 2018, the health plan collaborative offered a webinar on the interaction of behavioral health issues and opioids. Over 124 people attended the webinar and of those, 87.5% responded that the webinar addressed gaps in their knowledge and strategies that are relevant to their work.

HealthPartners Behavioral Health (BH) Staff education:
• Behavioral Health staff attended all of the webinars offered by the health plans working on this project.
• Several Behavioral Health staff attended conferences presented by Kente Circle – Healing in Community: Shifting the Burden of Dismantling Systemic Racism and Healing the Hidden Wounds of Racial Trauma. HealthPartners Behavioral Health Department was a sponsor of these events.

HealthPartners Clinic Partnerships

As part of this project, HealthPartners behavioral health leaders continue to work with our clinic groups to streamline both health plan and clinic processes and improve communication to create the best outcome for the member. Through this partnership, HealthPartners behavioral health staff participates on the Depression Expert Panel combining behavioral health expertise at the plan with primary care providers. An example of how this collaboration has improved processes and communications includes allowing the behavioral health staff to complete a needed PHQ9 and document the results in the medical record for the primary care provider. Anecdotally, care system leaders report this support from behavioral health staff to the clinic teams is extremely positive and valued. Approximately 82% of the MSHO population utilizes the HealthPartners Care Groups.

Partners in Excellence

The Partners in Excellence Program (PIE) is HealthPartners’ financial and public recognition for medical groups and pharmacies achieving high levels of performance on the Triple Aim of clinical quality, patient experience and affordability. The Antidepressant Medication Management measure was added to the Pharmacy PIE program in 2016. In the first year of the measure, two pharmacies won the Gold award and two pharmacies won the Silver award. In 2018, two pharmacies won Gold and three pharmacies won the Silver award for achievement on the AMM measure.

HealthPartners Community Partnerships

HealthPartners has a thirteen-year community partnership with the Minnesota chapter of the National Alliance on Mental Illness (NAMI MN) and was the founding sponsor of the NAMI Walk. We continue our strong partnership with this organization through our partnership and promotion of the NAMI Walk and the continuous development of the Make It OK campaign.

In 2016, HealthPartners, in partnership with America Public Media/ Minnesota Public Radio (MPR) began hosting podcasts titled “The Hilarious World of Depression”. These award winning programs with well-known comedians, such as, Peter Segal, Maria Bamford and Dick Cavett share their stories of how they live and cope with depression. These successful podcasts continue in 2018 with well-known musicians, actors and artists, such as Aimee Mann, Jeff Tweedy and Julie Klausner.

Make It OK continues to evolve with a freshened website experience based on new content and functionality. Between September 2016 and October 2017, there were more than 102,000 unique visitors to the Make It OK website, There was a substantial increase in traffic after the start of “The Hilarious World of Depression” podcasts. The Make It OK website averages 5,000 visitors per month and approximately 25% of these are new visitors. Make It OK conducted a survey and found 7 – 16% of local communities are aware of Make It OK. 2018 data is still being evaluated and analyzed.
Total Target Population

The number of enrollees for the HEDIS AMM measure in the denominator was 70. The denominator was seventy in each of the 3 measurement years.

Number of Enrollees or Providers Who Received Intervention(s)

The number of enrollees who received interventions was 322, through November 2018 dates of service.

Results and/or Percentage

- Over the course of the project, 322 members received at least one refill reminder letter. Of these, we identified 114 members who did not fill their prescription after receiving the refill reminder letter. Of the 114 members, we engaged 47 of them by telephone for an engagement rate of 41.2%. Of the 47 engaged, 13 refilled their prescription within seven days for a rate of 27.7%. 131 members had overdue refill reminder alert letters sent to their providers.
- It is worth noting that many members received multiple outreaches due to repeated late re-fills. This number reflects the number of unique members rather than the total number of unique outreach efforts.

Other Data or Results

AMM Members that had an office visit after initial medication fill

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Denominator</th>
<th>Numerator</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEDIS 2017</td>
<td>73</td>
<td>26</td>
<td>35.6%</td>
</tr>
<tr>
<td>HEDIS 2018</td>
<td>70</td>
<td>33</td>
<td>47.1%</td>
</tr>
</tbody>
</table>

Using claims data, we measured the percentage of members who scheduled a follow-up appointment after their initial anti-depressant medication order. As the project progressed the outreach resulted in a higher number of members who had an office visit after initial medication fill which demonstrated an increase of 11% from the previous year.

Results and Findings

The goal of the QIP project was to improve performance of HEDIS Antidepressant Medication Management (AMM Measure 6 month rate to 70% from baseline of 65.7%). HEDIS 2018 results of 64.3% did not meet the stated goal.

Analysis of Results or Findings

- Due to the small numbers the final result remained flat for this improvement measure. The MSHO population is typically older with more disease burden and may have increased side effects. These can be barriers to medication adherence for at least six months.
The data did demonstrate improvement in the number of members with a follow up appointment after the initial antidepressant medication fill.

**Barrier Analysis**

**Member Barriers**
- In general, members report several reasons for not refilling their prescription on time or at all. When members experience unexpected or severe side effects, they may decide to stop the medication. Others feel their medications did not work, or their symptoms improved so they feel the medication is not needed. Others report they did not understand the importance of continuing to take the medication, which could be the result of lack of education by the prescriber. Behavioral Health identifies and addresses any adherence barriers in partnership with the member during the call and provide additional resources to meet the member’s unique needs.

**Data Limitations**
- The timing of the specifications described in the measurement section shows how the HEDIS measure itself is a barrier to seeing improvement in the rate. The total length of the measurement period covers 18 months. That means that by the time the data is run, some of it is actually two years old. This makes it very challenging to determine which intervention made a difference. There are also eight months each year (May – Dec.) where two different cohorts are receiving the same process improvement efforts. This makes it very challenging to see year over year increases in medication adherence.
- With a small population such as ours, small changes in the numerator or denominator can lead to significant fluctuations in the results.

**Sustainability of the Activity**
- This project provided a great deal of education to care coordinators, providers, public health professionals and others. Education of staff and providers who continue to work with this population on this issue is the greatest form of sustainability. These opportunities will continue to be available to additional health professionals who desire an understanding of issues related to depression in seniors.
- HealthPartners continues to enhance the program through refinement of call scripts, work flow processes, policy changes and departmental resources which will further standardize this work. Policies are reviewed annually and needed revisions will be made.
- The Provider Toolkit, recorded webinars and any tools developed for this project remain on the Stratis Health website.
- This CCIP formally concluded 12/31/2018 but HealthPartners will continue member outreach activities to this population.
Chronic Care Improvement Program (CCIP): H4882

Journey Diabetic Nephropathy

Timeframe
The Diabetic Nephropathy CCIP began 1/1/2018 and will conclude 12/31/2020.

Description
According to an article in Diabetes Research and Clinical Practice, “Diabetic nephropathy is one of the most prevalent microvascular complications in patients suffering from diabetes and is reported to be the major cause of renal failure when compared to any other kidney disease.” The CDC has stated the only way to find out for sure if you have CKD (Chronic Kidney Disease) is through specific blood and urine tests, which measures both creatinine level in the blood and protein in the urine. By testing the urine for microalbumin in the Medicare Advantage population, we hope to identify members that have diabetic nephropathy and slow disease progression. According to CDC guidance, once CKD is detected it may be addressed through lifestyle changes, including making healthier choices about what you eat and drink, and can often be treated with medications which may keep CKD from getting worse or prevent additional health problems such as heart disease.

This project aims to increase nephropathy screening in the members with diabetes to identify diabetic nephropathy and potentially slow disease progression with treatment of ACE/ARB medication if clinically indicated.

Planned interventions
- Provider education in Fast Facts provider newsletter
- Enrollee outreach by identifying members not having a claim for diabetic nephropathy screening
- Enrollee/Caregiver Engagement by utilizing the annual wellness visit to identify chronic conditions and schedule follow up screenings if clinically appropriate

Goals
The goal of the CCIP is to reach the 5 Star HEDIS threshold for the diabetic nephropathy measure of 97%. The progress will be measured based on percent of members with diabetes who had a kidney function test during the year.

The current rate for the plan is 93.33% (140/150) with dates of service through December 31, 2018 and the targeted goal for the 5 Star threshold for the CDC-Kidney Disease Monitoring for 2018 was 98%.

The goal would be to increase from the 3 Star threshold to the 2018 5 Star threshold of 98%, which is approximately a 7 percent increase or an additional 7 members who meet the measure.

Measurement
The data source to identify this chronic condition is from the NCQA HEDIS 2017 Technical Specifications which is the percentage of diabetic MA enrollees 18-75 with diabetes (type 1 and type 2) (denominator) who had medical attention for nephropathy during the measurement year (numerator).

**Initiatives/Interventions**

- HealthPartners identified members with diabetes who did not having a claim for diabetic nephropathy screening yet in 2018. Those members were sent a Microalbumin Kit in the mail to complete and return for testing. The member will receive the results of the screening via US mail. The primary physician will also receive the results to discuss with the member next steps for treatment if clinically appropriate.
- HealthPartners is promoting the Annual Wellness Visit (AWV) with Medicare members as a way to encourage them to ensure all of their health care needs are addressed by their physician as needed. During an AWV all the members medical issues and chronic conditions should be reviewed and any preventive care needed identified.
- We included an article in the provider newsletter Fast Facts as a reminder to providers on the importance of diabetic nephropathy screening and medical attention for nephropathy. The article highlighted the ICSI guidelines for monitoring for nephropathy and the expectation of medically appropriate treatment: documentation of ESRD, chronic or acute renal failure, renal insufficiency, diabetic nephropathy, dialysis or renal transplant, or was a urine test for albumin or protein performed during the measurement year, or review for evidence of ACE inhibitor/ARB therapy in the measurement year.

**Barrier Analysis**

**Provider limitations**
- The Fast Facts article may have limited reach thereby impacting a small percentage of physicians to change practice patterns.
- Standard processes have yet to be developed for consistency in completing interventions for diabetic nephropathy.
- Limited annual wellness visit utilization.

**Data limitations**
- The 2018 5 Star threshold for the CDC-Kidney Disease Monitoring was 98%. This can be challenging to achieve in this population that may have other co-morbidities.
- Due to the small population of members, the difference between the next star ratings could be one or two members.

**Opportunities for Improvement: Results/Outcomes**

Targeting providers through fast facts education and annual wellness visit promotion will, overtime, increase the number of members receiving medical attention for nephropathy. The current rate is 93.33%, which is a 3 Star Rating.
2018 Dates of Service through December 2018

<table>
<thead>
<tr>
<th>Contract</th>
<th>Product Name</th>
<th>Denominator</th>
<th>Numerator</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>H4882</td>
<td>Journey/Robin</td>
<td>150</td>
<td>140</td>
<td>93.33%</td>
</tr>
</tbody>
</table>

**Utilize Annual Wellness Visit** to identify chronic conditions and ensure screenings that are clinically appropriate.

- Identify the Medicare Advantage members with the chronic condition of diabetes that need medical attention for nephropathy and conduct outreach to encourage them to complete an annual wellness visit.
- Of those identified for outreach related to an annual wellness visit, 20.77% have completed the visit through December 31, 2018 dates of service.

**Member outreach Microalbumin Test Kit** - Identify the members based on the HEDIS Metric for the percentage of diabetic Medicare Advantage enrollees 18-75 with diabetes (type 1 and type 2) (denominator) who had medical attention for nephropathy during the measurement year (numerator) based on the NCQA HEDIS 2018 Technical Specifications.

- Thirty-six Medicare Advantage members with diabetes were identified as not having nephropathy screening in measurement year and were sent a Microalbumin test kit.
- Of the 36 members identified for outreach, 7 returned the test kit for a return rate of 19%.

**Sustainability of the Activity**

Health Partners will continue to promote education on interventions for diabetic nephropathy. Annual Wellness visit promotion will continue with provider education and member outreach. Member outreach with microalbumin test kits will continue for those identified as not having nephropathy screening in the measure year.
Quality Improvement Program (QIP): H4882 Journey Annual Wellness Visit

Description
In 2011 Medicare introduced the Annual Wellness Visit (AWV), the first annual health check-up offered by Medicare at no cost to patients. The visits are intended to encourage evidence-based preventive care and mitigate health risks in aging patients. AWV use increased from 7.5 percent to 15.6 percent between 2011 and 2014. In some regions around the country, only about 3 percent of eligible patients received an AWV, compared to 34 percent in other areas. White urban residents, and those from higher-income areas, were more likely to receive an AWV, as were patients who received an AWV in the previous year, or belong to an Accountable Care Organization, a group of providers who collaborate to provide coordinated care for Medicare patients. Findings suggest that AWV use is probably driven more by practices and health systems deciding to offer the visit, than by patients requesting it. AWV were frequently co-billed with problem based visits, corroborating patient concerns about unexpected costs and emphasizing the need for conversations about potential cost-sharing. There were also notable socioeconomic disparities in AWV use.

The interventions proposed in this QIP are to incorporate strategies such as provider outreach, reward providers with incentives to accomplish AWV, and outreach activities to educate and remind members of the importance of AWV completion.

Goals
HealthPartners goal is to increase the percentage of Journey eligible enrollees who receive an Annual Wellness Visit. We set an initial goal of 20% which we have exceeded in 2018. We will select a new goal for 2019.

National Benchmark: 2014 AWV rate: 15.6 percent
HealthPartners 2018 Rate: 20.77 percent (260/1252) is the Journey Annual Wellness Visit percentage through December 31, 2018.

Initiatives/Interventions
Plan outreach to Providers
- Providers received the Fast Facts provider newsletter in May of 2018 Titled “Annual Wellness Visits-What are patients thinking?”
- Providers received the Fast Facts publication in September 2018 highlighting Annual Wellness Visit completion and falls discussions.
Measure of success for provider outreach will include the volume of AWV completions of those providers who received outreach. There were no provider incentives for the annual wellness visit.

Member interventions

- Enrollee member education and outreach regarding the value of personalized, proactive coordinated preventive care plans. The AWV improves future care experience for members and their families by incorporating personal and family preferences. It also supports activities of daily living, adherence to treatments and medications and identifies medical group and community resources to help with identified needs and concerns.
  - All new members receive a welcome packet with a reminder to complete the Annual Wellness Visit. All plan members enrolled received a January mailing promoting the AWV. Members also received reminder letters and an AWV Flyer/Calendar.
- HealthPartners conducted MyVoice surveys regarding member perceptions around Annual Wellness Visits and Falls Prevention insights. Insights were used to strengthen member outreach approaches.
- Member blogs educated members about how to prepare for appointments and prevent falls.

Barrier Analysis

Member limitations

Research was conducted through MyVoice surveys identified the following insights and barriers:

- Just over half of these members (56%) have completed an Annual Wellness Visit as a HealthPartners member on a Medicare plan.
- Members are unclear on what this visit includes and how it is different than an annual physical exam.
- Only 11% rate themselves as extremely confident in understanding what this visit includes. Those members assigning lower ratings to the importance of having an Annual Wellness Visit say they would like further explanation of the difference between this visit and an annual physical exam.

The top influences to schedule an Annual Wellness Visit are:

- Understanding what the visit includes
- Knowing there’s no cost
- Understanding how an Annual Wellness Visit would be helpful

Provider limitations
• The provider education FastFacts article may have only reached a small percentage of physicians to change practice patterns.
• Standard processes have yet to be developed for consistency in completing the annual wellness visit.
• Resource limitations on providing education to front-line staff when scheduling/prepping for the annual wellness visit

**Electronic Medical Record limitations**

• Some clinic groups program their EMR to only allow an AWV every 12 months.

**Opportunities for Improvement: Results/Outcomes**

This project achieved an annual wellness visit rate of 20.77% for Journey enrollee members 65 years of age and older with dates of service through December 31, 2018 which did slightly surpass the goal of 20%.

• Best practices: Member outreach combined with provider incentives have shown to have a higher completion rate for annual wellness visits.
• Lessons learned: Since there were no provider incentives this may have contributed to the lower completion rate.

**Sustainability of the Activity**

The plan will evaluate the interventions to determine how to sustain these in the years to come. The health plan will use the Plan, Do, Study, Act (PDSA) quality cycle to evaluate the effectiveness of these programs on making internal changes and to sustain these initiatives.

• This initiative provided education to providers and members on the importance of completing an AWV yearly. Per CMS direction this Quality Improvement Plan ended 12/31/2018.
Medical Record Documentation

Description

Medical record documentation standards should facilitate communication, coordination and continuity of care. HealthPartners conducts an annual audit to measure the quality of documentation of select indicators. The Medical Record Standards Advance Care Planning measure is a requirement under our DHS contract for State Public Program members. The measure includes PMAP, MNCare, MSHO and MSC+ members 19 years and older, seen at primary care clinics.

2018 Medical Record Documentation (DOS 2017) Indicators:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Source</th>
<th>Purpose</th>
<th>Results</th>
<th>Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Directives – note in PCP medical record that member has had a discussion with provider or has an advanced care plan within the record</td>
<td>Data set pulled for HEDIS – Preventive Services Public Program Members Up to Date – Adult (19 years and older) – same data specifications as HEDIS Advance Planning in Care of the Older Adult</td>
<td>Coordination of Care and adequacy of Medical Record Documentation</td>
<td>Eighteen medical groups were included in the Medical Record documentation clinical indicator audit.</td>
<td>Continue to monitor and report clinic specific results – 2018 Results letter sent to medical groups, requesting they work toward a specific goal of at least 20% in 2019.</td>
</tr>
</tbody>
</table>

Goals

HealthPartners will continue to monitor and report medical record audit data. The 2018 results letter from HealthPartners Quality and Compliance team notified medical groups of their performance on this measure and requested groups work to meet a specific goal of at least 20% in 2019.
Opportunities for Improvement: Results/Outcomes

Performance ranged from a high of 28.57 percent to a low of 0.00 percent. This report is a snapshot in time and performance is based on a sample of medical records. The variability in performance may, in part, be due to sample size. However, the levels of documentation do indicate a continued need to focus on this measure.
Interventions

- HealthPartners actively promoted Annual Wellness Visits (AWV) to both our members and to our care network. The nature of the AWV supports the discussion between the provider and member on Advance Directives.
- To streamline data collections, HealthPartners will collect 2019 Medical Record documentation data simultaneously with plan HEDIS medical record audits.
- In January of 2016 Medicare initiated payment to physicians to discuss end of life care planning with patients.
- HealthPartners promoted Advanced Care Decision Day in 2018 with a 3rd annual organization wide survey regarding advanced directives.
- During the Week of National Healthcare Decisions Day (NHDD), HealthPartners had a featured story in the Beat with a banner and link on the My Partner web site.
- During the Week of NHDD, raised awareness among employees with cafeteria table promotions including:
  - Wheel of Misfortune Activities
  - Short and Long form Advance Directives handed out
  - Assistance from an Advance Care Planning Facilitator to complete forms
- HealthPartners added completion of Advance Directive to the “Be Well” options in 2018 to satisfy employee wellness activities.
MSHO Model of Care Measureable Goals

**Description**

The MSHO Model of Care describes the management, procedures, and operational systems that HealthPartners has in place to provide access to services, coordination of care and the structure needed to best provide services and care for the MSHO population. The current MSHO Model of Care was approved for years 2018-2020. We have not presented historical data because the Model of Care Measureable Goals can differ from previous approved versions.

As we’ve implemented the goals and based on feedback from a 2017 mock audit, we are in the process of re-evaluating the measures and metrics used for these goals.

CMS requires plans to identify and define measurable goals and health outcomes for the Model of Care.

<table>
<thead>
<tr>
<th>MSHO Model of Care Measureable Goals</th>
<th>Measurable Goals Description</th>
<th>Results</th>
<th>Initiatives/Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meet 100% of Required Access Standards</td>
<td>Meet 100 percent of the access standards required by both Centers for Medicare and Medicaid Services (CMS) and Minnesota Department of Human Services (DHS).</td>
<td>Met</td>
<td>HealthPartners successfully submitted Health Service Delivery (HSD) tables to CMS in 2018 which ensured that the access standards were met (note: we submitted an Exception Request for Chisago County for Cardiac Surgery Program because there are no cardiac surgery programs in that county or nearby). HealthPartners complied with the DHS access standards by performing network analysis twice annually using GeoAccess software.</td>
</tr>
<tr>
<td>Maintain Zero Premium</td>
<td>Providing affordable care is achieved through our ability to offer a program with a zero premium. We achieve the goal when we receive CMS approval of our final bid with a zero premium.</td>
<td>Met</td>
<td>Appropriate planning and modeling with Actuarial Department to ensure a zero premium.</td>
</tr>
<tr>
<td>Initial Health Risk Assessment Rates</td>
<td>Achieve a 1% increase over the initial health risk assessments completed within 90 days of each beneficiary's initial</td>
<td>Met</td>
<td>Quarterly review of results from reports developed for this purpose. Results recorded on master grid to track progress over time.</td>
</tr>
</tbody>
</table>

2018 Quality Improvement Annual Evaluation 97
<table>
<thead>
<tr>
<th>MSHO Model of Care</th>
<th>Measurable Goals Description</th>
<th>Results</th>
<th>Initiatives/Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measurable Goals</td>
<td></td>
<td>2018</td>
<td>2019</td>
</tr>
<tr>
<td>Enrollment.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Risk</td>
<td>Achieve a 1% increase over the reassessments completed within 365 days of the previous health risk assessment.</td>
<td>Met</td>
<td></td>
</tr>
<tr>
<td>Reassessment Rates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhancing Care</td>
<td>Achieve a 1% increase over the baseline at the end of a three-year period of the percentage of beneficiaries with a post-discharge assessment completed after transitioning out of a hospital back to their regular setting.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Transitions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved Plan</td>
<td>Improve medication management which will result in a 7% decrease of 30-day readmissions for our MSHO population by the end of this three year project, which spans from 2016 through the end of 2019.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>All Cause Readmissions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>Improve osteoporosis management by 1% over the previous year’s rate for the female MSHO beneficiaries who experience a fracture.</td>
<td>NED</td>
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<td>Management in</td>
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<tr>
<td>Women Who had a Fracture</td>
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2018 Quality Improvement Annual Evaluation  98
<table>
<thead>
<tr>
<th>MSHO Model of Care Measurable Goals</th>
<th>Measurable Goals Description</th>
<th>Results</th>
<th>Initiatives/Interventions</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>2018</td>
<td>2019</td>
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HealthPartners performs an annual comprehensive review of the current measurable goals and health outcomes to determine if goals have met benchmarks and have been achieved. An evaluation of all measures is conducted to determine which measures will be continued, be reevaluated and redefined, or be removed and replaced with a new measure or outcome.
Behavioral Health

Description

Behavioral health conditions are prevalent and highly distressing to impacted members, their families and communities. Behavioral health conditions reduce member abilities to effectively 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 poor lifestyle choices. Finally, behavioral health conditions when undiagnosed or undertreated undermine the individual’s ability to experience wellbeing, satisfaction and joy. HealthPartners is pioneering improving the emotional well-being of members, patients and employees whether they have behavioral health diagnoses or not. This work focuses on building cognitive, emotional and interpersonal skills. Finally, 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 affordability of behavioral health care.
- Support smooth transitions in care by providing coordination across sites of care and amongst providers of care.
- Partner with community-wide initiatives to improve behavioral health services and outcomes for members, patients and the community and to reduce stigma regarding mental health.
- Increase the percentage of HealthPartners members, patients and employees who cope well with stress and are thriving

Initiatives/Interventions

Working with several medical groups, community partners and internal departments, HealthPartners Behavioral Health staff has initiated several programs to reach our goals. Each program is reviewed annually for potential ways to increase our effectiveness by finding new ways to engage members and patients, reduce barriers to care and services and increase the affordability of care.

The following programs are designed to support our most vulnerable members and their families in their quest to obtain optimal health.

Disease Management

HealthPartners has four Disease Management programs help educate members with key behavioral health conditions and support them to improve their condition self-management.
On Your Way® is for members with Depression who are newly starting an antidepressant medication. This program provides 6 monthly educational newsletters about depression, antidepressant refill reminder letters to the member and prescriber alert letters if members fail to refill their medication, so that care delivery teams can take action to support their patients.

A similar program of health education newsletters and medication refill reminders, called Moving Forward®, focuses on educating and supporting members with bipolar disorder or schizophrenia.

The third program called Step by Step® offers refill reminders to members who are prescribed anti-craving medication to reduce the likelihood of chemical dependency relapse.

Our newest program, Day by Day®, is for members with anxiety disorders to help them access evidence based care and minimize the use of benzodiazepines.

These four Behavioral Health Disease Management programs had combined member communications of over 227,000 among a group of over 66,500 members.

Case Management

HealthPartners Behavioral Health Case Management has innovative methods to identify and proactively reach out to members who are at high risk for psychiatric hospitalization, to help them understand their behavioral health clinical condition, adhere more closely to outpatient treatment recommendations and gain condition self-management skills. Health education, motivational interviewing, decision support and crisis plan creation and relapse prevention planning are provided telephonically by dedicated, licensed behavioral health professionals.

Typical members identified for Behavioral Health Case Management have three or more psychiatric conditions, some of which may be undiagnosed or undertreated. These individuals frequently need multiple types of treatment, including one or more psychiatric medications, therapy, partial hospitalization or intensive outpatient program. Matching member culture and cultural needs with network provider’s capabilities is one area in which Behavioral Health Case Management excels.

The Behavioral Health Case Management programs for members at high risk for psychiatric hospitalization had nearly 45,500 member communications which focus on education, care coordination, medication adherence and closing gaps in care with over 7,550 members.

The Behavioral Health Utilization Management programs helped assure coverage for appropriate levels of care for over 7,700 members. HealthPartners conducts medical necessity and level of care review for a few types of care, such as inpatient care at a non-contracted hospital, and residential level of care. HealthPartners has worked effectively to remove barriers to accessing care, so a narrowly focused utilization review approach is compatible.

2018 was the eighth year for Alcohol Screening, Brief Intervention or Referral to Treatment (SBIRT) supplied by Behavioral Health Centralized Services to HealthPartners Medical Group members and patients. In 2017, the same SBIRT service was extended all to members and patients at Park Nicollet Clinics.
Building Emotional Resilience

Beating the Blues (BTB) is an evidence-based online intervention of eight half hour sessions using cognitive behavioral therapy which teaches skills to decrease stress, depression and anxiety. This program is evidence based for reduction of depression, anxiety and stress and is available to all HealthPartners members and all HealthPartners family of care patients. Typically these sessions are completed in eight to 12 weeks.

- Available on desktop, laptop, tablet and new in 2018, smart phones with automatic synchronization across platforms.
- Engaging content, with several videos of actors who simulate having symptoms of stress or other emotional concerns and demonstrate how they used the new cognitive skills learned in each session.
- Ability to be self-administered or coached by a variety of health providers. HealthPartners coaches encourage participation and respond to a narrow range of questions about the purpose and functionality of the program.

Building on our 2015 successful pilot, HealthPartners Behavioral Health strongly promoted the online program to all HealthPartners Medical Group and Park Nicollet primary and specialty clinic sites, HealthPartners employees and multiple large and small employer groups in 2016.

In 2017 we maintained the promotional momentum and implemented additional direct to member notification of the program through refill reminder letters and disease management newsletters. For patients at HealthPartners Medical Group and Park Nicollet primary and specialty clinic sites, we added a telephone message promoting BTB and added it to the roster of options for HealthPartners clinics when a patient is on hold, one or more messages play. We refreshed the BTB message that displays on clinic wall monitors.

To expand the Building Emotional Resilience suite of services, we created several online learning topics and piloted with HealthPartners employees and spouses through Be Well. The aim is improved functioning in the workplace and beyond. These online courses have three 15 minute segments per topic. Topics include:

- Healthy Thinking
- Healthy Communications
- Finding Purpose and Meaning through Work

Two more topics were added in 2018:

- Choose Civility
- Bring Your Best Self to Work

Over 1900 HealthPartners employees and spouses completed these on-line courses in 2017 and nearly 1900 more employee and spouse completions in 2018.
Programs to Eliminate Stigma about Mental Illness

HealthPartners is aware that stigma is a barrier to getting prompt mental health evaluation and treatment, so we partnered with NAMI MN and Public Television TPT and created “Make It OK”, an award winning campaign to eliminate stigma regarding mental illness through education and personal insights. The Make It OK campaign consists of a website that includes:

- Stories by Minnesotans who are living productively with mental illness and “asking” them questions via this online interactive program
- Online interactive materials that challenge all of us to think about mental illnesses like we do physical illnesses
- Four half-hour public television programs which profile a variety of individuals living with mental illnesses. The television programs will air in rotation for another two years
- A logo-free tool box of electronic materials such as slides, posters and Web enabled short videos to enable providers and employers to implement Make It OK
- The website is also available on a mobile platform for smartphones

Washington and St. Croix counties and Lakeview Medical Center continued their partnership with others in the St. Croix Valley in 2018 to promote Make It OK in schools and clinics.

In 2016, HealthPartners in partnership with America Public Media/ Minnesota Public Radio (MPR) began hosting podcasts titled “The Hilarious World of Depression”. These award winning programs with well-known comedians, such as, Peter Segal, Maria Bamford and Dick Cavett share their stories of how they live and cope with depression. These successful podcasts continue in 2018 with well-known musicians, actors and artists, such as Aimee Mann, Jeff Tweedy and Julie Klausner.

Barrier Analysis

For the most complex members it is important to leverage all of our available resources. When the member with a complex behavioral health condition is also a patient at either HealthPartners Medical Group or Park Nicollet, we have significantly more information, combined resources and Triple Aim incentives to provide best practice care and coordination.

As part of our annual barrier analysis, we seek input from primary and behavioral health care clinicians, with health plan quality and behavioral health experts. The following were reviewed:

- Data analysis of the initial scores for the PHQ-9 and GAD-7 screening tools reveals 25% and 30% of the participants have moderate to severe depression or anxiety, respectively.
- Overall, our Behavioral Health Case Management engagement rates have been consistently in the 40 – 47% range the past 4 years.
- Data analysis from our 2017 intervention where after an identified high risk member visits the Emergency Department for a behavioral health diagnosis, the case manager reaches out to the member to offer assistance and support.
• HEDIS rates for Children and Adolescents on antipsychotic medications increased slightly between HEDIS 2017 and HEDIS 2018.
• Stigma continues to be a barrier to getting prompt mental health evaluation and treatment.

The following opportunities were identified:

• Greater integration of behavioral health and medical care.
• Support more members with depression and/or anxiety diagnoses by offering BTB directly to them.
• Support more BTB participants to complete at least 6 sessions of the program.
• Refined the technical specifications for our outreach to members who are at high risk for psychiatric hospitalization and had an Emergency Department visit for behavioral health issue.
• Support the parents of children and adolescents who are taking antipsychotic medications by providing timely guidance.
• Develop new ways to support members, patients and employees who are increasingly faced with challenges due to mild and moderate stress, sadness, tension, depression and anxiety.

Interventions:

• To support members and patients with depression and/or anxiety diagnoses, we added BTB information to On Your Way refill reminder letters and to the letters and newsletters in the Day by Day program.
• Developed targeted messaging:
  o for BTB participants who have not completed the program
  o for BTB participants who have completed the program over a year ago, encouraging them to refresh their skills and also informed them of the online Building Emotional Resilience three segment courses
  o for members who have behavioral health or chronic medical conditions, informing them of the BTB program and the online Building Emotional Resilience three segment courses
• After an identified high risk member visits the Emergency Department for a behavioral health diagnosis, the case manager contacts the member to offer assistance and support. We refined our technical specifications so that we could outreach to our members more timely, increasing our engagement rate.
• Continued sending letters to parents of children and adolescents on antipsychotic medications to encourage annual metabolic screening and/or addition of psychotherapy to obtain best outcomes. For those who had not had the lab testing completed by end of third quarter, we sent a second reminder letter.
• Partnered with Be Well to create a scalable solution for all members to access the Building Emotional Resilience series which includes online presentations on:
  o Healthy Thinking
Healthy Communications
Finding Meaning and Purpose in Work
Choose Civility
Bring Your Best Self to Work

Gaps in Care

Affordability and stigma are two major barriers for members/patients seeking behavioral health services. One way we have addressed both barriers is by offering a free online Cognitive Behavioral Therapy program titled Beating the Blues. Started in spring 2015, this program has been promoted to include all members, all patients and all employees in 2016 and 2017. For 2017, there were 2661 participants and in 2018 there were an additional 2703 unduplicated participants.

An additional gap in care is sometimes members/patients lack of adherence to medications for behavioral health conditions. In 2018, there were 31,434 instances where members in three of the disease management programs were at least five days overdue filling their prescriptions. In 2017, there were 19,238 instances where members in three of the disease management programs were at least five days overdue filling their prescriptions.

Opportunities for Improvement: Results/Outcomes

- Several behavioral health services were created to have positive impact on members with conditions. The following services were provided in 2018:
  - The On Your Way® depression program engaged 30,765 members across all insurance products and provided a total of 157,369 newsletters and refill reminder letters, of which, 73,326 or 47% were distributed via Secured Web Mail (SWM).
  - The Moving Forward® program which supports our members with schizophrenia or bipolar conditions, across all insurance products, engaged 21,250 members and provided a total of 48,014 newsletters and refill reminder letters, of which 18,440 or 38% were distributed via SWM.
  - Our third program called Step by Step®, across all insurance products, supported 11,625 members who are on an anti-craving medication to prevent chemical dependency relapse, with a total of 18,294 refill reminder letters, of which, 7,680 or 42% were distributed via SWM.
  - 2018 was the first full year for our fourth program, Day by Day®, across all insurance products, supported 1,440 members with Anxiety Disorders to help them access evidence based care and minimize the use of benzodiazepines for treatment of anxiety, with a total of 2323 letters and newsletters, of which, 1,344 or 58% were distributed via SWM.

- Another initiative was created to support primary care physicians with alcohol screening. The integration of our organization is exemplified by documentation of Behavioral Health Centralized Services (health plan) in HealthPartners Medical Group and Park Nicollet Clinics.
electronic medical record and the creation and maintenance of several detailed workflows which reflect the respective roles of clinicians and health plan staff.

- Proactive phone outreach to Medicaid members by Behavioral Health Centralized Services when the member is overdue in refilling their antidepressant, antipsychotic or mood stabilizer medication. In 2018 there were 2732 instances when members/patients were overdue. Fifty-two percent were engaged by phone and 43.4% of the engaged refilled their medication within 7 days of the phone call. This is 22.5% of the total identified or 615 individuals.

- Of the 3524 members engaged by Behavioral Health Case Management, member satisfaction was 97% in 2018 which indicates that this program is valued and of assistance to members.

- Of the 139 members outreached to after an Emergency Department visit for a behavioral health issue, 37% engaged in ongoing behavioral health case management.

- Preliminary analysis of BTB participants showed that the program is serving its intended function of reaching and helping those with mild to moderate stress, depression and anxiety. A three-point scale BTB participant survey revealed high satisfaction with 94% saying it has been helpful in their work life and 97% saying it has been helpful in their personal life.

- 2018 was the eighth year for SBIRT supplied by Behavioral Health Centralized Services to HealthPartners Medical Group and Park Nicollet Clinic members and patients. In 2018 there 560 patients were identified, with 37.3% engagement and completion of a standardized alcohol use screening tool and documentation of results in EPIC.

- Season two of “The Hilarious World of Depression” was in the top 20 downloads from iTunes. The second season which started in September 2017 had 1.4 million downloads in September and over 630,000 additional downloads in October.

- HealthPartners conducts an annual assessment of member satisfaction with aspects of behavioral health care, including access to care. In alternating years, the focus is on adult vs. child and adolescent behavioral health. Surveys regarding children or adolescents are directed to their parent/guardian. The 2018 child/adolescent survey sample size had a 95% confidence interval with plus or minus 5 percentage points of error with a response rate of 12% of the 3,427 members who were outreached.

- Review of the survey results revealed that respondents were very satisfied/satisfied:
  - with the availability of convenient appointments 77% of the time
  - with the length of time they waited between scheduling an initial appointment and the day of the visit 70% of the time
  - with the length of time they waited between scheduling ongoing appointments and the day of the visits 77% of the time
  - with the outcome of their care, i.e. that they were helped 79% of the time
  - with their behavioral health clinic and would recommend it to family/friends 88% of the time
Complex Case Management Hospital Readmission Rates

Description

HealthPartners Disease and Case Management department has an ongoing initiative to reduce avoidable hospital readmissions through care coordination initiatives.

Members identified for Complex Case Management have complex medical conditions and are at high risk for future hospitalization. Reduction of hospital readmission rates continues to be a priority for care systems, health plans and the Centers for Medicare and Medicaid Services. According to quantitative studies, quality and patient safety are compromised during the vulnerable period when patients transition between different settings because of high rates of medication errors, incomplete or inaccurate information transfer, and lack of appropriate follow-up care. These studies have shown that interventions such as personalized transition care, medication reconciliation, and post hospital telephone calls with education and linkage to community resources can reduce hospital readmission rates. JAMA Intern Med 2016 May 1

Multiple factors outside the direct control of hospitals affect health care outcomes. Health starts in our homes, neighborhoods, and families. In addition to eating well, staying active and doing preventative care, our health is influenced by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. By working to establish policies that positively influence social and economic conditions and those that support changes in individual behavior, we can improve health for large numbers of people in ways that can be sustained over time. HealthyPeople2020.

Goals

The objective for this initiative is to reduce the percentage of actively managed Complex Case Management patients who had an inpatient readmission within 30 days of a previous hospital admission.

The population includes all actively managed Complex Case Management patients in the case management system who had an inpatient admission with a length of stay > 0 within 30 days of a previous admission, a case actively managed in the reporting period and admission dates in the reporting period. Authorization/notification data from the case management system is used to identify admission dates.

Numerator
Number of readmissions for the denominator population. An admission is considered a readmission when the admit date is within 30 days of the discharge date of the previous admission.

Denominator
Number of admissions for Complex Case Management patients who were actively managed in the reporting period and had at least 1 admission in the reporting period. The complex case must have been
active for at least 60 days, and the admission must have occurred while the patient was in Complex Case Management.

Baseline
Reporting definitions to capture Readmission Rate data were redefined in 2018. While 2017 Readmission Rate data was based on CarePartner Authorization and Case Management data, the 2018 Readmission Rate data was based on Claims and CarePartner Case Management Data. A new baseline was established in 2018 due to this change.

2018 Goal
The 2018 goal for the Complex Case Management readmission rate was to establish a new baseline.

Initiatives/Interventions
Case managers provide post-discharge support for members participating in the Complex Case Management program who experience a hospital admission. This support can include the following actions:

- Enhanced engagement methods to meet the member needs, including new digital notification regarding our services to high-risk members with HealthPartners web-based accounts
- Assessment and care planning with interventions tailored to address the member’s unique needs, barriers, and identified clinical gaps in care
- Close collaboration with care team members including PCPs and health care home nurses, home care providers, MTM/pharmacy resources, and community based providers
- Connection to Medication Therapy Management (MTM) services for members with complex medication regimens or medication adherence concerns
- Collaboration with Social Work consultant to facilitate maximization of available community resources
- Inpatient Case Management services to support real-time identification and engagement of high-risk members to ensure milestones and care plans are implemented before discharge.

Additionally, case managers received the following trainings in 2018 to further enhance their expertise in working with members to reduce avoidable hospital readmissions:

- Motivational Interviewing: Motivational Interviewing is a style of arranging conversation that allows individuals to explore their motivations and reason for change, while taking into account how difficult it is to make behavioral changes. Case managers use this approach to improve member health by assisting members to identify internal motivation and encouraging them to make a commitment to positive change.
- Shared Decision Making: Shared Decision Making is a crucial component of patient-centered health care, wherein both the member and disease manager contribute to the decision-making process. Case managers and members come together to make decisions and set goals based on clinical evidence that are consistent with the member’s preferences and values.
- Social Determinants of Health: Social Determinants of Health are conditions in the places where people live, learn, work and play that affect health risks and outcomes. The case managers were
trained in assessing and mitigating these conditions through the use of a number of internal and community resources.

**Barrier Analysis**

There are challenges related to the reduction of avoidable hospital readmissions. Examples include medication adherence, health literacy, family/caregiver support, and social determinants of health such as transportation and cultural barriers. Seasonality impacts such as influenza and related respiratory issues during the winter months also add to this challenge.

There continue to be opportunities to reduce avoidable hospital readmissions. Case managers will continue to utilize Shared Decision Making and Motivational Interviewing to help members and families identify their personal goals for their plan of care. Additionally, case managers will continue to contact patients post discharge to support them through this transition and communicate with their primary care team regarding any identified concerns or barriers the member is experiencing.

**Gaps in Care**

Case Managers work closely with discharged members to close gaps in care encountered post discharge.

**Opportunities for Improvement: Results/Outcomes**

The 2018 goal for the Complex Case Management readmission rate was to establish a new baseline. The 2018 measurement period results were 22.6% for members engaged in Complex Case Management.

All interventions for this initiative have been integrated into standard care coordination processes and this initiative will continue in 2019.
**Denominator:** Number of admissions for Complex patients who were actively managed in the reporting period and had at least 1 admission in the reporting period. The Complex case must have been active for at least 90 days, and the admission must have occurred while the patient was in Complex Case Management. Admission information is received from paid claims data. Includes all lines of business except HMO/PM Corp., HPS Corp., Non-HMO Insured, HMO Medicare Advantage, HPS/PM Corp., Medicaid, Medicare (Cost, PDP, Select Individual and Supplemental Individual), and Employer Groups 32300, 32301.

**Numerator:** Number of readmissions for the denominator population above. An admission is considered a readmission when the admit date is within 30 days of the discharge date of the previous admission.
Continuity and Coordination of Medical Care

Introduction

Improving coordination of care is one of HealthPartners’ core strategies for delivering on our mission and the Triple Aim of improved health, experience, and affordability. Overall, continuity and coordination of care improvement initiatives promote efficient, effective, and safe care for members when they are transitioning between levels of care or receiving care from multiple providers. More specifically, continuity and coordination of medical care is the facilitation, across transitions and settings of care of:

- Patients getting the care or services they need, and
- Practitioners or providers getting the information they need to provide patient care.

HealthPartners monitors and takes action, as necessary, to improve continuity and coordination of care across the health care network. During 2018, HealthPartners monitored the following aspects of continuity and coordination of medical care:

- All cause readmission rates (monitoring patients getting care and services across transitions and settings of care)
- Low-intensity emergency room utilization (monitoring patients getting care and services across transitions and settings of care)
- Provider satisfaction with the quality of information they receive from other types of providers (monitoring providers getting the information they need to provide patient care)
- Pharmacotherapy management of COPD exacerbation - corticosteroid (monitoring patients getting care and services across transitions and settings of care) – may need to pick a new one.

This report describes the monitoring methodology, results, analysis, and actions for each monitor. Please note that we do not have monitors specific to the Wisconsin Marketplace Plans. HealthPartners launched this product January 1, 2017 and the plan is too small to report measures separately for this product line. The product only had 2,720 members in 2018. There were also insufficient Enrollee Experience survey results to generate a report. However, for purpose of analysis and actions we feel comfortable relying on our overall Commercial group data. The Wisconsin Marketplace plans are substantially similar to our commercial group networks, product types and features and plan administration.

In 2018, HealthPartners leaders made the strategic decision to discontinue Medicare NCQA accreditation. Therefore we have removed the Medicare measures from our monitors.

Monitor 1: Readmission ratios

Methodology

Commercial – HealthPartners used the HEDIS inpatient readmission measure as our core metric. Inpatient readmissions are an indicator of potential gaps in care. Readmissions may result when patients do not receive needed follow-up care or because primary care providers do not have all the information they need to develop an effective treatment plan to manage the patient’s condition. The commercial readmission goal was set based on improving HealthPartners performance to Band 3. Results of this measure over multiple years are noted below in the Results section. Numerator and denominator are not included in the chart below as this measure is calculated as a ratio instead of as a rate. We use the ratio measure, as it evaluates our performance taking into account the risk of the measured population. Results have been audited by an NCQA-accredited certification vendor.
### Commercial Results

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<tbody>
<tr>
<td>HEDIS All Cause Readmissions: Observed to expected ratio – Commercial Ratio</td>
<td>0.8327</td>
<td>0.8045</td>
<td>0.7965</td>
<td>0.6914</td>
<td>0.8815</td>
<td>.8734</td>
<td>.7582</td>
</tr>
</tbody>
</table>

HealthPartners uses the Chi-Square test to verify if rates change significantly from year to year. The rate decrease in 2018, where lower is better, was a significant change.

#### Performance goal

HealthPartners has improved from Band 6 performance to Band 4. Goal is to be at Band 3.

### Analysis

HealthPartners uses HEDIS readmission rates to assess potential gaps in coordination of care. As a result of varied strategies deployed to reduce inappropriate readmissions through improved continuity and coordination of care, overall commercial results improved between 2012 and 2015 and we achieved our goal of Band 3 performance. Despite slipping to Band 5 in 2016 and Band 6 in 2017, we have achieved Band 4 for 2018.

Multiple areas contributed to the 2018 barrier analysis including Quality Improvement, Health Informatics, Case and Disease Management and Pharmacy. Staff brainstormed the following potential barriers and opportunities for improvement. Additionally, to gain perspective and identify potential gaps, a team of staff from Health Informatics, Quality Improvement, Case Management, Behavioral Health and our care group reviewed the medical charts of members who had been readmitted. Although the chart review was limited in scope, several themes emerged:

- These are very complex, high risk members
- Members are often already receiving high-risk case management services from the plan
- Some members had a history of mental health/chemical dependency issues and there may be opportunities to direct members to behavioral health treatment services.

### Barrier

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Opportunity</th>
<th>Selected for Improvement?</th>
</tr>
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<tbody>
<tr>
<td>Challenges associated with timely communications between providers and</td>
<td>Promote enhanced communication methods between providers and support</td>
<td>Yes</td>
</tr>
<tr>
<td>care delivery settings. This may be due to limited EMR interfaces across</td>
<td>effective transmittal of key information via EMR interface and health plan</td>
<td></td>
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<tr>
<td>various platforms, lack of data standardization, and/or standardization of</td>
<td>high risk case management services.</td>
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<tr>
<td>communication tools</td>
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</table>
Since both of the above opportunities include intervention by plan case management services, the above work team continues to analyze the readmissions for members without case management, of which there were 49. Findings thus far:

- About half of the readmits were medical and half were behavioral health. We are currently reviewing the behavioral health readmits to seek opportunities for enhancing our case management identification algorithms.
- Two of the medical readmits identified potential changes in the case management work flow.
- We will be doing further analysis on admission notification as HealthPartners was not notified of five medical readmissions.

In addition to seeking feedback from our work team, HealthPartners validates potential barriers specific to coordination of care through a yearly provider survey. Lack of connectivity with other EMRs, lack of standard process, and not knowing which provider may have seen the patient were seen as the key barriers. The percentage of providers choosing “lack of designated staff to coordinate care” dropped by a noticeable amount. Connectivity with other EMRs was a barrier added to the survey in 2012 and has become the top barrier to coordination of care each year since. It likely contributed to some of the decreases seen in the other barriers, since the majority of respondents select it. With only two years of data, it is difficult to understand why fewer providers selected not knowing which provider may have seen the patient. We will continue to monitor this barrier in 2019.

<table>
<thead>
<tr>
<th>Top provider barriers to Coordination of Care (Percent Marked &quot;Yes&quot;)</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of connectivity with other EMRs</td>
<td>48%</td>
<td>46%</td>
<td>53%</td>
<td>60%</td>
<td>52%</td>
</tr>
<tr>
<td>Lack of standard process (defined roles, methods, timeliness)</td>
<td>36%</td>
<td>34%</td>
<td>31%</td>
<td>31%</td>
<td>20%</td>
</tr>
<tr>
<td>Don’t know which primary care or specialty providers may have seen patient. (new in 2017)</td>
<td>na</td>
<td>na</td>
<td>na</td>
<td>37%</td>
<td>13%</td>
</tr>
<tr>
<td>Lack of designated staff to coordinate care</td>
<td>27%</td>
<td>29%</td>
<td>32%</td>
<td>37%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Source: HealthPartners 2018 Provider Survey; Providers may select multiple responses, results do not add up to 100 percent.
<table>
<thead>
<tr>
<th>Date Initiated</th>
<th>Action Implemented</th>
<th>Barriers Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012 and ongoing</td>
<td>HealthPartners continues to administer total cost of care (TCOC) payment arrangements with contracted provider groups providing care for more than 85% of our membership. The TCOC payment strategy continues to evolve through 2018 as we continually seek to better align incentives.</td>
<td>Traditional reimbursement models do not reward or incent providers to improve coordination of care and improve the flow of communication between providers. HealthPartners TCOC methodology supports important provider initiatives to streamline communications and enhance continuity and coordination of care.</td>
</tr>
</tbody>
</table>
| 2016 and ongoing | HealthPartners recognizes 65 organizations that have been certified by the Minnesota Department of Health as a Health Care Home (378 clinics in total) with financial grants to support health care homes. Grant dollars may be used for:  
  - Care Coordinator salaries  
  - Data Systems including EMR enhancements  
  - Redesign and deployment of care processes that are aligned with their patient populations across the care delivery system  
 HealthPartners paid approximately $2.5 million annually in grants over the past several years. | Grants help remove financial barriers to implementing systems and processes that improve continuity and coordination of care which streamline communications and standardize protocols and handoffs between providers to ensure that patients received needed care. |
| 2017          | HEDIS/CMS Stars Steering Committee analyzed health plan performance and identified Plan All Cause Readmissions as a “Spotlight Measure” needing additional analysis and resources. Committee commissioned a new work group. | Work group will analyze data and conduct chart audits to determine events that trigger readmissions and identify barriers to improving performance. Work group will develop recommendations for Steering Committee to review and potentially approve. |
| 2018          | Work group has recommended analyzing readmission data for the presence of health plan high-risk case management services. Identify factors that may enable us to strengthen high-risk case management identification algorithms. During 2018, chart audits focused on medical cases and in 2019 we will focus on behavioral health. | Case managers are in a unique position to coordinate information sharing between providers and facilities. Their interventions minimize gaps in EMR interfaces and improve transitions between providers. |
Monitor 2: Low Intensity Emergency room utilization

Methodology

Unnecessary or low intensity emergency room visits may cause fragmented care and gaps in continuity and coordination of care. In many cases, patients would be better served by receiving care from their primary care clinic which would have their complete medical history. However, patients may choose to use the emergency room if poor care coordination has resulted in an unmet care need. HealthPartners obtained the New York University (NYU) algorithm that identifies potentially avoidable emergency room visits. We calculated the rate of non-emergent emergency room visits for our Commercial members. This rate is calculated based on a percentage of visits as compared with the broader HEDIS emergency room measure which is based on member months.

Commercial Results

<table>
<thead>
<tr>
<th>Indicator title</th>
<th>2016*</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>35,702</td>
<td>34,905</td>
<td>36,171</td>
</tr>
<tr>
<td>Denominator</td>
<td>124,667</td>
<td>126,198</td>
<td>131,103</td>
</tr>
<tr>
<td>Rate</td>
<td>28.6%</td>
<td>27.7%</td>
<td>27.6%</td>
</tr>
</tbody>
</table>

HealthPartners used the Chi-square test to determine if rates change significantly from year to year. The 2016/2017 changes were statistically significant. We do not set a goal for this measure because public benchmarks are not widely available.

(In 2016, the methodology changed: diagnosis codes previously deemed having a 0.6 probability of being non-emergent changed to a 0.7 probability. Rates have been re-stated.)

Commercial – HealthPartners also monitors the rate of emergency room utilization using the standard HEDIS measure. While the HEDIS measure tracks all emergency room admissions (except behavioral health), we feel it is a valid indicator of continuity and coordination of care because we know that a proportion of the visits are related to low-intensity services. We use this metric as supporting evidence of our overall actions to improve continuity and coordination of care. Additionally, the HEDIS measure enables us to benchmark our performance against other health plans and thus set a targeted goal for improvement.

Commercial Results

<table>
<thead>
<tr>
<th>Indicator title</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>73,507</td>
<td>65,997</td>
<td>73,331</td>
<td>79,139</td>
<td>88,456</td>
<td>86,425</td>
</tr>
<tr>
<td>Denominator</td>
<td>6,076,822</td>
<td>5,759,743</td>
<td>6,459,016</td>
<td>6,896,476</td>
<td>7,467,786</td>
<td>7,414,060</td>
</tr>
<tr>
<td>Rate</td>
<td>145.16</td>
<td>137.50</td>
<td>136.24</td>
<td>137.70</td>
<td>142.14</td>
<td>139.88</td>
</tr>
</tbody>
</table>

HealthPartners used the Chi-square test to determine if rates change significantly from year to year. The 2017/2018 changes were statistically significant.

Performance goal 140.2 or less (goal met in 2018)
Analysis

HealthPartners uses non-emergent Emergency Department Visit rates to assess for potential gaps and opportunities to improve continuity and coordination of care. From 2016 through 2018, non-emergent emergency room visits trended downward. Overall emergency room rates for the commercial population have not shown consistent performance year over year. Our results on impacting the non-emergent emergency Department Visit rate reflects the positive impact of multiple, concurrent strategies to better support members' needs for care. The mixed results in non-emergent Emergency Department visits suggest that additional interventions to specifically address this rate may be needed. Although we met our goal in 2018, we cannot be certain that we will maintain this performance in 2019. We see the need to better educate our members regarding ED alternatives that will meet their needs as well as implement initiatives designed to create access to primary care.

HealthPartners used a robust process to identify potential barriers to improvement and vetted these ideas with key stakeholders. This also included seeking provider survey feedback. The following barriers are associated with reducing the rate of low-intensity emergency department (ED) visits.

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Opportunity</th>
<th>Selected for Improvement?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenges associated with communication between providers and care delivery settings can lead to avoidable ED visits when members do not receive appropriate care management.</td>
<td>HealthPartners will promote enhanced communication methods between providers and support effective transmittal of key information via EMR interface and other means to ensure appropriate members of the care team have access to member care plans and other resources.</td>
<td>Yes</td>
</tr>
<tr>
<td>Members do not understand alternatives to the Emergency Department such as urgent care and primary care</td>
<td>Educate members about alternatives so they can make better choices of where to get care.</td>
<td>Yes</td>
</tr>
<tr>
<td>Limited access to patient medical record data outside normal clinic hours results in members being directed to the ED because the covering medical team is not familiar with the patient’s condition. Care delivery systems may utilize multiple electronic medical record systems.</td>
<td>Provide financial assistance to medical groups specifically to improve consistent electronic medical record access to care teams.</td>
<td>Yes</td>
</tr>
<tr>
<td>Date Initiated</td>
<td>Action Implemented</td>
<td>Barriers Addressed</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2012 and ongoing</td>
<td>HealthPartners continues to administer total cost of care (TCOC) payment arrangements with contracted provider groups providing care for more than 85% of our membership. The TCOC payment strategy continues to evolve through 2018 as we continually seek to better align incentives.</td>
<td>Traditional reimbursement models do not reward or incent providers to improve coordination of care and improve the flow of communication between providers. HealthPartners TCOC methodology supports important provider initiatives to streamline communications and enhance continuity and coordination of care.</td>
</tr>
</tbody>
</table>
| 2015 and ongoing | HealthPartners currently recognizes 65 organizations that have been certified by the Minnesota Department of Health as a Health Care Home (378 clinics in total) with financial grants to support health care homes. Grant dollars may be used for:  
- Care Coordinator salaries  
- Data Systems including EMR enhancements  
- Redesign and deploy care processes that are aligned with their patient populations across the care delivery system  
HealthPartners paid approximately $2.5 million annually in grants over the past several years. | Grants help remove financial barriers to implementing systems and processes that improve continuity and coordination of care which streamline communications and standardize protocols and handoffs between providers to ensure that patients received needed care. |
<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
</table>
| 2017 | HealthPartners deployed two member campaigns to educate members about alternatives to seeking care in the ED.  
1. HealthPartners used predictive modeling to identify members who had a high likelihood of using the Emergency Room for low intensity care needs. We sent these members information regarding in-network online or urgent care clinic options in their neighborhood  
2. We conducted a pilot program targeting “unattributed” members – members who do not have a history of using a primary care clinic. We sent these members information about the importance of having a relationship with a primary care provider and used predictive analytics to suggest several primary care options near their home. | These campaigns addressed the following lack of member awareness regarding:  
- Alternatives to the emergency department  
- How to find an in-network provider  
- The importance of having a primary care provider |
| 2018 | HealthPartners worked with key network partners to encourage them to make primary care easier to access including promoting walk-in appointments and adjusting clinic hours more unscheduled access. | The member outreach campaigns described above drive demand for primary care and our 2018 initiatives worked to increase access at critical network locations. |

**Monitor 3: Provider satisfaction with the quality of information they receive from other types of providers.**

**Methodology**

To more completely align with accreditation standards, past survey measures were updated to assess provider satisfaction with:

- timely communication from other providers or care sites
- complete communication from other providers or care sites

2018 is the first measurement cycle and no trends or benchmarks are available.

The 2018 QI/UM Provider Survey was mailed in March 2018 to a total of 740 providers and their office managers. All providers had interaction with HealthPartners members; all providers in the survey had requested authorizations from the health plan during the last 15-month period. The majority of the 300 primary care physicians, 300 specialists and 140 psychiatrists surveyed requested two or more authorizations. Using these selection criteria enables HealthPartners to target providers who interact
with our plan and may have more experience with plan-related programs and services versus those providers who care for relatively few HealthPartners members. There is overlap in the providers who participate in our commercial network and our marketplace network. As such, we did not field separate surveys for each population.

Surveys were received through June. HealthPartners received a total of 62 completed surveys; 43 surveys were returned unanswered due to bad addresses. The adjusted response rate was 9%, which is lower than 2017’s 14% response rate. The 2018 results have a margin of error of ±7 percentage points with a 90 percent confidence interval. We have not attempted to segment the results by product due to the relatively low response rate and the high degree of overlap between our commercial and Marketplace networks.

Results

The results of the survey are reported below. We did not report satisfaction levels of psychiatrists due to the small number respondents. There were only 10 respondents in 2018, too few to reliably conduct tests of statistical significance and to report some questions.

= Statistically significant change

### AGGREGATE RESULTS: In general, how well does each of the following provide you with the information you expect to receive about your patients? (% Excellent + Very good + Good)

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>74%</td>
<td>71%</td>
<td>73%</td>
<td>85%</td>
<td>92%</td>
<td>91%</td>
<td>80%</td>
</tr>
<tr>
<td>Emergency rooms (new in 2016)</td>
<td>80%</td>
<td>53%</td>
<td>59%</td>
<td>60%</td>
<td>77%</td>
<td>85%</td>
<td>80%</td>
</tr>
<tr>
<td>Behavioral health providers</td>
<td>80%</td>
<td>82%</td>
<td>77%</td>
<td>75%</td>
<td>89%</td>
<td>91%</td>
<td>80%</td>
</tr>
<tr>
<td>Primary care providers</td>
<td>80%</td>
<td>82%</td>
<td>77%</td>
<td>75%</td>
<td>89%</td>
<td>91%</td>
<td>80%</td>
</tr>
<tr>
<td>Specialty providers</td>
<td>87%</td>
<td>85%</td>
<td>82%</td>
<td>87%</td>
<td>96%</td>
<td>93%</td>
<td>80%</td>
</tr>
<tr>
<td>Skilled nursing facilities (new in 2017)</td>
<td>65%</td>
<td>68%</td>
<td>94%</td>
<td>96%</td>
<td>91%</td>
<td>93%</td>
<td>80%</td>
</tr>
<tr>
<td>MTM pharmacist (new in 2015)</td>
<td>64%</td>
<td>73%</td>
<td>80%</td>
<td>82%</td>
<td>83%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Urgent care centers</td>
<td>63%</td>
<td>49%</td>
<td>51%</td>
<td>63%</td>
<td>82%</td>
<td>92%</td>
<td>80%</td>
</tr>
</tbody>
</table>

*How well do each of the following provide you with timely and complete patient information? (% Excellent + Average)

### PRIMARY CARE RESULTS: In general, how well does each of the following provide you with the information you expect to receive about your patients? (% Excellent + Very good + Good)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>80%</td>
<td>70%</td>
<td>80%</td>
<td>83%</td>
<td>93%</td>
<td>92%</td>
<td>80%</td>
</tr>
<tr>
<td>Emergency rooms (new in 2016)</td>
<td>80%</td>
<td>70%</td>
<td>96%</td>
<td>100%</td>
<td>91%</td>
<td>93%</td>
<td>80%</td>
</tr>
<tr>
<td>Behavioral health providers</td>
<td>62%</td>
<td>36%</td>
<td>66%</td>
<td>53%</td>
<td>68%</td>
<td>79%</td>
<td>80%</td>
</tr>
<tr>
<td>Primary care providers</td>
<td>85%</td>
<td>83%</td>
<td>91%</td>
<td>92%</td>
<td>91%</td>
<td>93%</td>
<td>80%</td>
</tr>
</tbody>
</table>
Analysis

HealthPartners restructured our survey questions in 2018 to gain more detail regarding the elements that contribute to effective communication between facilities and practitioners. To support overall continuity and coordination of care, communications need to be both timely and complete. Because of this change, data is not directly comparable between 2018 and previous years. However, the questions do align and overall, provider satisfaction with timely and complete patient information received from other practitioners and facilities is mostly strong. Emergency rooms, hospitals, specialists and primary care receive the highest scores for both providing timely and complete patient information. On the other hand, patient information from behavioral health providers and skilled nursing facilities receive the lowest scores for both timeliness and completeness. HealthPartners has initiatives that are addressing continuity and coordination of care with behavioral health providers and these interventions are detailed in a separate report (QI 6 Continuity and Coordination between Medical and Behavioral Healthcare).

- Overall, specialists are noticeable less satisfied than primary care providers. Particularly for timely and complete information from Emergency Rooms.
- Skilled nursing facilities: both primary care and specialists rate timely and complete patient information low; specialists are noticeably less satisfied on complete patient information, however.
- There is room to improve patient information from urgent care centers as well. Both primary care providers and specialists give somewhat strong ratings on timeliness; however, specialists are more critical about the completeness of patient information.

Based on the barrier analysis previously described, HealthPartners identified the following:

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Opportunity</th>
<th>Selected for Improvement?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of designated staff to coordinate care and lack of standard processes (e.g. defined roles, methods, etc.) to ensure smooth transitions.</td>
<td>ACO models of care improve continuity and coordination of care. Under an ACO model, the care system implements standardized processes and programs to support their patients.</td>
<td>Yes – continued from prior years</td>
</tr>
<tr>
<td>Poor coordination between primary care, including providers that are not affiliated with the same ACO.</td>
<td>Focus on collaboration and improving coordination of care between primary care providers inside and outside the ACO.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| MTM pharmacists play an important role on the care team. Due to their close interaction with patients, it is crucial that MTM records be available to other treating practitioners. | HealthPartners regularly audits our MTM provider network including monitoring pharmacist communication with the member’s primary care team. To improve continuity and coordination of care we will cite MTM providers who do not appropriately follow-up. | No, due to improving satisfaction rates. We chose not to focus on this activity in 2018.
## Actions

<table>
<thead>
<tr>
<th>Date Initiated</th>
<th>Action Implemented</th>
<th>Barriers Addressed</th>
</tr>
</thead>
</table>
| 2016           | HealthPartners provides ongoing staff support to key care delivery partners to promote the development and ongoing success of their ACO model of care initiatives. Examples of this work include:  
- Collaboration with the HealthPartners Medical Group to maintain NCQA ACO Level 3 accreditation and enhance care model process. HealthPartners provides the medical group ongoing consultation, strategic leadership, clinical leadership, practitioner reimbursement, analytical support, project management expertise, and EMR support.  
- Support for the Park Nicollet Medical Group Pioneer ACO Designation takes the form of ongoing consultation, strategic leadership, clinical leadership, practitioner reimbursement, analytical support and EMR support  
- Beyond our own family of care, HealthPartners supports Essentia Health with ongoing consultative and analytical support to help them maintain their NCQA ACO accreditation. | HealthPartners supports the development of ACO models of care because they are an effective means to improve continuity and coordination of care. ACO models improve communication between providers and sites of care, support standardized processes and communications tools within the ACO and improve handoffs between providers.  
2012 – Fairview Health Services and Allina Clinics and Hospitals achieved Pioneer ACO status and continue to extend their agreement with CMMI.  
2015 – HealthPartners Medical Group reaccredited NCQA ACO Level III  
2016 Park Nicollet will participate in Next Generation ACO with CMS.  
2017 – HealthPartners Medical Group decided to retain its NCQA ACO accreditation status; work groups forming in 2018 to include health plan representation for support and consultation. |
| 2017           | Implemented the CareQuality query function so that practitioners may query patient records even if the other practitioner isn’t using the Epic medical record system. Allows access to a summary report.                                                                                                                                                                                                                                                                                                                                                                                                  | This functionality improves accessibility of medical records between providers who are not part of the same care delivery system – improving continuity and coordination of care across the entire provider network. |
### Disease and Case Management

Case managers ensure smooth and safe transitions from hospital to Nursing Home/Skilled Nursing Facility/Transitional Care Unit, for members that meet high risk criteria and are appropriate for lower level of care at discharge from the hospital to a Nursing Home (NH), Transitional Care Unit (TCU), and/or Skilled Nursing Facility (SNF). Case managers coordinate and collaborate with the transitional facility during the stay, and communicate with provider as appropriate at transition and to support the plan of care.

**Process: NH/TCU/SNF:**
- DCM case managers will contact the facility to ensure orders are received, needed services are arranged, facility is aware of services available through plan. As well as communicate to provider the member discharged to a certain facility or lower level of care.
- DCM nurse will contact facility social worker intermittently based on length of stay and level of need to coordinate and collaborate on the plan of care and potential discharge date.
- At discharge from NH/TCU/SNF DCM case manager will outreach to complete a post discharge call with the member.
- DCM case manager will communicate updates regarding member’s transition of care, coordinate and collaborate on the plan of care, and continue to support the provider plan of care.
- During the post discharge call the DCM case manager guides intervention’s related to patients understanding, need for education, and advocacy, to reduce risk of readmission to the hospital and visits to the ER.

### Monitor 4: Pharmacotherapy Management of COPD Exacerbation: Corticosteroids

**Methodology**

Members with COPD are likely to encounter issues with continuity and coordination of care. This population often has other co-morbid conditions and their care may be fragmented between primary care and various specialists. Additionally, they may seek acute care in urgent care or emergency room.
settings. Members with COPD may be getting various medications and instructions from multiple providers making it challenging for them to understand how to effectively manage their condition.

**Commercial Results**

<table>
<thead>
<tr>
<th>Indicator title</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEDIS Pharmacotherapy Management of COPD Exacerbation: Corticosteroids</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
<td>110</td>
<td>135</td>
<td>155</td>
<td>152</td>
<td>163</td>
<td>161</td>
</tr>
<tr>
<td>Denominator</td>
<td>135</td>
<td>164</td>
<td>185</td>
<td>194</td>
<td>205</td>
<td>201</td>
</tr>
<tr>
<td>Rate</td>
<td>81.5%</td>
<td>82.3%</td>
<td>83.8%</td>
<td>78.4%</td>
<td>79.5%</td>
<td>80.1%</td>
</tr>
<tr>
<td>Statistical Significance Test &amp; Results</td>
<td>HealthPartners uses the Chi-Square test to verify if rates change significantly from year to year. The above rates were not significantly different from year to year.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Analysis**

Commercial rates slowly increased through 2015, 2016 results dropped and rates improved directionally, but not statistically significantly in 2017 and 2018. The number of commercial members monitored in this measure is relatively small which increases the volatility of our performance. HealthPartners is currently at Band 2 – below goal. The Marketplace population is too small to report separately. HealthPartners offers the same medical management programs to both the Commercial and Marketplace populations so we believe Marketplace performance on this measure will align with our Commercial population. We will likely retire this monitor for 2019 and select a topic more relevant to the Commercial and Marketplace populations.

Our relatively flat performance may be due to the type of initiative we have chosen to implement. Our pharmacy team has implemented medication therapy management (MTM) initiatives intended to help members avoid COPD exacerbations in the first place rather than focusing on ensuring that appropriate medications are dispensed post-discharge.

Performance is strong; yet to attain goal, HealthPartners identified the following barriers to improvement:

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Opportunity</th>
<th>Selected for Improvement?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complicated treatment regimen involving multiple drugs. Corticosteroids are an add-on medication often used in addition to bronchodilators. Additionally, many members with COPD have comorbid conditions such as angina, depression and myocardial infarction which also require medication. Members often seek</td>
<td>Simplify treatment for patients so they can better manage their condition</td>
<td>Yes</td>
</tr>
<tr>
<td>Care from several providers and various care delivery settings which fragments care. Some members are homebound which limits their access to care.</td>
<td>Make it easy for members to regularly take their medications. Clarify provider instructions, educate on proper way to administer the medications, eliminate duplicative medications.</td>
<td>No – HealthPartners has maximized our interventions with MTM.</td>
</tr>
</tbody>
</table>
**Actions**

This monitor is an important element of HealthPartners continuity and coordination of care activities. Our efforts focus on reducing fragmented care by promoting the use of health plan registry reports.

<table>
<thead>
<tr>
<th>Date Initiated</th>
<th>Action Implemented</th>
<th>Barriers Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>HealthPartners produces detailed registry reports that identify COPD members with potential gaps in care and notes data elements including:</td>
<td>Fragmented care received in multiple settings. Registries enhance access to patient data when members receive care outside their normal clinic system.</td>
</tr>
<tr>
<td></td>
<td>• Date of last office visit with COPD as diagnosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pulmonologist visit flag</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Date of last acute exacerbation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Date of last oxygen therapy evaluation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Date of last spirometry testing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Fill dates for corticosteroids, bronchodilators and oxygen therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Date of last hospital admission, ED visit and readmission flag</td>
<td></td>
</tr>
</tbody>
</table>

The registry helps providers manage their patient population by providing data that the provider may not have captured if the patient received services outside the clinic system. When incorporated with the providers EMR data, registries help provide a more complete picture of the services the patient may need for optimal care. In 2018, HealthPartners identified opportunities to integrate our registries into other provider reports. We began the integration process and this work will continue into 2019. By integrating registries with other reporting functions, we create a one-stop-shop for providers by making it easier and more convenient for them to access important information.
<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016 - present</td>
<td>Many pharmacy programs such as Medication Therapy Management and Medication Optimization that support members with COPD and other chronic conditions are highly dependent upon effective communication to educate the patient. To better meet the needs of a diverse patient population, Pharmacy administration worked in partnership with HP Diversity and Inclusion to conduct e-learning classes. The objective is to embed awareness of diversity and inclusion more deeply among all pharmacy staff.</td>
<td>This program works to ensure patient-centered communication methods are used and thereby improve the effectiveness of our ongoing pharmacy management programs to support continuity and coordination of care.</td>
</tr>
</tbody>
</table>
| 2015 - present | Although piloted in 2014, our home visit program for high risk patients did not reach full implementation until 2015. HealthPartners MTM pharmacists conduct home visits for patients who are at highest risk for medication-related problems. These patients have serious chronic illnesses, take multiple medications and are homebound, which makes continuity and coordination of care with their primary care clinic difficult. Careful attention to medication management is especially important for patients with COPD. We have continued this intervention into 2018. | MTM pharmacists:  
  - Review every medication the member is taking and coordinate adjusting medications or dosages with the patient’s primary care team  
  - Ensure the patient understands how to take the medication as prescribed by their doctor  
  Program coordinates prescription drug treatment plans between the patient, the MTM pharmacist and the patient’s care team to ensure member care needs are met. |
Reporting

This QI activity was reported to the following HealthPartners enterprise committees:

<table>
<thead>
<tr>
<th>Committee Name</th>
<th>Meeting Date</th>
<th>Committee Actions or Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Council</td>
<td>May 2018</td>
<td>Analysis reviewed and approved</td>
</tr>
<tr>
<td>Quality Committee of the HealthPartners Board of Directors</td>
<td>June 2018</td>
<td>Analysis reviewed and approved</td>
</tr>
</tbody>
</table>
Continuity and Coordination of Medical and Behavioral Health

2018 Report
Production Date: December 2018

Report data includes Commercial and Market Place products

Standard: The organization collaborates with behavioral health specialists to monitor and improve coordination between medical and behavioral health care

Introduction:
For more than 20 years HealthPartners has been setting ambitious goals about every five years to improve health in our community. HealthPartners long history of leadership in supporting improved health care outcomes is defined by setting stretch goals, defining measurement parameters and partnering with health care systems on best practices. Our Partners for Better Health program targets selected conditions for collaborative, multi-year quality improvement efforts.

In 1999, Partners for Better Health added depression to the list of conditions. Health plan and care delivery system leaders teamed up to launch depression screening and treatment efforts and we have worked together on various strategies since then. The Optimal Depression Care rate represents the percentage of members ages 18 and older who were diagnosed with a new episode of major depression treated with antidepressant medication and are optimally managed. Optimal Depression Care measure was a Clinical Indicator from 1999 through 2013 after which we adopted the Minnesota Community Measurement Depression Remission, Response, and PHQ-9 Follow-up at 6 and 12 months.

Depression screening uses the PHQ-9. Response and remission are measured at 6 months.
- Response is defined as a 50% reduction in the PHQ-9
- Remission is defined as a score of less than 10 on the PHQ-9

The Partners in Excellence program forms the basis for HealthPartners’ financial and public recognition for medical or specialty groups achieving high levels of performance on the Triple Aim of exceptional clinical quality, patient experience, and affordable care.
- Our goal is to recognize and reward groups who deliver on the Triple Aim
- Financial rewards are based on performance as measured using Minnesota Community Measurement and HealthPartners developed and reported measures

The Partners in Excellence program focuses on recognizing performance across meaningful quality clusters within the dimensions of health and patient experience. Each quality cluster consists of several individual measures that are assigned points based on a target performance that is then translated into a star rating for that quality cluster overall.

Silver award level is available when the measures in the cluster achieve 75% of the available points, equating to an overall four-star rating for the cluster.

Gold award level is available when an overall four-star rating is achieved for the cluster and the group's Total Cost Index is less than 1.0.
In 2018:
- 3 Primary Care Groups attained Gold awards and 1 attained Silver awards
- 0 Behavioral Health Groups attained Gold awards and 0 attained Silver award

Conclusions and Lessons learned:
- Multi-year stretch goals constitute a great road map for achieving significant quality improvement.
- Using valid measurements with public reporting and then aligning this with financial incentives is a powerful combination which has encouraged meaningful, year over year health outcome improvements.
- Collaborating on quality improvements helps provider groups move forward and share successes.
- Finally, quality improvement is an evolution. The Optimal Depression Care measurement was retired in 2013 in favor of another measure that HealthPartners contributed to developing; Minnesota Community Measurement’s Depression Remission, Response, and PHQ-9 Follow-up at 6 and 12 months. Without the Optimal Depression Care Measure, it is doubtful that a provider self-report Depression measure on a statewide basis would have evolved so rapidly.

Element A1: Measures of Exchange of information

Minnesota started down the road of Electronic Health/Medical record interoperability in 2007 with a law that requires all health care providers to have an interoperable electronic EHR system by January 1, 2015 (Minn. Stat. §62J.495). Only MN and MA require health care providers to have EHRs. Interoperability is defined as “the secure exchange of patient data across systems and organizations, through using standards for exchange and by connecting to a State-Certified Health Information Exchange (HIE) Service Provider.” (from MDH “Guidance for Understanding the Minnesota 2015 Interoperable EHR Mandate).

From AHRQ “The State of Minnesota is perhaps the most aggressive in promoting the adoption of standards-based electronic health records to support statewide electronic health information infrastructure. Minnesota has done this through a combination of legislative mandates and grants and loans programs.”

From CDC:
- In 2015 the average percentage of office-based physicians who sent patient health information electronically was 38.2%. Minnesota’s rate was 45.8%, putting us in eight place.
- In 2015, the average percentage of office-based physicians who received patient health information electronically was 38.3%. Minnesota’s rate was 55%, putting us in third place.

In 2010, after three years of work, a new process for sharing data in MN was implemented. This new process is entitled “Care Everywhere” and the patient consents to share limited health information between EPIC users, for that particular visit. In 2012, Phase 2 of this project is “Care Anywhere”, where the patients’ written consent to share information between most EMR’s is effective for 12 months. This reduces the need for patients to sign a consent form every time they are in a healthcare setting and expands the ability to share information across multiple EMR platforms.
The Minnesota Department of Health and the Minnesota e-Health Initiative oversee implementation, utilization and interoperability of Electronic Health Records (EHR) systems in Minnesota. In 2016 an assessment of EHR’s was undertaken and found:

- 69% clinics exchanged information with unaffiliated hospitals and clinics
- 72% hospitals exchanged information with unaffiliated hospitals and clinics
- 56% hospitals sent electronic alerts to primary care physicians

As you can see, the use of integrated electronic health records in Minnesota is very prevalent. HealthPartners providers use fully integrated electronic medical records where primary care and behavioral health practitioners can access each other’s documentation. The use of integrated electronic health records meets this standard.

**Element A2: Measures of appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care**

Depression, Anxiety and Attention Deficit Hyperactivity Disorder (ADHD) are the three most common childhood mental health diagnoses and are typically first identified and cared for by pediatricians. For ADHD, pediatricians have well developed protocols for diagnosis and treatment. However, if the child or adolescent also has an Anxiety Disorder and/or Depression, the treatment becomes more complex and typically results in co-management with either a child psychiatrist or child therapist.

To support appropriate diagnosis, treatment and referral of more complex behavioral health patients seen by pediatricians, HealthPartners health plan worked with a specific pediatric practice to monitor and assist with referrals to behavioral health care. This pediatric practice accounts for 37,937 members.

We measured how this practice is meeting the care coordination challenge for more complex behavioral health conditions among children and adolescents. See Table 1 to see how we can support their efforts.

**Analysis of HealthPartners Medical Group Child and Adolescent Members/Patients with Depression, Anxiety and ADHD to Identify Rates of Collaboration between Pediatricians and Behavioral Health Professionals**

**Proxy dates are October 2017 – September 2018**

**Conclusion:** In the proxy for 2018 DOS (the 12 months ending September 2018) three of seven goals were met.

**Table 1: 2018 DOS: Behavioral Health conditions in children and adolescents**

<table>
<thead>
<tr>
<th>Behavioral Health condition(s)</th>
<th># of Members with Condition(s)</th>
<th>Number / percentage of Members with Behavioral Health condition and on Antipsychotic Medication</th>
<th>% with Pediatric and Behavioral Health Providers</th>
<th>Goal % having both Pediatrician and Behavioral Health Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>436</td>
<td>13 (3.0%)</td>
<td>10.8%</td>
<td>≥ 10%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>795</td>
<td>13 (1.6%)</td>
<td>10.7%</td>
<td>≥ 10%</td>
</tr>
<tr>
<td>ADHD</td>
<td>1119</td>
<td>23 (2.1%)</td>
<td>14.2%</td>
<td>≥ 15%</td>
</tr>
<tr>
<td>Depression, Anxiety, ADHD</td>
<td>260</td>
<td>23 (8.8%)</td>
<td>28.5%</td>
<td>≥ 30%</td>
</tr>
<tr>
<td>Depression, ADHD</td>
<td>58</td>
<td>10 (17.2%)</td>
<td>29.3%</td>
<td>≥ 30%</td>
</tr>
<tr>
<td>Anxiety, ADHD</td>
<td>185</td>
<td>10 (5.4%)</td>
<td>32.4%</td>
<td>≥ 30%</td>
</tr>
</tbody>
</table>

2018 Quality Improvement Annual Evaluation
Proxy dates are October 2016 – September 2017

**Conclusion:** In the proxy for 2017 DOS (the 12 months ending September 2017) four of seven goals were met.

**Table 2: 2017 DOS: Behavioral Health conditions in children and adolescents**

<table>
<thead>
<tr>
<th>Behavioral Health condition(s)</th>
<th># of Members with Condition(s)</th>
<th>Number / percentage of Members with Behavioral Health condition and on Antipsychotic Medication</th>
<th>% with Pediatric and Behavioral Health Providers</th>
<th>Goal % having both Pediatrician and Behavioral Health Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>271</td>
<td>14 (5.2%)</td>
<td>11.8%</td>
<td>≥ 10%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>584</td>
<td>6 (1.0%)</td>
<td>10.4%</td>
<td>≥ 10%</td>
</tr>
<tr>
<td>ADHD</td>
<td>1001</td>
<td>14 (1.4%)</td>
<td>13.8%</td>
<td>≥ 15%</td>
</tr>
<tr>
<td>Depression, Anxiety</td>
<td>195</td>
<td>18 (9.2%)</td>
<td>29.7%</td>
<td>≥ 30%</td>
</tr>
<tr>
<td>Depression, ADHD</td>
<td>55</td>
<td>5 (9.1%)</td>
<td>29.1%</td>
<td>≥ 30%</td>
</tr>
<tr>
<td>Anxiety, ADHD</td>
<td>169</td>
<td>9 (5.3%)</td>
<td>32.5%</td>
<td>≥ 30%</td>
</tr>
<tr>
<td>Depression, Anxiety, ADHD</td>
<td>49</td>
<td>12 (24.5%)</td>
<td>36.7%</td>
<td>≥ 35%</td>
</tr>
</tbody>
</table>

Numbers in red denote goal not met.

**Element A3: Measure of appropriate use of psychotropic medications.**

Analysis of pharmaceutical utilization data for appropriateness of a psychotropic medication was adopted by the HealthPartners Member Focused Behavioral Health Advisory Group.

HealthPartners Member Focused Behavioral Health Advisory Group reviews objective data of several types annually and provides input from a provider perspective to help focus quality improvement activities. This group has reviewed HEDIS Antidepressant Medication Management annually for several years continues to see this as a principle measure of the degree of appropriate care in primary care and in integrated behavioral health / primary care. Ensuring evidence-based treatment for depression is consistently utilized among these practitioners as a key objective of this measure.

HealthPartners health plan supports improvement on HEDIS Antidepressant Medication Management outcomes, through helping providers identify members who are overdue in refilling their antidepressant medications. This initiative was identified by the Member Focused Behavioral Health Advisory Group and endorsed by HealthPartners leadership for ongoing implementation. Prescribers are mailed a letter when their patient is 10 days overdue for refilling their prescription, allowing the care team to reach out to support the patient.
Table 3: Commercial HEDIS results for 2016 through 2018 (dates of reports)
Conclusion: 2018 goals not met

<table>
<thead>
<tr>
<th>HEDIS Measure:</th>
<th>Goal</th>
<th>HEDIS 2018</th>
<th>HEDIS 2017</th>
<th>HEDIS 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressant Medication Management</td>
<td>85.1%</td>
<td>78.3%</td>
<td>77.8%</td>
<td>76.9%</td>
</tr>
</tbody>
</table>

Table 4: 2018 DOS: Chronic Medical Conditions with Co-morbid Depression

<table>
<thead>
<tr>
<th>Chronic condition(s)</th>
<th># of Members with Condition(s)</th>
<th>Number / percentage of Members with Depression &amp; chronic condition</th>
<th>% with dep. and medical dx having BH visit*</th>
<th>Goal % having BH visit</th>
<th>% members in CM/DM programs</th>
<th>Goal % members in CM / DM programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAD</td>
<td>11,525</td>
<td>1,919 (16.7%)</td>
<td>28.9%</td>
<td>≥25%</td>
<td>65.1%</td>
<td>&gt;30%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>37,311</td>
<td>7,725 (20.7%)</td>
<td>31.4%</td>
<td>≥25%</td>
<td>66.8%</td>
<td>&gt;30%</td>
</tr>
<tr>
<td>CHF</td>
<td>1,427</td>
<td>216 (15.1%)</td>
<td>31.0%</td>
<td>≥25%</td>
<td>60.2%</td>
<td>&gt;30%</td>
</tr>
<tr>
<td>Diabetes, CAD</td>
<td>3,810</td>
<td>897 (23.5%)</td>
<td>29.1%</td>
<td>≥25%</td>
<td>73.8%</td>
<td>&gt;50%</td>
</tr>
<tr>
<td>Diabetes, CHF</td>
<td>754</td>
<td>146 (19.4%)</td>
<td>29.5%</td>
<td>≥25%</td>
<td>60.3%</td>
<td>&gt;50%</td>
</tr>
<tr>
<td>CAD,CHF</td>
<td>516</td>
<td>123 (23.8%)</td>
<td>33.3%</td>
<td>≥25%</td>
<td>69.1%</td>
<td>&gt;50%</td>
</tr>
<tr>
<td>Diabetes, CAD, CHF</td>
<td>439</td>
<td>116 (26.4%)</td>
<td>35.3%</td>
<td>≥25%</td>
<td>76.7%</td>
<td>&gt;70%</td>
</tr>
</tbody>
</table>

*BH visit defined as at least one claim paid to a behavioral health provider for a behavioral health condition

One note: The CM/DM programs that are included are: telephonic, self-directed, active Behavioral Health cases, Moving Forward, On Your Way, and Step-by-Step; we are working to increase engagement in all of these

Element A4: Measures of the management of treatment access and follow-up for members with coexisting medical and behavioral health disorders.

HealthPartners measures treatment access and follow-up for members with chronic conditions that have a coexisting diagnosis of Depression. We use this information to the effectiveness of treatment across medical and behavioral health care, as well as to inform our methods of identification, outreach and engagement in HealthPartners Case and Disease Management programs, so that we can further support any needs for coordination of care. This is accomplished through deep data mining and multiple steps:

- The first step is identifying members through claims data for several chronic conditions – CAD, Diabetes and CHF.
- Taking these people, we do another claims run to see who has depression diagnoses.
- Of those with one or more of the medical conditions and depression, claims are again examined to see how many of these members had a visit with a Behavioral Health provider.
- We use our case management tracking systems to identify how many members with a medical and behavioral health condition are engaged in case management.

Analysis of Members with Depression and Various Medical Co-morbidities to Identify Rates of Engagement in Behavioral Health Treatment, Case Management and Disease Management

2018 Co-morbidities Analysis
Proxy dates are October 2017 – September 2018
Conclusion: In the proxy for 2018 DOS (the 12 months ending September 2018) fourteen of fourteen goals were met.
2017 Co-morbidities Analysis

Proxy dates are October 2016 – September 2017

Conclusion: In the proxy for 2017 DOS (the 12 months ending September 2017) nine of fourteen goals were met. Fewer than 25% of members in each of these conditions that have CAD and CHF and Diabetes, CAD & CHF had a behavioral health visit. Members solely with CAD, Diabetes, CHF, as well as members with Diabetes and CAD and Diabetes and CHF met the visit goals. All members with CAD, Diabetes and CHF solely, as well as members with Diabetes and CAD met engagement goals for Case and Disease Management.

Table 5: 2017 DOS: Chronic Medical Conditions with Co-morbid Depression

<table>
<thead>
<tr>
<th>Chronic condition(s)</th>
<th># of Members with Condition(s)</th>
<th>No. / % of Members with Depression &amp; chronic condition</th>
<th>% with dep. and medical dx having BH visit*</th>
<th>Goal % having BH visit</th>
<th>% members in CM/DM programs</th>
<th>Goal % members in CM / DM programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAD</td>
<td>11,353</td>
<td>1,591 (14.0%)</td>
<td>27.7%</td>
<td>≥25%</td>
<td>52.9%</td>
<td>&gt;30%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>35,659</td>
<td>6,465 (18.1%)</td>
<td>31.3%</td>
<td>≥25%</td>
<td>55.4%</td>
<td>&gt;30%</td>
</tr>
<tr>
<td>CHF</td>
<td>1,361</td>
<td>165 (12.1%)</td>
<td>29.7%</td>
<td>≥25%</td>
<td>32.1%</td>
<td>&gt;30%</td>
</tr>
<tr>
<td>Diabetes, CAD</td>
<td>3,681</td>
<td>750 (20.4%)</td>
<td>29.6%</td>
<td>≥25%</td>
<td>59.3%</td>
<td>&gt;50%</td>
</tr>
<tr>
<td>Diabetes, CHF</td>
<td>696</td>
<td>114 (16.4%)</td>
<td>28.1%</td>
<td>≥25%</td>
<td>43.9%</td>
<td>&gt;50%</td>
</tr>
<tr>
<td>CAD, CHF</td>
<td>432</td>
<td>85 (19.7%)</td>
<td>20.0%</td>
<td>≥25%</td>
<td>49.4%</td>
<td>&gt;50%</td>
</tr>
<tr>
<td>Diabetes, CAD, CHF</td>
<td>385</td>
<td>96 (24.9%)</td>
<td>19.9%</td>
<td>≥25%</td>
<td>66.7%</td>
<td>&gt;70%</td>
</tr>
</tbody>
</table>

*BH visit defined as at least one claim paid to a behavioral health provider for a behavioral health condition. Numbers in red denote goal not met.

One note: The CM/DM programs that are included are: telephonic, self-directed, active Behavioral Health cases, Moving Forward, On Your Way, and Step-by-Step; we are working to increase engagement in all of these.

2016 Co-morbidities Analysis

Proxy dates are October 2015 – September 2016

Conclusion: In the proxy for 2016 DOS (the 12 months ending September 2016) nine of fourteen goals were met. Fewer than 25% of members in each of these conditions that have only CAD, Diabetes, as well as member who have Diabetes & CAD, Diabetes & CHF and Diabetes, CAD & CHF had a behavioral health visit. Members with CAD and CHF, as well as members with CHF met the visit goals. All members with CAD, Diabetes and CHF solely or in combination met engagement goals for Case and Disease Management.

Table 6: 2016 DOS: Chronic Medical Conditions with Co-morbid Depression

<table>
<thead>
<tr>
<th>Chronic condition(s)</th>
<th># of Members with Condition(s)</th>
<th>Number / percentage of Members with Depression &amp; chronic condition</th>
<th>% with dep. and medical dx having BH visit*</th>
<th>Goal % having BH visit</th>
<th>% members in CM/DM programs</th>
<th>Goal % members in CM / DM programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAD</td>
<td>7,723</td>
<td>1,188 (15.4%)</td>
<td>21.0%</td>
<td>≥25%</td>
<td>77.5%</td>
<td>&gt;30%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>23,481</td>
<td>4,352 (18.5%)</td>
<td>24.3%</td>
<td>≥25%</td>
<td>81.9%</td>
<td>&gt;30%</td>
</tr>
<tr>
<td>CHF</td>
<td>378</td>
<td>81 (21.4%)</td>
<td>25.9%</td>
<td>≥25%</td>
<td>72.8%</td>
<td>&gt;30%</td>
</tr>
<tr>
<td>Diabetes, CAD</td>
<td>2,170</td>
<td>476 (21.9%)</td>
<td>25.9%</td>
<td>≥25%</td>
<td>82.6%</td>
<td>&gt;50%</td>
</tr>
<tr>
<td>Diabetes, CHF</td>
<td>146</td>
<td>33 (22.6%)</td>
<td>15.2%</td>
<td>≥25%</td>
<td>81.8%</td>
<td>&gt;50%</td>
</tr>
<tr>
<td>CAD, CHF</td>
<td>236</td>
<td>49 (20.8%)</td>
<td>26.5%</td>
<td>≥25%</td>
<td>95.9%</td>
<td>&gt;50%</td>
</tr>
<tr>
<td>Diabetes, CAD, CHF</td>
<td>158</td>
<td>46 (29.1%)</td>
<td>23.9%</td>
<td>≥25%</td>
<td>87.0%</td>
<td>&gt;70%</td>
</tr>
</tbody>
</table>

*BH visit defined as at least one claim paid to a behavioral health provider for a behavioral health condition. Numbers in red denote goal not met.

A couple notes:

- ICD10 codes were implemented on October 1st, 2015, which may cause unknown fluctuation from last year’s report.
- The CM/DM programs that are included are: telephonic, self-directed, active Behavioral Health cases, Moving Forward, On Your Way, and Step-by-Step; we are working to increase engagement in all of these.
Element A5: Measures of primary or secondary preventive behavioral health program implementation

Table 7: HealthPartners’ secondary preventive behavioral health improvement program is a program that was developed several years ago with input from both primary care and behavioral health practitioners who wanted to have a way to provide standardized depression education.

The first part of this standardized depression education is six monthly newsletters. These newsletters:

- Provide health education about depression so the member knows what they are going through may be quite typical
- Support the provider / patient relationship through encouraging members to continue to dialogue with their providers e.g. if they have questions, write them down between office visits or call or email their care team
- Identify several self-management tools and lifestyle changes the member can implement on their own as they feel better
- Encourage members to discuss their depression with trusted family and friends particularly to share how depression is impacting them and to be able to request periodic support
- Provides hope for recovery, which can be in short supply for people with depression, through providing real life examples of others who have successfully managed depression and feel better

For some of our members, this may be the first time that they need to routinely take a medication. This program includes six just-in-time refill reminders and missed refill reminders if the member has not refilled their prescription in a timely manner. Psychiatrists, therapists and primary care physicians provided input and feedback regarding the program concepts and on each of the newsletters.

Prescribers thought it was very important to know when their patient stops taking an antidepressant too early because adherence was an issue care systems were working on. The prescriber alert was developed for primary care physicians, psychiatrists and advance practice nurses with prescribing authority to inform them within 10 days of their own patient missing antidepressant refill. This has allowed primary care and behavioral health to work together to outreach and support patients when they are overdue in filling needed medications.

Our aim is to help prevent complications from people discontinuing medications too early in two ways:

- Providing more information and encouragement to patients/members (On Your Way® newsletters)
- Giving real time and actionable information to psychiatrists, primary care providers and advanced practice nurses (prescriber alerts). When providers are aware the patient has discontinued their medication, they can then contact the patient to discuss concerns and restart medications or consider alternative treatment options.

*On Your Way®* is a series of six months of depression health education newsletters for adults newly diagnosed with depression, antidepressant refill reminders and prescriber alerts when medication is not refilled.

**Table 7: Note - 2018 Population is a proxy using 12 months ending November 30, 2018**

|-----------------------------------------------|-----------------|-----------------|-----------------|---------------------|

2018 Quality Improvement Annual Evaluation 135
Studies indicate that up to 68% of people on an antidepressant medication discontinue the medication within 3 months. During the past 3 years, our HEDIS data indicates that our members discontinue their medications at a much lower rate – between 20 – 25%. When the number of members needing two or more prescriber alerts increase, our HEDIS AMM measure results decrease. Conclusion: Goal has been met.

**Element A6: Special needs of members with severe and persistent mental illness**

A high priority for HealthPartners is improving health and avoiding predictable, preventable crises and hospitalizations, therefore, identifying and assisting members with Severe and Persistent Mental Illness (SPMI) is important.

As a health plan we support our members through our Behavioral Health Case Management program. Our proprietary algorithms focus on patterns of care such as combinations of diagnoses, types of services, sequence, place of service, and patterns of medication use. The program and its predicative analytics were developed to identify those members highly likely to be hospitalized for complex behavioral health conditions within the next 6 months. Most members identified have severe and persistent mental illness, with diagnoses of Schizophrenia, Bi-polar disorder, psychosis and multiple coexisting behavioral health conditions.

Our independently licensed behavioral health professionals assess the acuity of members’ complex, and often comorbid, behavioral health and medical conditions, readiness for change, existing treatment plan, and any barriers to treatment. Case managers support members in working with their provider team and treatment plan (including medication adherence) to increase clinical stability by acquiring self-management skills, preventing decompensation and develop a relapse prevention plan.

We also provide education and encouragement to Behavioral Health and Primary Care providers to attend to the physical health needs of members who have SPMI. This is important as research indicates on average, persons with SPMI die 25 years earlier than the general population. Communication and coordination of care between Behavioral Health and Primary Care providers has been an opportunity for improvement over time.

To draw provider attention to and gain support of improvement in treating medical conditions for people with SPMI, in 2010, HealthPartners built an Optimal Clinical Indicator measurement for SPMI to compare provider performance for a specific set of quality interventions. Our measure identifies members who had a clinic visit, were prescribed an antipsychotic or mood stabilizer medication and were optimally managed. To be optimally managed, the member would have to have all of the following assessments completed in the measurement year: tobacco use, alcohol use, BMI, blood pressure, blood lipids and...
blood sugar. Our most recent data analysis showed that for 2017 dates of service an average of 36.8 percent (up from 29 percent in 2011) of HealthPartners members with schizophrenia or bipolar disorder had all of these assessments completed. Unfortunately, it does not get us to our established goal of 50% members optimally managed.

Table 8:

<table>
<thead>
<tr>
<th>Optimal Management for Severe Mental Illness</th>
<th>Optimally managed goal</th>
<th>2017</th>
<th>2016</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimally Managed - Non-BH Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optimally Managed – BH Providers</td>
<td></td>
<td>43.6%</td>
<td>40.4%</td>
<td>44.8%</td>
<td>42.3%</td>
</tr>
<tr>
<td>Optimally Managed – All Providers</td>
<td></td>
<td>50%</td>
<td>36.8%</td>
<td>33.3%</td>
<td>38.8%</td>
</tr>
</tbody>
</table>

**Conclusion: Goal has not been met**

Research shows that mental illness starts early in a person's life. The data shows that 50% of mental illness begins to occur by age 14. For individuals with Severe and Persistent Mental Illness (SPMI), 75% will have symptoms by age 24. Data shows that approximately 2.9% of the population will have a Bipolar Disorder diagnosis and 2.6% will have severe symptoms. If a child develops Bipolar disorder, the likelihood of them needing an antipsychotic medication goes up as they age:

- 13 – 14 y.o. - 1.9%
- 15 – 16 y.o. - 3.1%
- 16 – 17 y.o. - 4.3%

Prevalence of Schizophrenia is 1%. Men will typically begin having symptoms in their late teens and early 20's. Females typically have symptoms in their 20's.

Autism has a prevalence rate of 1.7% and is more prevalent in boys (2.7%) than girls (0.7%) at age 8.

In 2017, HealthPartners began focusing on child/adolescents using antipsychotic medications. As stated earlier, adults taking antipsychotic medications will have a shorter life span in part due to increased likelihood of metabolic syndrome. Research has identified that child/adolescents are more sensitive to the side effects of these medications, such as causing rapid weight gain, increased induction of diabetes and increased cholesterol, which can lead to heart disease. For these reasons, metabolic monitoring of children and adolescents on antipsychotics is important to identify emerging physical conditions and provide appropriate medical management as needed.

Table 9: Commercial HEDIS results for 2016 through 2018 (dates of reports)

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>60%</td>
<td>42.2%</td>
<td>39.5%</td>
<td>42.6%</td>
</tr>
</tbody>
</table>

**Element B: Collaborative Activities: The organization's activities to improve the coordination of behavioral healthcare and general medical care.**

**Element B1: Collaboration with behavioral health providers.**
One forum, HealthPartners HEDIS Behavioral Health Committee involves collaboration between actively practicing primary care physicians, psychiatrists and behavioral health therapists along with the health plan Behavioral Health Disease and Case Management programs. This is an integrated enterprise committee composed of Regional Assistant Medical Director of Primary Care, Director of Nursing of Primary Care, Psychiatry Medical Director, Senior Director of Behavioral Health, Manager of Behavioral Health Case Management and Quality Improvement professionals. Enterprise-wide quality forums exist to foster collaboration between behavioral health providers and primary care providers.

**Element B2: Quantitative and causal analysis of data to identify improvement opportunities.**

HEDIS results are reviewed regularly by our Behavioral Health HEDIS Collaborative group which includes primary care and behavioral health actively practicing professionals as well as quality improvement and operational leaders. This group meets six to twelve times per year depending on analysis and action plans needed, to review data and conduct barrier analyses and create work plans and pilots.

**A.) Analysis #1: Appropriate diagnosis, treatment and referral of children and adolescents with more complex behavioral health conditions**

HealthPartners Medical Group clinical leadership recognized a growing need to support pediatricians in serving child and adolescent patients with complex behavioral health conditions. Increasingly leadership was hearing dissatisfaction from both the clinicians and some parents of these children about the referral process and the availability of care and treatment. Clinicians also expressed concerns that the current workflow process was not working. Leadership was concerned with the need to avoid pediatrician burn-out and potential for employee turnover, requested a quality improvement study and engaged a director of system quality. The quality director completed a needs analysis. Our data from Element A2 shows a relatively low rate of co-management between pediatricians and behavioral health professionals, except for members with more than one behavioral health diagnosis.

**Table 10: 2018 DOS: Behavioral Health conditions in children and adolescents**

<table>
<thead>
<tr>
<th>Behavioral Health condition(s)</th>
<th># of Members with Condition(s)</th>
<th>Number /percentage of Members with Behavioral Health condition and on Antipsychotic Medication</th>
<th>% with Pediatric and Behavioral Health Providers</th>
<th>Goal % having both Pediatric and Behavioral Health Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>436</td>
<td>13 (3.0%)</td>
<td>10.8%</td>
<td>≥ 10%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>795</td>
<td>13 (1.6%)</td>
<td>10.7%</td>
<td>≥ 10%</td>
</tr>
<tr>
<td>ADHD</td>
<td>1119</td>
<td>23 (2.1%)</td>
<td>14.2%</td>
<td>≥ 15%</td>
</tr>
<tr>
<td>Depression, Anxiety</td>
<td>260</td>
<td>23 (8.8%)</td>
<td>28.5%</td>
<td>≥ 30%</td>
</tr>
<tr>
<td>Depression, ADHD</td>
<td>58</td>
<td>10 (17.2%)</td>
<td>29.3%</td>
<td>≥ 30%</td>
</tr>
<tr>
<td>Anxiety, ADHD</td>
<td>185</td>
<td>10 (5.4%)</td>
<td>32.4%</td>
<td>≥ 30%</td>
</tr>
<tr>
<td>Depression, Anxiety, ADHD</td>
<td>45</td>
<td>8 (17.8%)</td>
<td>26.7%</td>
<td>≥ 35%</td>
</tr>
</tbody>
</table>

Numbers in red denote goal not met.
Opportunities for improvement appear to include increasing supports for pediatricians that identify child/adolescents behavioral health symptoms needing treatment and identify available behavioral health practitioners. Some of the barriers identified in the needs assessment are:

- Pediatricians may lack both knowledge of and time for treating children and adolescents with complex behavioral health conditions in a primary care setting.
- Time to set up outpatient visits – typically, one needs to coordinate both the working parents schedule and the child’s school schedule.
- Sometimes the parent(s) may have a behavioral health condition, which complicates their approach for the treatment needs of their child or interferes with follow through on attending appointments.
- Cost may be prohibitive for some families, especially if the child’s condition is complex.

**B.) Analysis # 2: Supporting members with SPMI to prevent medical co-morbidities**

Characteristics of this population impede their understanding, adherence and then follow through. They may have insecure housing and their cognitive function can sometimes be impaired reducing their ability to make good judgments regarding their holistic health needs. Their emotions and symptoms may sometimes interfere with attending to their healthcare needs and healthcare appointments. Their socioeconomic status is low and their disposable income is small to nonexistent. Finally, their ability to organize their days and weeks is impaired due to all of these factors. So devising ways to support our members and their primary care providers is an ongoing endeavor.

Review of the Optimal Management for SPMI measure reveals that our latest rates are flat and therefore we continue to miss our goal of 50%. A subgroup of the Behavioral Health HEDIS Collaborative met to review the data in more depth, identify current work that we could leverage and identify potential barriers.

Our 2016 analysis lead us to take action in 2017 to improve the rate of glucose and LDL screenings – namely implementation of an electronic decision support for providers who have patients on antipsychotic medications and a diagnosis of SPMI. As we await results of the effectiveness of the electronic decision support, we are turning attention to our younger members with SPMI. Knowing that antipsychotic medications can have a negative effect for adults with SPMI, we are concerned that it might also be an issue for our younger members on antipsychotic medications.

Comparison of our HEDIS 2016 and 2017 data for the Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) measure revealed an increase in the number of members in the denominator and a decrease in our rates. This prompted discussion regarding how we can best help support the providers and parents of these children to obtain best practice screenings.

**Table 11: Commercial HEDIS results for 2016 through 2018 (dates of reports)**

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>60%</td>
<td>42.2%</td>
<td>39.5%</td>
<td>42.6%</td>
<td></td>
</tr>
</tbody>
</table>

Parents with children/adolescents who have SPMI may face more barriers than adult patients in obtaining lab screenings:
• Since antipsychotics are prescribed by child psychiatrists, parents frequently need to take their child to another clinic for lab draws, which can be a time challenge with parent and child schedules.
• Parents may fear that if the lab screenings reveal a medical concern, the medication may be stopped.
• The medical clinic may find it more challenging to acknowledge a stand-alone lab request if the child is not seen at that clinic
• When a psychiatrist is willing to order labs, they will need to find a lab or coordinate with the child’s medical provider.

**Element B3: Identifying and selecting one opportunity for improvement from Element A**

HealthPartners has selected the topic of gathering a psychosocial assessment when ordered by a pediatrician for children/adolescents with complex behavioral health conditions as the first focused improvement initiative. This includes the following elements:

**Opportunity #1: Appropriate diagnosis, treatment and referral of children and adolescents with more complex behavioral health conditions**

This measure was selected due to pediatrician’s requests for additional resources and due to the importance of identifying and making appropriate referrals for behavioral health treatment of clinical needs among children and adolescents.

**Element B4: Identifying and selecting a second opportunity for improvement from Element A**

HealthPartners has selected the topic of attending to the physical health needs of our child and adolescent members using antipsychotic medications to prevent medical comorbidities. This includes the following elements:

**Opportunity #2: Supporting Child and Adolescent members with SPMI to prevent medical comorbidities**

This measure was selected because it is well known that many antipsychotic medications cause metabolic syndrome, a precursor to diabetes and heart disease. Research shows that children and adolescents are more sensitive to these side effects (metabolic syndrome). There is no research that informs us of the long term effects of these medications on children and adolescents. Some of these children and adolescents will need to remain on these medications long term. By encouraging parents and providers to focus on physical health and medical conditions along with behavioral health conditions, adverse outcomes can be minimized.

**Element B5: Taking Collaborative Action to Address One Identified Opportunity for Improvement from Element A**
Appropriate diagnosis, treatment and referral of children and adolescents with more complex behavioral health conditions

With facilitation from a quality improvement professional and care delivery leaders from pediatrics and child psychiatry along with health plan leaders in Behavioral Health an agreement was made to create and implement a pilot, testing the feasibility of collaborative work to collect psychosocial history, identify informant and type of clinical need and recommend type and level of behavioral health care utilization.

The pilot includes five pediatric clinicians who will refer 10 patients to Behavioral Health case management. Behavioral health case managers will collect psychosocial history, identify informant and type of clinical need, then recommend type and location of care for behavioral health treatment interventions. All of the above is documented in the patient’s electronic medical record for use by the child’s care delivery team. After the tenth case is concluded, an assessment of the feasibility and utility of the pilot process and work flow will be determined.

We had one opportunity to use the tool during the measurement time frame. Following a pediatric visit, the pediatrician places an order for a psychosocial assessment to assist in identifying an appropriate referral for behavioral health treatment. HealthPartners Behavioral Health licensed processional successfully reached out to parents and collected 18 elements including current concerns questions, patient history, current providers, diagnosis, and medications. This information was documented into the electronic medical record which then resulted in a referral and a follow up communication with pediatrician.

Element B6: Taking Collaborative Action to Address a Second Identified Opportunity for Improvement from Element A

Supporting members with SPMI to prevent medical co-morbidities

Behavioral Health HEDIS Collaborative group reviewed various options to supporting child and adolescents taking antipsychotic medications to prevent medical co-morbidities. One option reviewed is to see if labs could be drawn at the clinic based pharmacy at one of the prescription refills. Exploration of this option began in 2nd quarter 2018 and it was abandoned as untenable.

Another option discussed is to see if we can both support and educate providers and parents of the need for these metabolic tests. 531 parents received this letter educating them on the importance of obtaining lab tests for their child taking antipsychotic medication. The letter was created in collaboration with primary care, pediatricians, and behavioral health professionals

Element C: The Organization Annually Measures the Effectiveness of Improvement Actions taken for Two Opportunities

Element C1: The first opportunity
Collaborative action #1: Appropriate diagnosis, treatment and referral of children and adolescents with more complex behavioral health conditions

Proxy dates are October 2017 – September 2018

Table 12: 2018 DOS: Behavioral Health conditions in children and adolescents for the five pediatricians in the pilot

<table>
<thead>
<tr>
<th>Behavioral Health condition(s)</th>
<th># of Members with Condition(s)</th>
<th>Number / percentage of Members with Behavioral Health condition and on Antipsychotic Medication</th>
<th>% with Pediatric and Behavioral Health Providers</th>
<th>Goal % having both Pediatrician and Behavioral Health Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>7</td>
<td>0</td>
<td>0%</td>
<td>≥ 10%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>13</td>
<td>0</td>
<td>38.5%</td>
<td>≥ 10%</td>
</tr>
<tr>
<td>ADHD</td>
<td>45</td>
<td>0</td>
<td>26.7%</td>
<td>≥ 15%</td>
</tr>
<tr>
<td>Depression, Anxiety</td>
<td>6</td>
<td>0</td>
<td>66.7%</td>
<td>≥ 30%</td>
</tr>
<tr>
<td>Depression, ADHD</td>
<td>2</td>
<td>0</td>
<td>50.0%</td>
<td>≥ 30%</td>
</tr>
<tr>
<td>Anxiety, ADHD</td>
<td>3</td>
<td>0</td>
<td>100%</td>
<td>≥ 30%</td>
</tr>
<tr>
<td>Depression, Anxiety, ADHD</td>
<td>1</td>
<td>1 (100%)</td>
<td>100%</td>
<td>≥ 35%</td>
</tr>
</tbody>
</table>

Numbers in red denote goal not met.

The pilot was started in October of 2018. We will monitor its effectiveness throughout 2019 and hope to see improved co-management of children and adolescents with complex behavioral health conditions.

Element C2: The second opportunity.

Collaborative action #2: Supporting members with SPMI to prevent medical co-morbidities

The reminder letter initiative mailed to parents of children and adolescents taking antipsychotic medication began in the fourth quarter of 2017. Monitoring of proxy data lead us to amend our program to send a second parental and also a provider letter starting in 4th quarter 2018. We anticipate an improved result for our HEDIS 2019 rate for this measure.
Hemoglobin A1c Screening for Diabetics

Description

According to the Center for Disease Control and Prevention (CDC), over 100 million Americans are living with diabetes or prediabetes. Additionally, the CDC noted diabetes as the seventh leading cause of death in the US in 2015. Best practice guidelines per the American Diabetes Association state that a diabetic who is meeting treatment goals should complete a hemoglobin A1C test two times per year and quarterly when treatment goals are not met. Optimal diabetes management requires an organized, systemic approach and the involvement of a coordinated team of dedicated health care professionals working in an environment where patient-centered high-quality care is a priority. Clinical Diabetes 2018 Jan; 36 (1): 14-37

HealthPartners Disease Management program supports five core conditions, including diabetes. Members are identified for Disease Management based on patterns of care and gaps in clinical care. Gaps in clinical care pertaining to individuals with diabetes include, but are not limited to, nonadherence to current treatment plan and lack of screenings for A1c. Closing gaps and optimizing member health is an ongoing initiative for Disease Management. We address this for our members with diabetes by providing diabetic education materials based on the members patient activation measure (PAM). Our disease managers use behavior change coaching techniques, and close collaboration and coordination with provider care teams to ensure optimization of member health.

Goals

The objective for this initiative is to increase the percentage of annual hemoglobin A1c screenings for diabetic members participating in the Disease Management program.

The population selected for the hemoglobin A1c screening performance measure includes all diabetics aged 18 and older who are interactively managed in the Disease Management program for at least 60 days.

Numerator: The number of patients aged 18 and older who had a hemoglobin A1C screening complete during the reporting period.
Denominator: The number of patients aged 18 and older interactively managed in the Disease Management program for at least 60 days.

Baseline
The average percentage of diabetic patients participating in the Disease Management program who completed a hemoglobin A1c screening in 2016 was 84.4%.

2018 Goal
The goal established for 2018 was to increase the percentage of annual hemoglobin A1c screenings to 88.6% for diabetic members who participated in the Disease Management program.
Initiatives/Interventions

High-risk diabetic members are assessed during each interaction with a nurse for potential gaps in care including hemoglobin A1c screening. Disease managers start assessing for gaps in care during the first call with the member.

Disease managers received training in 2018 to further develop their knowledge base of diabetes management including the continued importance of hemoglobin A1c screenings. Training was presented in various formats to cater to multiple learning styles. The 2018 trainings included independent study through CE Direct for a course entitled, “Healthcare Providers Can Be Diabetes Detectives.”

Additionally, disease managers participated in the following multi-media and in-person trainings to further their expertise around working with members:

- Motivational Interviewing: Motivational Interviewing is a style of arranging conversation that allows individuals to explore their motivations and reason for change, while taking into account how difficult it is to make behavioral changes. Disease managers use this approach to improve member health by assisting members to identify internal motivation and encouraging them to make a commitment to positive change.
- Shared Decision Making: Shared Decision Making is a crucial component of patient-centered health care, wherein both the member and disease manager contribute to the decision-making process. Disease managers and members come together to make decisions and set goals based on clinical evidence that are consistent with the member’s preferences and values.
- Social Determinants of Health: Social determinants of health are social and economic factors that can impact health status. In 2018, disease managers completed training focused on the identification of various social determinants of health. The disease managers were trained in assessing and alleviating these factors through the use of a variety of internal and community resources.

Barrier Analysis

Challenges related to ensuring all diabetic members obtain their A1c screenings include adherence to the plan of care, health literacy, family/caregiver support, transportation and cultural barriers. There continue to be opportunities to improve A1c screenings for our diabetic members. Disease Managers will utilize Shared Decision Making and Motivational Interviewing to help members and families identify their personal goals for their plan of care.

Opportunities for Improvement: Results/Outcomes

HealthPartners Disease Management achieved 88.4% of the goal of 88.6% for diabetic members screened for A1c. Although we are slightly under goal it is important to note, hemoglobin A1c screenings for high-
Risk diabetes members in Disease Management improved considerably in 2018 from previous years. Screening improved by 2.7% from 2017 to 2018 and by 4% from 2016 to 2018.

Disease Management will continue to provide coaching to members on the importance of obtaining hemoglobin A1c screenings per the provider’s plan of care and best practice guidelines to assist in closing this gap in care. Diabetes clinical screenings (including hemoglobin A1c) will continue to be reviewed with staff each quarter to increase their understanding of best practice guidelines for diabetes care. We will also continue to review the diabetic clinical screening report with staff as this report provides disease managers oversight on members they are currently working with who have active gaps in diabetes care.
Health Promotion

Description

The Health Promotion Department is dedicated to improving the health and well-being of our members through promotion of healthy lifestyle choices, including optimal lifestyle behaviors, and helping to prevent and manage disease. Services provided by Health Promotion include behavior change programs that support the health and well-being of individuals across the continuum of health.

Goals

- Improve optimal lifestyle health behaviors across the member and participant population
- Provide engaging, easy to use and relevant well-being programs and tools to help participants make positive behavior changes, adopt healthy habits and reach their health and well-being goals
- Evaluate health and well-being participant experience to help drive engagement and participation

Initiatives/Interventions

- Comprehensive health assessment that is easy to complete, validated by research, and provides teachable moments and immediate feedback so participants understand their health and opportunities for improvement
- Personalized experience that shows activities and content that is relevant to the individual. Activities and resources are recommended based on what we know about a participant’s health needs and interests, including an option for a tailored menu of incentive eligible activities that are prescribed based on participant’s risk levels informed by data
- Online lifestyle management programs including weight management, stress, physical activity, sleep and tobacco cessation. Activities offer a variety of behavior change methodologies such as readiness to change, tracking and journaling.
- Responsive, online platform design detects user’s screen size and orientation and changes the layout accordingly to allow for a seamless participant experience
- Phone-based health coaching promotes optimal lifestyle management and behavior change support through intrinsic motivation with topics including: tobacco cessation, weight management, healthy eating, physical activity, stress, back health, sleep, family health, and management of high cholesterol and hypertension. We also offer topics through 1:1 video coaching and group telephonic coaching.
- We created an updated and enhanced framework for well-being activities that leverages behavior change tactics. Participants get actionable bits of knowledge combined with practical tips to apply daily, and tips to help consider the impact of their environment, social support and planning for set-backs that can reinforce healthy habits
- Online well-being challenges focusing on weight loss, physical activity and nutrition
- On-site workplace health and well-being programs and health coaching for participating employer groups
• Health and well-being tools and resources on healthpartners.com include access to information on Frequent Fitness, Healthy Discounts, interactive tools, decision support health resources and preventive care guidelines

• Integrated approach across HealthPartners to ensure lifestyle management tools and resources are available for use with members

• Easy referral capability for providers to refer to health and well-being programs through HealthPartners Connect

• Community collaboration for tobacco cessation through the Call it Quits® collaborative and Fax Referral Program

• Adult obesity counseling program to comply with Affordable Care Act requirement for coverage of a comprehensive obesity counseling program that meets the recommendations of the US Preventive Services Task Force

• Satisfaction and outcomes analysis are evaluated using an experience measurement survey. Healthy behaviors for participants in health coaching and online lifestyle management programs are documented with results provided below

• Well-being tools and programs, including the Health Assessment and family coaching were expanded into Medicare and Medicaid markets

• Consultative services to employer groups to help assess, address and enhance organizational policies and environmental factors affecting employee health and well-being

Barrier Analysis

• Higher health and well-being engagement rates are tied to employer based incentives, but not all employer groups offer an incentive for participation in a wellness program or completion of health assessment

• Expectations from well-being clients and participants remain high in the areas of technology and innovation, resulting in difficulty meeting all market expectations. We’ve made significant progress through the new Health and Care Engagement platform, but technology expectations among purchasers remains high.

• Effective communications to members about the benefit of healthy living to overall quality of life proves challenging given the diversity of employee populations

• Some members are not ready to make positive behavior changes. Health coaching programs are helping to increase intrinsic motivation for participants, but engagement in health coaching is lower than other lifestyle management programs

• Maintaining accurate contact information is a challenge. Members may change their place of residence and/or change their phone number

• Keeping participants engaged in health and well-being programs year round can be a challenge. Through our programs we try to help people make health and well-being part of their day-to-day life and not as a limited activity that they must do to meet an employer based incentive.

• Employers may be hesitant to adapt work environments and organizational policies to maximize employee health and well-being. We offer strategic tools to assess organizational policies and environments, and work with employers to make improvements in these areas.
• Health and well-being products and solutions can be created for employers, and consultation can be provided on how to improve the health and well-being of a workforce, but little change will happen without a positive culture and strong leadership support

• Employers have a wide range of employees that can lead to language, technology and literacy barriers when engaging in health and well-being solutions

Results/Outcomes

Lifestyle Management Experience Outcomes:

Health Assessment and web experience

• Overall satisfaction (very satisfied & satisfied): 95%
• Usefulness of information in setting well-being goals: 88%

Program experience

• Overall satisfaction (very satisfied & satisfied): 94%
• I would sign up for another program (strongly agree & agree): 88%
• The program(s) helped to improve my overall quality-of-life (strongly agree & agree): 83%
• The programs were relevant to my individual needs (strongly agree & agree): 89%

Coaching

• 97% of participants engaged in the phone coaching program were either very satisfied or satisfied

Lifestyle Management Program Outcomes*:

• Participants focusing on weight management lost an average of 7.9 lbs.
• Participants focusing on sleep reported sleeping an average of 6.7 hours per night
• 62% of participants who focused on nutrition reported meeting national guideline of eating at least 5 fruits and vegetables on a daily basis
• 72% of participants focusing on physical activity reported meeting physical activity guideline of 150 minutes of moderate or vigorous physical activity on a weekly basis
• 69% of participants focusing on stress management reported that their stress level has improved as a result of the program
• 86% of participants focusing on gratitude reported an increase in positive emotions such as joy, compassion and optimism
• Six month sustained quit rate for tobacco cessation coaching participants: 77%

*Outcomes reported after three to four months of participation unless otherwise noted
Health Disparities

Description

HealthPartners’ commitment to reducing health disparities is grounded in the mission, vision and values established by our consumer-elected Board of Directors. Our mission is to improve health and well-being in partnership with our members, patients and the community. Our Partners for Better Health Goals 2020 reflects this mission. We seek to deliver outstanding care and service that is safe, timely, effective, equitable, efficient and patient/member/family centered.

Goals

Our goal is to reduce health disparities among our members and patients to improve their health and experience. We seek to develop community partnerships to support social, economic and environmental health and well-being for our patients and members, and to decrease the gaps in socioeconomic and physical environmental health determinants.

Initiatives/Interventions

HealthPartners has a longstanding commitment to improve the health of the diverse communities we serve. The Health Equity Sponsor Group oversees the efforts across the organization to decrease disparities. Our strong leadership commitment is reflected in the awards and recognitions we’ve received for these efforts. Some examples include:

- HealthPartners is one of the top-rated private health plans in Minnesota and one of the highest-rated plans in the nation, with a rating of 4.5 out of 5, according to the NCQA Private Health Insurance Plan Ratings 2018-2019.
- HealthPartners was also one of two organizations to receive the Centers for Medicare and Medicaid Services’ 2019 CMS Equity Award. The award recognizes organizations that demonstrate an exceptional commitment to health equity by reducing disparities among minority and other underserved populations.
- HealthPartners was awarded the Innovator of the Year award by the MN Colon Cancer Coalition for utilizing home test kits to increase colon cancer screening.

Healthy Equity Sponsor Group

Our Health Equity Sponsor Group provides strategic leadership in planning and executing activities aimed at improving health equity through reducing health care disparities, improving access, and supporting an inclusive culture. The group aligns health equity activities across the organization through inclusion in annual plans, and supports tracking and monitoring of progress.
The Health Equity Sponsor Group:

- Provides organization-wide approach to measure and reduce health care disparities
- Supports workforce development initiatives aimed at reinforcing cultural humility and respect, and increasing awareness of cultural issues
- Improves care and service for persons who have limited English proficiency and patients who are hearing impaired
- Involves patients and members in the planning and implementation of health equity approaches
- Engages communities in strategies and partnerships to promote health equity
- Provides recommendations and direction for data collection, analysis and reporting across the organization
- Communicates progress on initiatives across the organization, and externally as appropriate

Community collaboration to gain insights and engage community

We have built a culture of health equity in our organization through partnerships with community organizations. Our 2018 Community Health Needs Assessments and Plans, conducted by each of our hospitals, framed health equity as an underlying driver for all of the hospital Community Health Implementation Plans. During that process, we engaged community members, public health, and our own clinicians to more deeply understand how we might impact the health of our community.

Community partnership development is a core strategy in our work to promote health equity. We invest in six general areas: healthy children, mental health, nutrition and fitness, health equity, wellness and prevention and research and education. We also have larger, multi-year partnerships and campaigns with community-based organizations to impact health determinants, such as the MakeltOK campaign, PowerUp and Little Moments Count. Examples of partners include organizations such as the Wilder Foundation/ St. Paul Promise Neighborhood, the YWCA, Northside Achievement Zone, NAMI, over 60 schools throughout the region, Hunger Solutions, and many others.

- In 2016, HealthPartners joined forces with Greater Twin Cities United Way to help promote community conversation on the importance of early brain development and the health disparities resulting from not enough interaction with babies and young children, especially in stressed communities. Over the past three years, the two organizations have created, hosted and convened over 500 yearly annual attendees representing 200 organizations at conferences on the topic. Additionally, we convened a Little Moments County (LMC) Leadership Council to plan shared activities to promote early brain development with 25 public and private partner agencies. In 2018, a Community Cultural Consultants subgroup was also formed to help inform and direct this statewide action. Goals of LMC include raising awareness of the importance of frequent, early interaction with babies and young children, as well as to see and measure these awareness and behavior changes in parents, caretakers, and the community. HealthPartners CEO, Andrea Walsh, has also been convening healthcare system and business leaders to discuss additional collective action to support and promote this work.

- HealthPartners Children’s Health Initiative also promotes early brain development with Reach Out and Read. We now provide books to families in well child visits and the 32 week obstetrics visit, and our dental clinics also provide books to families. This work is linked to our Little Moments Count
initiative to promote early brain development. In 2019, we will build on Reach Out and Read to include brain development messages for families.

- We continue our work with the Itasca Project. This is an employer-led alliance to address regional issues that affect our future competitiveness and quality of life. A major focus of the Itasca Project is closing the gap on socioeconomic disparities in the region through collective action by businesses.

- HealthPartners sponsored the Twin Cities Public Television production, “Out North,” the first-ever film to honor our state’s LGBTQ history. The full-length film features the stories of many LGBTQ Minnesotans; sheds light on the past and present of Minnesota’s lesbian, gay, bisexual and transgender community; and inspires diversity and inclusion. The film debuted on Monday, October 16, 2017. The documentary and resources are still available to the community at: https://www.tpt.org/out-north/video/out-north-mnlgtbq-history-06spot/

- For many years HealthPartners’ has been a sponsor of the YWCA of Minneapolis’ It’s Time to Talk: Forums on Race. Over 1,000 diverse leaders from business, education, arts and community service came together to move Minnesota forward through honest conversation about race. The focus of this event was to educate about facets of racism, equity and inclusion, engage in dialogue, discussion and self-reflection, and empower communities to lead sustainable change.

- In late 2018 and into 2019, HealthPartners sponsored and partnered with the YWCA Minneapolis to move from conversation to action with a four part series called It’s Time to Act. The series focused on honest conversations to empower participants to engage in deeper conversations around race, equity, faith and social justice. Topics included: Systemic Racism: Identifying It and Dismantling It with Dr. Nell Irvin Painter; White Fragility: Unpacking Privilege with Dr. Robin DiAngelo; Before Jesus Was White: Unlearning Our Truths with Rev Dr. Curtiss De Young and Anthony Galloway; and Racism and Sexism: Revealing the Intersectionality with John Biewen.

- HealthPartners is a sponsor of The Forum on Workplace Inclusion, hosted by the University of St. Thomas. The Forum on Workplace Inclusion serves as a convening hub for Diversity and Inclusion Leaders across the country and is an opportunity to engage and advance ideas for igniting change towards a more inclusive workplace community.

- For the 2nd year, our Cross Cultural Leadership Network partnered with Girls Scouts to introduce girls (ages 10 to 12) to careers in health care. More than 30 girls attended to listen, engage, and ask questions about this year’s theme “G.I.R.L.: Go-getter, Innovator, Risk-Taker and Leader.”

- HealthPartners sponsored a spring build in West St Paul and a fall build in Minneapolis with Twin Cities Habitat for Humanity. Our 159 volunteers contributed 1272 hours of build service.

- 2018 marked HealthPartners 21st year in the Pride Festival and 3rd year in the Pride Parade. More than 100 employees walked in the 2018 parade and volunteered at the HealthPartners festival booth. This event brings together the greater LGBTQ community to foster inclusion, educate, and celebrate achievements in equality. With more than 400,000 attendees annually, the Twin Cities boasts one of the biggest Pride festivals in the country. Also in 2018, HealthPartners was honored with the Twin Cities Pride 2018 Corporate Champion of PRIDE award. The award was giving in recognition of the work our organization and teams do each day to end LGBTQ health disparities.

- Methodist Hospital has hosted a Mom Baby Café for over three years, offering support, camaraderie, and lactation support for mothers postpartum. Starting in September of 2018, our Chanhassen Clinic began a partnership with Carver County’s Statewide Health Improvement Partnership (SHIP) Program to host our first extension of the Methodist program. Since September, there have been ten
sessions, ranging from one to five moms per session with an average of three. This expansion has been successful in providing a more regional resource for moms looking for breastfeeding and baby care support that is of no cost and significantly closer to their homes.

- For the past 3 years, Park Nicollet has partnered with Minneapolis Roosevelt High School’s Health Careers Program to offer mentorship opportunities for career exploration in the health care setting. In 2018 Park Nicollet hosted 20 students on site for 8 hours each. The students are assigned a mentor and spend time shadowing a specialty or health career of their interest. Park Nicollet Women’s Services also provided scholarships to 10 Roosevelt High School students to take the Nursing Assistant certification test through Minneapolis Community and Technology College. In addition Park Nicollet Women’s Services provides $250 to the program to purchase scrubs for the students to attend their clinicals.

- The Gender Services Team has participated in clinician and support staff education across the organization and beyond through many presentations including nursing grand rounds, Methodist Hospital Grand Rounds, presentations at AORN (Association of Operating Room Nurses), the Opportunity Conference (previously sponsored by Rainbow Health Initiative and now through JustUs Health), and the Minnesota Academy of Family Physicians.

- HealthPartners and Regions Hospital targets the stigma surrounding mental illness with a campaign called Make It Ok. Our award-winning work in reducing the stigma related to mental illnesses added a new and innovative partner, Minnesota Public Radio, in 2016. John Moe’s “Hilarious World of Depression” podcast series shares the stories of comedians and entertainers around the country who have experienced mental illnesses and stigma. The podcasts were so popular that we have now partnered for more than three years. This has been influential in tripling traffic to the Make It OK website, and more than 15,000 people have now taken the pledge to reduce stigma. Remarkably, there have been over 9 million downloads of the successful podcast series. We have had inquiries from around the world with people interested in the campaign or in sharing their own stories. From Sydney, Australia to St. Paul, MN, people are finding value in our campaign and starting a very needed conversation.

- Hmong Stroke Education Translation Project: From the Regions Stroke program data review, we learned that compared with White patients, Hmong patients:
  - Have their strokes, on average, 10 years younger.
  - Have more brain hemorrhages.
  - Have less control of risk factors (diabetes, hypertension, high cholesterol).
  - Have more frequent blockages of arteries inside the head causing their strokes.
  - Less frequently arrive by ambulance
  - Less frequently use acute rehabilitation services.

A Hmong Community Stroke Education and Awareness Initiative group, composed of Hmong community and Regions Hospital team members, has been meeting since December 2016 to establish effective strategies for connecting in the Hmong community to promote stroke awareness and reduce disparity of health care resource utilization. A Hmong stroke community survey was conducted during the 37th Annual Hmong International Freedom Festival in Saint Paul (July 1-2, 2017) with the support of the Hmong Health Care Professionals Coalition. From this survey, we learned there are knowledge gaps for knowing what a stroke is, identifying stroke signs and symptoms, and knowing the best action to take when you suspect stroke. As a response to the survey results and in an effort to promote stroke awareness among the Hmong community and reduce disparity of health care resource utilization, the Hmong Community Stroke Education and Awareness Initiative group applied
for and received a grant through the Regions Hospital Foundation in 2018 to translate eight American Heart Association (AHA) stroke education materials into the Hmong language. The Hmong Stroke Education Translation Project focused on providing effective translated print material for use in hospitalized Hmong stroke patients. The translations aimed to design specific Hmong-friendly stroke resources; simple messages (culturally relevant), appropriate images (culturally relatable). Hmong community members were recruited to be volunteer models for the translated documents. This project was completed in December 2018.

- School Challenge and PowerUp for Kids: In 2011, HealthPartners began a partnership with schools in Minnesota and western Wisconsin to make it easier for children and families to eat fruits and vegetables and more. More than 150,000 students have participated since 2012. HealthPartners PowerUp School Challenge is a fun-filled, three-week school challenge program. It encourages students from kindergarten through fifth grade to try to eat five fruits and vegetables and to be physically active every day. Healthy habits are formed at an early age and have a big impact on a child’s health. The program engages kids to “Try for 5” fruits and vegetables, including sampling veggies right in the classroom. School participation rates remained high, even after multiple years of the program. Surveys showed that 70% of families and more than 85% of school staff observed that kids show more interest in trying or eating fruits and veggies. Schools in the east metropolitan area are going even further to create a culture of health at school and in the community. Schools focus on evidenced-based strategies to make lasting change, including using physical activity as a reward, reducing or eliminating sugary beverages in school and at school events, including a physical activity break in classrooms daily, and promoting activity-based celebrations, fundraisers and events.

- We continued to expand the fruit and veggie prescription program (Fruits and Veggie Rx). The number of fruit and vegetable “prescriptions” (vouchers) we distributed increased from 16,550 in 2016 to 29,758 in 2018. The program is popular with families and our clinicians, with the message to try new fruits and vegetables. Cub Foods is our partner in the metro area for the Fruit and Veggie voucher redemption. Our distribution continues to grow each year, as does the number of locations were we will use the vouchers. Expansion has included school-based clinics and our Well@Work clinics.

- Camp 5210 was held June 24-28, 2018. This was the 9th year that HealthPartners and Park Nicollet have partnered with One Heartland to hold camp 5210 at their camp in Willow River, MN. Camp was created for kids 7 to 17 years old who face challenges achieving a healthy weight. Overall satisfaction with camp was positive by both parents and kids. Since Camp 5210, 70% of kids said that being more physically active is more important to them and 92% of parents shared that eating healthy foods as a family is important to them.

- St. Paul Promise Neighborhood (SPPN) and Freedom School: The Promise Neighborhood (Wilder Foundation, Ramsey County, and St. Paul Public Schools) is a community-wide initiative to provide academic, social and health supports children need to succeed in school and life. The focus is on families with children birth to age 5. HealthPartners is a partner on the Advisory Council and Health and Wellness Committee. SPPN is addressing the opportunity gap. All students and families have access to educational opportunities that honor and fully integrate their cultural practices, values, communication preferences and learning styles.

- Since 2014, HealthPartners has sponsored the Saint Paul Public Library Bookmobile, which is one of the last urban bookmobile still in operation. The Bookmobile visits elementary schools, senior centers, public housing and neighborhoods that experience poor access and other barriers. In addition to a financial contribution, HealthPartners also volunteered helping the Bookmobile at

2018 Quality Improvement Annual Evaluation 153
Rondo Parade, Rice Street Festival Parade and the Peace Celebration.

- HealthPartners is a proud sponsor of the Rondo Commemorative Plaza. In the 1930s, the Rondo neighborhood was a thriving and vibrant community. By the 1950s, about 85% of Saint Paul’s African-American population lived in the neighborhood. The community bond was strong, local businesses were thriving, and residents were gaining financial stability that comes with home ownership. In the 1960’s, however, the neighborhood of Rondo was removed from the map for the construction of Interstate 94. 600 families lost their homes along with numerous businesses and institutions. In the summer of 2018, the Rondo Commemorative Plaza was installed to capture the history of loss endured, lessons learned and the will to reconnect.

- In 2018, HealthPartners supported the Science Museum of Minnesota’s development of the Mental Health: Mind Matters exhibit. This exhibit was originally developed in Finland, but did not use culturally appropriate language or approaches for the United States, as well as did not provide culturally-relevant resources. HealthPartners provided important financial support and subject matter expertise and content on resources, including creation of a dedicated resource area for adults and children. This resource area included culturally-relevant resources in many languages and also included dedicated pieces for perinatal psychiatric disorders, and African American, recent refugee immigrant, Somali and Latin American communities.

- Teen Pregnancy Prevention: In 2018, all 55 of our primary care clinics implemented a standard process to talk to adolescents and their parents about sexual health, pregnancy prevention, and other important adolescent well-being topics. Parents and teens now receive letters that explain what will happen in clinic as children transition to adolescent care. Adolescents also complete a teen questionnaire to assess their sexual health and other needs. Most importantly, it is now a standard of care in our clinics that all adolescents, beginning at age 12, have some private time with their clinician to discuss the topics that are most important to them. We have developed training materials for our primary care clinicians about how to initiate effective private time with adolescents and their parents.

- We continue to expand our collaboration with community partners to further support our most vulnerable patients and members. We work to identify and refer our eligible mothers who are patients or members to Nurse Family Partnership and other county public health nurse home visiting programs.

- Methodist Hospital’s maternal and newborn home visit program, known as the Maternal Child Health Home Care program, is being assessed for possible expansion across the HealthPartners system. The goal of the program would be to offer a home visit to every individual who delivered at one of our family hospitals. The home visit will encompass crucial aspects of maternal and infant care, including health assessments for both, answering questions, addressing breastfeeding concerns, and troubleshooting any possible socioeconomic concerns. This program will also focus on creating a stronger partnership with county programs and connecting our patients with appropriate resources.

- Infant mortality is low in Minnesota compared with the rest of the nation, but nationally and in Minnesota, African American babies have over twice the rate of infant mortality compared with white babies. With this known disparity, leadership wanted to better understand where HealthPartners stood, so we formed a Perinatal Measures Council. The Council is working on creating (1) a standardized scorecard with measures looking at maternal health (hypertension, hemorrhage, preeclampsia, and DVT) and (2) a system-wide dashboard, which would allow obstetrics units to review other pertinent measures for assessing their outcomes and areas for improvement.
• Park Nicollet Foundation provided over $1.6 million in grants to support community health initiatives, including school-based health, dental and mental health programs and food access for seniors.
  o School-Based Health Centers in 4 locations had over 3500 medical visits with youth from birth through high school graduation.
  o Through the Growing through Grief program, Park Nicollet counselors provided group and one-on-one grief counseling to students at 72 schools in 13 school districts. These services support more than 520 students per week.
  o NOW! (No Obstacles to Well-Being), an in-school mental health program, provided nearly 828 sessions through the 2017-18 school year via secure video technology at three schools.

• We participate in The Exchange, a collaborative of Minnesota health-related organizations, whose members share their translated health materials. The Exchange also disseminates information on issues of literacy, class, culture, race and spirituality as they affect health disparities.

• We are a member of the Minnesota Health Literacy Partnership, a collaborative of hospitals, clinic systems, health plans and community and public organizations. This group shares information and engages in joint planning on health literacy issues. The group is committed to advancing health literacy, so all people in our community can understand and engage in their health and health care.

• We worked with Minneapolis Public Schools and their STEP-UP Achieve internship program to provide summer internships, mentoring and career coaching for 7 racially diverse students in 2018. In addition, we offered training on Microsoft Outlook and resume building.

• HealthPartners sponsors and is a key player in the Greater Minneapolis/St. Paul initiative called Make It. MSP, which is an initiative to help make the Minneapolis/St. Paul region a top performer in attracting and retaining people. As part of this initiative, we have representation on (1) the Make It. MSP People of Color Cohort, which is focusing on recruiting and retaining people of color to positions in the region and (2) the enterprise talent team, which focuses on recruitment into the region.

• HealthPartners assists with mock interview in the Twin Cities Rise partnership. The aim of the partnership is to transform lives, especially men of color, through meaningful employment, so they can achieve long-term job success to support their families.

• HealthPartners attended BITCON2018 (Blacks In Technology, now Techquity). https://www.bitcon2018.com/), hosting a sponsor table at the event for recruiting.

• Regions Hospital partnered with the St. Paul Right Track program to provide summer internships and career coaching to 10 racially diverse high school students.

• Regions Hospital continues to support Scrubs Camp, a student experience that introduces young people to a variety of careers within health care. Regions Hospital supports this program through financial contributions to provide scholarships as well as supporting the student experience by leading tours or learning sessions.

• HealthPartners Interpreter Services leaders are members of the Interpreter Services Leadership Group, a Minnesota-based group of health care interpreter services leaders who meet to share best practices and work towards common goals related to quality improvement, education, and affordability of language access services.
• Regions Hospital interpreters were involved in a significant number of activities that benefit our patients, members and community. In 2018, these activities included:
  o Training 7 interpreting student interns from Century College and St. Catherine University and providing unique observation hours to an additional four students in an advanced simultaneous interpreting course
  o Participating in numerous community benefit activities, including:
    ▪ Reviewing translated Hmong stroke education materials for cultural and linguistic accuracy
    ▪ Reviewing and editing translations of children’s books used in our Reach Out and Read program.
    ▪ Presenting at two health career fairs for high school students.
• Our partnership with Washington Magnet School invites a diverse group of students in for experiential learning about health careers. Students interact with our staff and with medical equipment in our simulation center.
• As a supporting member of Health Occupations Students of America (HOSA), we help promote health care careers to high school students providing leadership on their board of directors, hosting student tours, and participating in numerous student experiences and competitions each year.
• We serve as a member of The CCAP Workforce Development Group. The group focuses on building a work force that is more representative of local neighborhoods, which can lead to better health care and student achievement outcomes.
  o We continued with our 5 nurses from Regions participating in the Nursing Initiative which supports the advancing of their career by pursuing a baccalaureate in nursing.
  o C3 Fellows, an outcome of the CCAP Workforce Development Groups, helps place students who are currently enrolled in health care programs into jobs within the health care industry while they are in school. Goals/impacts of this program include student’s economic advancement, increased academic success and employability. We support this program through assisting student with mock interviews, resume writing, tours and informational sessions and interview opportunities.
• We partnered with AVIVO (previously RESOURCE), a nonprofit organization that helps all job seekers achieve their goals through its specialized job-skills training and employment services for candidates, to provide their job seekers with an overview of entry-level corporate and clinic positions. We also presented on resume building, provided interview tips and walked through our online application process.
• We partnered with the Karen Organization of Minnesota (KOM), a nonprofit organization supporting the Karen and Burmese refugees with tools and resources to help them settle, integrate and become self-sufficient. In addition, KOM provides education and employment classes and opportunities. We partner by helping their community understand our job postings and walk them through our online application process.
• Starting in 2011 and continuing through 2018, HealthPartners and Regions Hospital have participated in a corporate work study program through Cristo Rey Jesuit High School (part of the nationwide Cristo Rey Network that provide a quality, Catholic, college preparatory education to young people who live in urban communities with limited educational options). This program provides students with real world work experience. Each year, both HealthPartners and Regions Hospital employ a team of 4 to 5 students to work throughout the school year. Cristo Rey has a 100% college acceptance rate.
In 2018 our new enhanced tuition assistance program was piloted with 5 participants. This program exists through a partnership with Eastside Financial Center to increase economic growth and jobs for residents of St. Paul’s eastside community. This program will be offered again in 2019 and expanded to allow for up to 10 participants.

St. Paul Schools CTE Committee: Regions Hospital’s Food & Nutrition Services department has representation on this committee which is a technical careers advisory team for nine St. Paul public schools. As a partner, Regions will be hosting three separate groups of 30 students each to provide engaging and interactive experiences that help promote careers in health and nutrition services.

In 2018 Regions piloted a new UAP to RN Apprenticeship Program which offers on-the-job training and development to employees working in PCA or ERT roles who are pursuing an RN degree. This pilot is designed to support the employee’s education and success in school by offering additional training, support, and hands-on experience to apply what they are learning. Apprentices gain skill, confidence and enhance their classroom learning through hands on, practical application.

In 2018, we participated in the Hennepin Workforce Leadership Council Meeting engaging with the work related to health careers pathways.

We participate in MN Community Measurement (MNCM), a collaborative to improve health by publicly reporting health care information. The 2018 MNCM Health Care Disparities Report includes 10 publicly reported measures.

Collection and Use of Data on Race, Ethnicity and Language Preferences

HealthPartners systematically collects data on race/ethnicity, language and country of origin directly from patients and members in a variety of ways, all of them voluntary. These data collection sources include healthpartners.com, telephone contacts with HealthPartners Case Management department, online through our health assessment, the electronic medical record in our care delivery system and in our dental group. We’ve found that collecting this information face-to-face from patients at the point of care or health plan contact is an effective data collection method. Across our care delivery system, we have collected race and language information for over 90% of our patients.

We use these data to monitor the quality of care delivered and patient experience by race/ethnicity and language. We also use the data to identify strategies to reduce health disparities in treatment, outcomes and service.

We include race/ethnicity data on the member registries we make available to network providers, so they can identify and address disparities among their patients.

Where data are voluntarily available on provider race/ethnicity, language and/or country of origin, we use those data as a resource to respond to patient requests.

Language Assistance

We provide interpreter services in all key languages spoken by patients and have access to over 200 languages through telephone and the use of video remote interpretation. We consistently provide high quality face-to-face (including dedicated staff in high-volume locations), telephone and video remote interpreter services to our patients in their preferred language for health care.
• 100% of employed interpreters at HealthPartners have a minimum of 40 hours of professional training and 66% hold some national certification.

• Updated annually, our Language Assistance Plan sets organizational best practices and expectations, and is accompanied by the practical Your Guide to Interpreter Services. Your Guide provides answers to questions such as how to access an interpreter and how to talk with patients who wish to rely on family members to interpret. Training is conducted on these tools to support continued improvement in health and experience outcomes. Most recently, it has been updated to reflect the video remote technology we use for interpretation services, the federal government guidance on notification to members and patients on their right to language services (ACA 1557), and state (Minnesota Department of Human Services) guidance on health plan language assistance plans.

• Our biennial interpreter satisfaction survey allows staff and providers to give feedback on all interpreter types (agency, staff, telephonic, video). The results of these surveys are reviewed and acted upon to support improvement. Meetings are held quarterly with all contracted interpreter agencies to review satisfaction surveys and performance, and to continue agency engagement and outcomes that support the Triple Aim.

• Vocera units have been activated and dual handset phones deployed at admission at our largest hospital to support improved access to and use of telephonic language services. Several clinic sites also made improvements to their infrastructure and workflow to offer improved telephonic language services, and video remote services are available widely throughout our hospitals and clinics.

• Interpreter awareness education continues to be offered in multiple new employee settings as a regular part of the agenda, including provider NEO at HealthPartners, HSC NEW, Regions NEO, and New Resident Orientation. HealthPartners member services, sales, case management and other representatives also are trained in how to use telephonic interpreter services. HealthPartners and Park Nicollet also sponsor several interpreter continuing education workshops each year for both employed and contracted interpreters. In 2018, workshops were offered on (1) notetaking for health care interpreters; (2) cardiovascular disorders, diagnostic tests and treatment; (3) OB/Gyn topics, including race and pregnancy, the role of nurse midwives, hysterectomies, and prenatal testing for congenital anomalies; and 4) sexual assault nursing exams for American Sign Language interpreters.

• HealthPartners interpreters are involved in a significant number of activities that benefit our patients, members and community. In 2018, these activities included:
  o Providing internship opportunities for interpreting students from Century College (spoken language) and St. Catherine University (American Sign Language).
  o Participating in community benefit and organizational development activities, including:
    ▪ Providing cultural and linguistic expertise in program or research design
    ▪ Presenting at career fairs
    ▪ Providing cultural education to health care providers.
    ▪ Reviewing translated stroke education materials to ensure cultural and linguistic appropriateness

• A total of 26 staff interpreters trained in simultaneous interpreting began providing services in seven languages for mental health group therapy sessions in early 2017. Services were aimed at improving limited English proficient (LEP) patient access to the full array of available inpatient therapies, with an ultimate goal of reducing excess inpatient days for LEP patients. This new program contributed to a 4-day improvement in length of stay for LEP patients from program inception through end of 2018.
• Through our partnership with Healthwise, more than 3,600 Patient Instructions are now available in Epic in English and Spanish. These instructions can be added to the After Visit Summary/Discharge Instructions and printed for patients.

Member Materials & Communications

• Member materials are created using a consumer-friendly checklist to ensure that communications are understandable, conversational and consistent.

• Benefit summaries are available in Spanish, Hmong and Somali, or other languages as needed, upon request.

• Promotional materials reflect the demographics that exist in the population, making photos racially, ethnically and age diverse.

• Many custom communications developed for employer groups have been translated to better serve our Spanish-speaking members.

• Open enrollment materials for commercial products are available in Spanish and English.

• We maintain a Spanish-language microsite (healthpartners.com/espanol) to better serve our Spanish-speaking members.

• HealthPartners Minnesota Health Care Programs language blocks: We use a language block template our organization developed in compliance with Section 1557 of the Patient Protection and Affordable Care Act (ACA). This document includes a revised language block that adds additional languages, updates the discrimination language, includes information on where discrimination complaints can be filed, and provides information on free language assistance and auxiliary aids and services. The language block is used on all Minnesota Health Care Programs member materials and communications when model requires it.

• The Minnesota Health Care Programs materials are translated upon request, including the Medicaid/MSHO/SNBC welcome sheet and welcome letter.

• The MSHO Sales Cover Letter is translated upon request.

• The Affordable Care Act Section 1557 Non-Discrimination Notice and Taglines are provided to all members.

Building an Effective Workforce to Support Equitable Care and Service

• We continue to focus on diversity and cross-cultural care through leadership and staff training on equitable care issues. Our Diversity & Inclusion team helps our organization achieve its full potential by ensuring that every person who touches our organization feels welcomed, included and valued. We do this by aligning our people, practices, and policies with our commitment to diversity and inclusion. We do this by: 1) Fostering a culture of inclusion, 2) helping build a diverse workforce with equitable access to career opportunities, and 3) position ourselves as leaders in the community advancing diversity, equity and inclusion.

• HealthPartners has collaborated with community members and organizations to improve the experience of patients, members, and colleagues who identify as LGBTQ in our clinics, hospitals, and workplace. That work began in 2016, and as a continuation of this work, in 2018 we developed and
launched two trainings: A foundational training on LGBTQ awareness (designed for all staff) and a clinician training that focuses on care of transgender patients (for primary care and other clinicians).

- HealthPartners’ employees can experience bias from patients and members. A comprehensive set of materials, including a leader toolkit, video, and eLearning module, serve as resources to assist leaders in working with their teams to identify ways to support one another and create a plan for addressing instances of patient and member bias when it occurs. Examples include comments in favor of or against a staff member based on identity (e.g. race, ethnicity, religion, age, gender, language, LGBTQ identification).

- HealthPartners has two Business Engagement Networks (Cross Cultural Leadership Network, and the Lesbians, Gay, Bi-Sexual, Transgender, Queer & Questioning Network) to help us serve the diverse and individual needs of patients, members and customers, as well as strengthen respect and inclusion in our workplace. These groups are involved in influencing and executing organization priorities, creating and participating in development opportunities, and/or community outreach efforts. In 2018, we provided a Business Engagement Network learning cohort training session that included focused learning on diversity & inclusion leadership topics.

- HealthPartners hosted the 4th annual It’s Time to Talk event for employees. With the support of trained facilitators, It’s Time to Talk participants were led through a session that inspired authentic conversations about tough topics. The open dialogue helped participants understand themselves – and each other – better, as well as identify ways to connect with and better meet the needs of patients and members and create an inclusive environment. More than 120 employees participated in dialogue around this year’s topic on disability. Past events have focused on language and accent, poverty, and transgender and gender identity.

- We have extensive internal communications to build staff understanding and capabilities in cultural humility. The bimonthly “Culture Roots” newsletter continues to be an organization-wide educational tool. Culture Roots’ subscription base again grew by 5% this year as more HealthPartners employees became aware of Culture Roots through internal, organization-wide communications; health equity-related trainings; and other activities. The Culture Roots subscriber list is currently at 702. Topics for 2018 included patient bias, weight bias, disparities in palliative care, interpreting versus translating, Medicare enrollment changes (health literacy) and managing family members’ requests to be interpreters (tips and strategies).

- The HealthPartners Equitable Care Champions program continued in 2018. The champions are staff members and providers who receive expert training so they can become advocates and serve as local resources for their colleagues in caring for patients from diverse cultures and those with limited English proficiency.
  - Nearly 150 Champions participated in 2018—including 34 new members.
  - In 2018, the program launched an online orientation for new Equitable Care Champions. All 34 of our new Champions completed this orientation.
  - In addition to producing Culture Roots, the Equitable Care Champions team distributed several e-blasts and announcements to help increase Champions’ awareness of and participation of various health-equity-related events and activities.
  - In 2018, in response to feedback generated through our November 2017 survey, the Equitable Care Champions program launched quarterly WebExes presentations to help Champions stay...
updated on health equity activities, programs and initiatives happening across our system. The WebExes were well-attended and generated positive feedback.

- The 2018 Equitable Care Champions annual event was held on May 1 on the HealthPartners campus. At this event, the Champions sponsored a presentation on caring for transgender patients and members. The speaker, John Parker-Der Boghossian, Equity and Inclusion Education Manager at JustUs Health (formerly Rainbow Health Initiative), discussed:
  - The need for people working in health care to have a basic understanding of transgender identities
  - How to use personal gender pronouns correctly and why it’s important
  - How health disparities affect transgender populations
  - How to practice cultural humility when caring for and serving the transgender community

- We continue to expand our Equitable Care and Service intranet site with cross-cultural resources for providers and staff.

**Assessment of Effectiveness**

We routinely review and analyze race and ethnicity data to identify, test and implement strategies to reduce disparities in treatment outcomes and service. We have found that developing consistent workflows that help caregivers identify and offer needed services to all patients—and then customizing those services based on cultural, linguistic, socioeconomic or other differences—helps reduce health disparities. Our approach is to continually improve our performance. Following are examples of disparities-reduction initiatives that we continued to refine and improve in 2018.

**Mammography Screening Improvement**

In 2007, we identified disparities in mammography screening rates between patients of color and white patients and between government programs patients and other patients. Since then, we have conducted many interventions to continually improve our performance. Interventions included culturally humble scripting on preventive services, same-day mammograms, and telephone outreach to patients of color and government program populations of women ages 50 to 75 who were not up-to-date on a mammogram. We implement focused interventions with consultant support at clinics with the greatest opportunities.

In 2010, we began piloting use of short videos we produced in Spanish and Somali about the importance of screening for breast cancer, cervical cancer and colorectal cancer. Women who visited the clinic for any reason who were not up-to-date on mammography screening were offered the opportunity to view a 3- to 5-minute video about the importance of mammography screening. They viewed the video in the exam room before the provider entered. By having the women view the video first, the provider could then answer questions about mammography, reinforce messages in the video and offer assistance in arranging the screening. Patient feedback was positive.

In 2017, we focused on sharing best practices and alignment across our expanding care group, which now includes HealthPartners Medical Group, HealthPartners Central MN Clinic, Stillwater Medical Group,
Park Nicollet, Amery, and Westfields. Together we provide care to over 100,000 women ages 52 to 74 years, including 12,000 women of color. We implemented a new Breast Cancer Screening Outreach Registry beginning in Q2 2017, providing telephone reminders to over 6,112 women overdue for screening. Of these, 18% of all patients and 17% of patients of color completed mammogram within 2 months of receiving an outreach call. We also spread same-day and walk-in mammogram availability across our care group, providing 8,102 same-day/walk-in appointments to women ages 50 to 74 years who were overdue for screening.

In 2018, we continue to work together across the family of care focusing on Breast Cancer Screening. We have 26 locations with on-site mammography, with 62% offering 3D technology. The mobile Mammo-a-go-go truck travels to 10 Park Nicollet sites. Work has continued on enhancing the Breast Cancer Outreach Registry to include a batch letter sending process. We have outreached to over 18,000 women in 2018, through the registry with a completion of a mammogram within 2 months of receiving outreach of 15.6%. Patients of color had a completed rate of 12.7%. We captured 8000 patients with a same day or walk in mammogram appointment.

We continue to learn about how we can best reach our patients and get them in for the screening tests they need. The goals for mammography screening rates are to increase rates for all women and to decrease the disparity in rates between patients of color and white patients (as well as between government program patients and other-insured patients).

**Barrier Analysis**

Member/patient barriers include: cultural perceptions about health and medical care, role of the individual in health and decision making, socioeconomic factors, language, access to care, lack of understanding of the health care system, and limited health literacy. According to HealthPartners’ myVoice Survey in Jan 2018, concerns for pain, cost, and no family history of breast cancer are the top reasons women might be behind on their screening.

Staff and provider barriers include: not understanding cultural beliefs and approaches of patients and members, comfort with using interpreters and translated information, sufficiency of translated information in needed languages, and time to spend on increasing knowledge and using equitable care resources. HealthPartners’ myVoice survey results were shared with our Adult Preventive Services Expert Panel in Feb 2018. The Expert Panel was surprised to learn that concern for pain was a top reason why women may be behind on screening.

Organization and system barriers include: the many competing priorities that are part of a changing health care system, keeping up with best practices, and keeping care and service affordable.
Opportunities for Improvement: Results/Outcomes

Breast Cancer Screening by Race

Interventions

- Same day access
- Customized messages based on consumer insights data
- Community outreach

Colorectal Cancer Screening Improvement

Our goal is to increase colorectal cancer screening rates in patients to at least 80 percent, while also bringing race and payer rates into alignment with the overall population. In order to achieve this goal, we have developed a care model process that allows us to easily and effectively initiate the process, while also taking into account disparities in colorectal screenings and making proactive strides to reduce this gap.

Interventions include:

- Increasing visibility and stressing the importance of colorectal screenings in patients. A health maintenance modifier is added to a patient’s record once he or she reaches the age in which they should begin regular screenings. For Native Americans and African Americans, who experience a 48 percent higher rate of colorectal cancer deaths than Caucasians, this is added once the patient reaches age of 45. For other patients who are considered average risk, this is added at age 50.
- While completing pre-visit planning nursing staff are prompted to click a box indicating patients are due for a colorectal cancer screening.
During the rooming process, our staff use pre-approved scripting to inquire as to whether or not the patient has had screenings, and to offer education on the importance of colorectal screenings as well as how the process works.

Other tactics we utilize to increase awareness and education for patients include distributing blue wristbands and posters to all of our clinics in March for Colon Cancer Awareness Month; social media postings and advertising on our waiting room monitors; letter reminders sent to patients that are due for screenings; and by developing education materials in six different languages to reach a broader patient base.

While these systems have proven effective, we have an expert panel of senior leaders, doctors and researchers that meets twice a year to review evidence and set goals related to colorectal cancer screening. Additionally, we have a multi-disciplinary team that meets on a monthly basis to review data and discuss strategies, in order to continue our progress without stagnating.

Barrier Analysis

Often there are misconceptions about the screening process, and we work to make patients feel comfortable. We demonstrate at-home screening kits, known as FIT (fecal immunochemical test) kits, provide in-room educational materials, and answer questions about colonoscopy and FIT screening options. When the patient agrees to the services, our staff orders the screening. If they do not agree to the screening, the clinician will re-affirm the importance of colorectal screenings. If the FIT test is the screening method chosen, and a patient completes the test, the patient will be automatically mailed a follow up kit in a year. In addition, a letter will be sent to the patient after the kit has been mailed, if they have not returned the kit within 2 weeks.

As a result of the efforts mentioned, colorectal screening percentage for patients of color at HealthPartners Medical Group has gone from 43% in 2009, to 68.1% percent in December 2018. This data speaks to the fact that our systems are making an impact on improving the number of screenings.

Opportunities for Improvement–Results/Outcomes

Colorectal Cancer Screening by Race

![Graph](image)

Interventions

- Decision supports in the electronic record
- Shared decision making (FIT/colonoscopy)
- Addressing clinician unconscious bias (FIT/colonoscopy)
- Patient outreach

*Black and Native American patients start screening at age 45, age 50 for all other races

2018 Quality Improvement Annual Evaluation 164
2018 FIT Project: Overall Results

2018 FIT Project: Patients of Color
2018 FIT Project: Patients with Medicaid

Immunization Disparities Improvement

The primary functions of the Immunization Disparities Workgroup are to (1) increase and maintain vaccination completion rates of childhood immunizations and adolescent immunizations, and (2) reduce disparities in our vaccination completion rates across all Families of Care including the HP Health Plan, which include HPMG/HPCMC, Park Nicollet and the Valley/Western Wisconsin.

Interventions for reducing disparities with immunizations include:

- Coordination of existing work across the organization that is focused on improving vaccination rates.
  - Use of dynamic Smartsets for immunizations in well-child, pre-visit planning, and immunization-specific Smartsets—all of which guide and order the required vaccinations based off of the Health Maintenance Alert (HMA) in the patient’s chart.
  - Continued education around standard rooming and review of HMAs that are due at the visit—and then offering these overdue vaccines at all office visits, rather than just at the Well Child or Preventive visit.
  - Sibling clinics—Looking for opportunities to pair clinic sites with similar location and demographics across the organization. The idea is to share and compile information from the sites on best practices, what is working well, and what has not worked well, and how they can partner to improve rates. From this work, we will create a best-practices checklist for sites to use as a guide and auditing tool.
  - In-depth quality reviews of sites and clinicians who are low performers – identify gaps and assumptions; celebrate progress.
• Immunization and Well Child Registries—These new registries will identify all patients under the age of 18 who are overdue for a well child visit or overdue for vaccines. This registry will allow us to efficiently target outreach to patient/family via letter, MyChart messaging (based off of age and access), and potentially phone calls. These new registries will also allow us to potentially filter by language and by payor if appropriate. Several Park Nicollet and HPMG sites currently have access to a draft copy of a well child and HPV second-dose registries. We have seen improvement in our volumes. Park Nicollet Pediatrics volumes increased by 10% in 2018 and sites that are using the HPV second dose registry have seen improvement in their completion rates. The tentative timeline for build and rollout of these registries across HealthPartners family of care would be no earlier than July 2019.

• HPV Maintenance of Certification program – This is a yearlong endeavor with The American Cancer Society, focusing on the HPV VAC’s (Vaccinate Adolescents Against Cancer) program. The goal is to increase HPV vaccination rates and eliminate missed vaccination opportunities through quality improvement and improved clinical processes. It combines evidence-based interventions with proven tools and the latest research to maximize the project outcomes. This work also included a live WebEx series on HPV by Dr. Garrett Jones from Park Nicollet Brookdale Clinic.

• Expanded offering of vaccines in different care settings. For example, Primary Care and Urgent Care will be partnering together to improve vaccination rates. It is known that not all children stay on track with their well child visits but do come in to Urgent Care or the clinic for acute visits. This is a great time to offer those vaccines that the patient is behind on. Urgent Care already offers flu vaccines if patients are due for them and are willing to trial offering the second HPV dose to complete the series at Urgent Care visits. We also continue to investigate opportunities to vaccinate with our school-based clinics and specialty sites as well.

• We continue to Partner with the plan around ways to improve outcomes and coordinate efforts when we can.

**Barrier Analysis**

Member and patient barriers may include:

- Cultural perceptions or misconceptions around vaccines. There can be cultural differences that make it more challenging to complete the course of certain vaccines, such as MMR and HPV.

- Anti-vaccine movements exist in pockets. In these cases, families are choosing not to vaccinate their children at all.

Staff and provider barriers include:

- Standard rooming is not standard within families of care or across the organization. Consequently, standard rooming audits have revealed that HMAs are not always being reviewed and/or offered at the appropriate times.

- Variation can occur in the way providers or staff introduce vaccines to the patient and the family, allowing the family to think certain vaccines are considered “optional.” (For instance, some clinicians may simply be omitting the non-school required vaccines in the discussion.)
Clinician and staff opinions on vaccines may influence which ones are offered and not offered.

Organization barriers include:
  - Lack of current immunization and well-child registries across the organization. We need a standard way to identify these populations and efficiently outreach to them.

**Opportunities for Improvement—Results/Outcomes**

As a result of the interventions and analyses mentioned above, we saw improvement in our Pediatric Combo 10 by Payor disparity gap. We decreased the gap between commercial and government pay by 2.35% in 2018. Our overall screening rates for Adolescent Combo 2 went up for every family of care in 2018, and as an organization we saw a 3.85% increase for 2018.

**2018 Immunization Rates: By Payor**

<table>
<thead>
<tr>
<th>All Families of Care</th>
<th>Jan-18</th>
<th>Dec-18</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Patients</td>
<td>56.57%</td>
<td>58.69%</td>
<td>2.12%</td>
</tr>
<tr>
<td>Commercial Payors</td>
<td>70.96%</td>
<td>71.68%</td>
<td>0.72%</td>
</tr>
<tr>
<td>Government Payors</td>
<td>38.29%</td>
<td>41.36%</td>
<td>3.07%</td>
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</table>

**2018 Immunization Rates: By Race**

<table>
<thead>
<tr>
<th>All Families of Care</th>
<th>Jan-18</th>
<th>Dec-18</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Patients</td>
<td>56.57%</td>
<td>58.69%</td>
<td>2.12%</td>
</tr>
<tr>
<td>Patients of Color</td>
<td>46.46%</td>
<td>49.02%</td>
<td>2.56%</td>
</tr>
<tr>
<td>White Patients</td>
<td>65.28%</td>
<td>68.42%</td>
<td>3.14%</td>
</tr>
</tbody>
</table>

**Reducing Disparities in Inpatient Mental Health Length of Stay**

Each year, Regions cares for more than 3500 inpatients who speak language other than English. Every month, an average of 11 or 12 of these patients receive care in Regions’ mental health units.

Regions Hospital noticed a difference in average length of stay (LOS) between patients with limited English proficiency (LEP) and patients whose preferred language is English in the mental health unit. In late 2016, the average length of mental health unit inpatient stay for patients with limited English proficiency was 17.5 days—compared with 9.9 in English-speaking patients.
Barrier Analysis

Group therapy is one of the most effective treatments for depression and other mental illnesses. Group therapy can help because it allows people to hear stories of recovery from others who have gone through something similar. It encourages members of the group to think about how they feel and can make symptoms easier to manage. Being in a supportive group helps members understand their illness and find acceptance.

Group therapy has traditionally been out of reach for patients who do not speak English. Medical interpreters are often only trained in consecutive interpreting. With consecutive interpreting, there are many pauses while interpretation takes place. It works well when a patient is talking with a single caregiver. But it can be disruptive in a group therapy session.

Intervention:
Regions Hospital partnered with a local interpreter training program to train 26 staff interpreters who interpret for seven different languages in simultaneous interpreting. With this method, interpreters use a microphone and interpret what they are hearing at the same time they are hearing it. Patients listen to the interpretation through earphones that are hooked up to the interpreter’s mic. This technology allows for others in the group therapy session not to hear the interpretation, allowing participants to keep up the flow of communication without any slowdown. In March of 2017 these interpreters began offering simultaneous services using specialized equipment to provide better access to group therapy sessions for patients with LEP while creating minimum disruption for other group participants.

Opportunities for Improvement—Results/Outcomes

Since the inception of simultaneous interpreting, the hospital has seen a 4-day reduction in average length of stay for patients with LEP and significantly reduced a persistent disparity. Most important, all patients now have an opportunity to share their story and find support.

Average Length of Stay by Language—Regions Hospital Mental Health
Reducing Disparities in Antidepressant Medication Management

Upon initial diagnosis of depression and starting an antidepressant, a patient may see results in a few weeks, but most people need to remain on the medication for at least 6 months to ensure adequate response to symptoms. The Antidepressant Medication Management (AMM) HEDIS measure, continuation phase, looks at the percentage of members who remained on an antidepressant for at least 180 days (6 months).

This section describes HealthPartners activities related to a DHS Performance Improvement Project (PIP) to reduce disparity related to this measure.

**Barriers**

Understanding a new diagnosis and the recommended treatment options can be difficult for any condition, but an initial diagnosis of depression can be overwhelming. In addition, many racial and ethnic disparities exist in the diagnosis and management of depression for people of color. Factors such as a lack of culturally competent care contribute to this disparity by deterring ethnic and racial minority groups from seeking adequate care. Failure to recognize how culture impacts the experience of depression can also lead to inaccurate diagnoses, inappropriate treatment, and non-adherence to treatment (Sanchez et al., 2012).

This project aims to reduce the racial disparity among Medicaid members and increase the rate of MSHO members who remain compliant with their antidepressant medication for 6 months. We also hope to impact barriers in member and provider knowledge and understanding of disease and pharmacotherapy treatment complexity of depression.

**Measurement**

The source of measurement for this project will be the HEDIS measure, Antidepressant Medication Management (AMM) – Effective Continuation Phase Treatment: The percentage of members 18 years of age and older with a diagnosis of major depression and were treated with antidepressant medication, and who remained on an antidepressant medication for at least 180 days (6 months).

While this is a three year project, the timing of the members entering the numerator and denominator means that HEDIS 2017 results are the first results that reflect a full year of interventions. A complete picture of the impact of the PIP’s interventions will not be available until 2019 or beyond, as 2019 HEDIS rates will reflect dates of service in 2017 and 2018. HealthPartners tracks our progress on key HEDIS measures monthly and this measure is included in this monitoring.

The timeline of the HEDIS Anti-depressant Medication Measure further illustrates the complexity of the measurement periods in relation to the timeframe that member interventions will have an impact on those members in the denominator.
**Initiatives/Interventions**

The interventions for this project are a combination of outreach to HealthPartners members by our Behavioral Health area and collaborative activities for providers and others working with diverse populations on issues related to mental health and depression, including adherence.

The interventions implemented as part of this project include a variety of approaches to this issue, as research indicates that multi-faceted projects are the most successful. HealthPartners implemented interventions focused on the member, on the provider community (both our HealthPartners family of providers, as well as contracted providers available to HealthPartners membership) and the community at large. Key to these interventions is a common element of recognition of the diversity of the population. Where appropriate, HealthPartners collaborated with the other PMAP health plans (the Collaborative) to bring resources and education to the provider community to diminish duplicative messaging to providers, and to increase buy-in.

**Member Interventions**

HealthPartners committed significant analytics resources to enhance our ability to match race data to members. Beginning in mid-2016, we were fully able to focus our efforts on those members who fall into the PIP/QIP target group for this measure.

- **First Fill Outreach**—HealthPartners calls all Medicaid and MSHO members when they start a new antidepressant medication. The goal of these calls is to supplement the provider’s instructions and enhance understanding of the importance of the medication. Upon notification that a member has newly started an antidepressant medication, an independently licensed Behavioral Health professional from the HealthPartners Behavioral Health team contacts the member to educate them about the medication. Part of this conversation includes education about how long it can take to see benefits of taking the antidepressant medication and that it is recommended to continue an antidepressant medication for at least six months to see the maximum benefits.

  During the call, the member is given an opportunity to discuss any questions or barriers they may have regarding medication adherence including barriers such as side effects or difficulty remembering to take their medication. The goal is to help remove any barriers and answer any questions or concerns that might be identified.

  Staff are trained regarding disparities and cultural considerations around antidepressant medication adherence. To enhance the cultural responsiveness of the calls, we utilized multiple data sources to improve our ability to correctly identify the race of the member to help us direct the calls to the most culturally appropriate staff. For example, African American staff typically call African American members and Asian staff call Asian members. Anecdotally, this has helped build the connection between behavioral health staff and members. Additionally, members are more likely to accept the call and the information provided.

  As the Behavioral Health staff conduct calls, they respond to the concerns or barriers to compliance that the members may share by making appropriate referrals to social services,
primary care providers, medication therapy management (MTM) resources or other needed services. On occasion, the needs are so complex that the member may be transferred into Behavioral Health Case Management so more time can be allocated to their care coordination.

- Refill reminders—HealthPartners Behavioral Health Program uses a refill reminder program for our Medicaid and MSHO population. We mail members a reminder letter when their medication is due to be filled. If the prescription is not filled, we send the member a more specific letter and call the member. Additionally, we send the prescriber a letter to alert them that their patient has not refilled their medication.

**Provider Interventions**

The health plan Collaborative engaged the provider community in a variety of ways to educate about the importance of culturally and age-sensitive depression care and provide resources and strategies for providers to use. In addition to the collaborative activities, HealthPartners offered educational opportunities to our staff to enhance their cultural and age understanding of member issues.

- Behavioral Health staff attended the following webinars that were organized by Stratis Health and the health plans working on this project:
  - Providing Mental Health Services to Latinos
  - Depression in Older Adults
  - Gray Matters-Depression in Older Adults
  - Gray Matters-Anxiety in Older Adults
  - Trauma in Communities of Color

- Several Behavioral Health staff attended a two day conference called Healing in Community: Shifting the Burden of Dismantling Systemic Racism by Kente Circle. HealthPartners Behavioral Health Department was a sponsor of this event.

**HealthPartners PSearch Tool**

For mental health referrals, it may be important to our members that they see a practitioner of the same culture or gender to provide an enhanced level of comfort and trust.

HealthPartners created a new function in our internal provider locator tool, called PSearch, which allows staff to search for a HealthPartners mental health provider that matches a patient’s preferred ethnicity, gender or language. There are 19 different languages to choose from including American Sign Language. This tool is updated on a quarterly basis to add new providers who support diverse populations and to accurately reflect our provider network.

**HealthPartners Clinic Partnerships**

As part of this project, HealthPartners behavioral health leaders continue to work with our clinic groups to streamline both health plan and clinic processes and improve communication to create the best outcome for the member. Through this partnership, HealthPartners behavioral health staff participates on the Depression Expert Panel combining behavioral health expertise at the plan with primary care
providers. An example of how this collaboration has improved processes and communications includes allowing the behavioral health staff to complete a needed PHQ9 and document the results in the medical record for the primary care provider. Anecdotally, care system leaders report this support from behavioral health staff to the clinic teams is extremely positive and valued.

**Collaborative Provider Interventions**

During 2017 the Collaborative updated resources developed in the first two years of the project and continued to offer webinars for providers who work with culturally diverse patients experiencing depression. The resources address best practices for depression care, with an emphasis on the importance of delivering such care in a culturally appropriate way.

- **Provider Toolkit**—The Collaborative developed *Antidepressant Medication Management: A Provider Toolkit* in the first year of this project. The toolkit (available on the Stratis Health website for this project) provides relevant resources and tools for providers working with culturally diverse Medicaid patients who have depression. The toolkit focuses on issues related to medication adherence with an emphasis on racial and cultural perspectives. Annually, the collaborative reviews toolkit materials, updates links and adds new resources such as tools for seniors and patients in rural areas.

  The Collaborative promotes the toolkit through multiple channels. To assist with promotion, the Collaborative utilizes a postcard with a Quick Response Code. Feedback on the toolkit has been positive and analysis of the web hits suggests that promotion of the toolkit through provider communications, newsletter articles, social media, webinars and conferences has driven interest.

- **Webinars**—The Collaborative continues to offer highly successful webinars which address various areas associated with culturally sensitive depression care. Those attending the webinars represented a variety of disciplines including Care Coordination, Behavioral Health Clinicians, Nurses, Public Health, Social Workers and Social Services providers and others. In 2017 the collaborative offered six webinars on a range of topics related to depression in our focus populations.

- **Newsletters**—The Collaborative also used newsletter articles to share information with providers.
  - Each health plan published a provider newsletter story discussing the availability of translated prescription medication information at select pharmacies. Providers rarely use this resource and the Collaborative believes enhancing provider knowledge may support compliance among patients whose preferred language is not English.
  - Each health plan involved in the Collaborative published an article in its provider newsletter informing their network about the availability of the updated toolkit.

- **Community Outreach & Partnerships**—The Collaborative initiated a partnership with two Catholic churches, St. Alphonsus in Brooklyn Center, and Ascension in Minneapolis, to plan a Latino Family Health Fair. The event raised awareness, reduced stigma and provided
education on mental illness to their majority Latino congregations. The health fair featured a Spanish-language Make it Ok presentation. Delta Dental, Hennepin County Child & Teen Checkups, Portico Healthnet, and American Cancer Society also provided health information and promotional giveaways. Additionally, the American Cancer Society offered mobile mammography and Minnesota Visiting Nurses Association provided flu shots.

Most health plans sponsored the NAMI Walk in 2018. The event is a 5K walk to increase public awareness of mental illnesses, fight stigma, and raise funds for NAMI Minnesota.

**Barrier Analysis**

Due to the timing of HEDIS measurement, the primary outcome measure did not reflect any impact of the PIP’s interventions until HEDIS 2016. A full year of PIP interventions was reflected beginning with HEDIS 2017. As indicated, the full impact of PIP interventions will be reflected in HEDIS rates in 2019. This timing has made it difficult to be nimble with interventions and make adjustments during the course of the project.

- We have learned much during our outreach to persons of color about their feelings and beliefs around taking antidepressants. In general, African-Americans have several concerns with taking medications. These concerns can be barriers to medication adherence. Some of the most common concerns expressed by our members include:
  
  o Medications are viewed as a form of ‘mind control’. Education on depression and the chemical imbalance in the brain can help decrease this concern.
  o Patients do not like to be told what to do. Frequently when medications are prescribed for depression it does not feel like a shared decision. Members feel they are not given other options to care for their depression. By taking the time to explain options and how the medications can help them, members feel more empowered in their own care.
  o There is a lot of well-founded distrust of the healthcare community. African-American members tend to have more respect for what ‘elders’ say, especially someone from their own community. Because the staff member making phone calls is from this community she understands the concerns and fears and is able to help the member make decisions based on facts rather than pressure from others.

- In general, all members report several reasons for not refilling their prescription on time or at all. When members experience unexpected or severe side effects, they may decide to stop the medication. Others feel their medications did not work, or their symptoms improved so they feel the medication is not needed. Others report they did not understand the importance of continuing to take the medication, which could be the result of lack of education by the prescriber. Behavioral Health staff identifies and addresses any adherence barriers in partnership with the member during the call and provide additional resources to meet the member’s unique needs. In some cases, the need for support and resources can be so complex that the member is enrolled in ongoing Behavioral Health Case Management.
• When side effects are a barrier to continuing medication adherence, members can be referred to our Medication Therapy Management (MTM) program for consultation and an MTM pharmacist will work with the member’s provider to resolve the situation.

• Our ability to contact members is limited by the demographic information that we have. We do not always have the most updated phone number and address. As a health care system, we work closely with our clinics to enhance the contact information we receive on members from the state but this continues to be a barrier to successful outreach.

• The timing of the specifications described in the measurement section shows how the HEDIS measure itself is a barrier to seeing improvement in the rate. The total length of the measurement period covers 18 months. That means that by the time the data is run, some of it is actually two years old. This makes it very challenging to determine which intervention made a difference. There are also eight months (May – Dec.) where two different cohorts are receiving the same process improvement efforts. This makes it very challenging to see year over year increases in medication adherence.

• HealthPartners is striving to reduce the disparity that exists on this measure between our white members and non-white members. However the information we receive from DHS does not include race data for approximately 15 percent of Medicaid members. We feel there is an opportunity to verify race/ethnicity data to more accurately meet the cultural needs of our members and increase our success in decreasing the disparity gap. We have done extensive work on this internally and continue to improve the accuracy of our data.

**Opportunities for Improvement: Results/Outcomes**

Although the timing of this measure makes it difficult to see results in a timely way, we can see over the course of the PIP project that significant progress was made to reduce the disparity in antidepressant medication compliance between whites and non-whites. The goal of the project was to reduce the disparity by a 20% relative improvement rate (3.72% absolute decrease) and we exceeded this goal and decreased the disparity by 5.92% over the course of the project.

**AMM PIP: Continuation Rates by Race**

<table>
<thead>
<tr>
<th></th>
<th>2015 HEDIS</th>
<th>2016 HEDIS</th>
<th>2017 HEDIS</th>
<th>2018 HEDIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>43.36%</td>
<td>44.82%</td>
<td>43.46%</td>
<td>41.62%</td>
</tr>
<tr>
<td>Non-white</td>
<td>24.65%</td>
<td>24.19%</td>
<td>24.49%</td>
<td>28.83%</td>
</tr>
<tr>
<td>Medicaid Total</td>
<td>35.68%</td>
<td>37.14%</td>
<td>36.86%</td>
<td>37.48%</td>
</tr>
<tr>
<td>Disparity</td>
<td>18.71%</td>
<td>20.63%</td>
<td>18.97%</td>
<td>12.79%</td>
</tr>
</tbody>
</table>
While this is a three year project, the timing of the members entering the numerator and denominator means that HEDIS 2018 results are the first results that reflect a full year of interventions. A complete picture of the impact of the PIP’s interventions will not be available until 2020 or beyond.
Service Initiatives

Description

HealthPartners deploys multiple initiatives designed to improve member satisfaction with the plan and deliver an exceptional experience that customers want and deserve at an affordable cost. Every year a subset of the Service Quality Council uses identified key drivers to develop the Annual Plan.

Goal

The HealthPartners 2018 Experience Annual Plan focused on the following experience objectives:

- Coverage
- Cost
- Help
- Value

The overall objective of member service initiatives is to increase member engagement and satisfaction with the plan. We identify the key drivers, monitor and evaluate our success through survey results (JD Power, CAHPS, and the semi-annual Member Experience survey) and various member feedback methods (complaint reports, employer and patient council feedback and online panel results).

Initiatives/Interventions

Coverage:

- Developed a personalized message prioritization and coordination system and process to better target key communications to members.
- Created and implemented a new health care engagement platform to allow for a personalized, integrated and seamless experience for members, patients, families and participants when receiving services from our care management team.
- Increased onboarding email messaging.
- Designed a new member experience for narrow network products.
- Built and implemented an in-network request process to ensure members have access to medically necessary care at the in-network benefit level.
- Developed a new process to address member experience issues in real-time and commission system interventions as needed.
- Made CDHP bank information available on web and mobile replaced the manual process for receiving direct deposit information with an online form.
- Developed and implemented strategies to improve the process/experience for Medicare and Medicaid open enrollment by proactively communicating with members/potential members, improved/expanded the Medicare public website, enhanced digital campaigns and making
outbound calls. Created an integrated call experience between care group and health plan for seamless services.

- Expanded more web and mobile features that include easier to use services, more comprehensive decision support tools, easier proxy process and improved employer support tools.
  - A few examples include: easier online account creation; redesigned doctor bio pages and improvements to the find care tool; enhanced plan for me comparison tool.

Cost:

- New member/patient EPIC cost transparency pilots completed and plans are being created for expansion to other clinic systems and establishing protocols to manage the process.
- Implemented a digital and paperless experience for State Public Programs members with 17% of members adopting in the first year.
- Trained CareLine staff to better assist members and direct them to on-line tools to help them understand cost prior to care.
- Expanded the capabilities of the Rx shopping tool to provide more drug cost transparency.

Help:

- Enhanced care management for transplants from beginning to end with member decision support.
- Identified and implemented an effective tool to support CareLine RN’s with understanding scope of service for urgent care locations and optimal referrals.
- Incorporated the Patient Activation Measure into the health assessment to improve member participation.
- Significantly enhanced coordination and shared resource tools across all member touchpoints to better support members in need of gender services.
- Redesigned several member submitted forms for better ease of use and created functionality to submit electronically.

Value:

- Continued to implement medication optimization initiatives to support high-risk and high cost members to improve clinical outcomes and adherence results.
- Made more health information available and easy to access via a mobile device.

Barrier Analysis

Our causal analysis of barriers to improving member satisfaction and the experience continues to remain relatively the same from one year to the next. Key barriers in 2018 include:
1. Consumer sentiment about value heavily influences perceptions of experience, particularly health plan ratings. Among the top drivers is feeling that my plan is a good value. A modest 60% of members give a Top 3 rating (% 8, 9, 10). Increased premiums and out-of-pocket costs are a significant barrier to member satisfaction.

2. High deductible plans and new narrow network plans continue to be popular with employers purchasing insurance for their groups and also members who purchase insurance individually. In the case of narrow network plans, members need to adjust to obtaining care from a much smaller network. Providers are also confused, which compounds the challenge.

3. The majority of our Medicare Cost members needed to shop for and select a new plan for 2019. These members had a lot of questions about their options and how their new plan would work.

4. Addresses of State Public Program enrollees are often inaccurate and important health plan information is returned by the postal service, creating a significant barrier to communicating with these enrollees.

**Results and Outcomes**

We believe the results show that the initiatives and interventions that we implemented in 2018 were generally effective in achieving our service goals. According to results from CAHPS surveys, our Member Experience survey and the J.D. Power and Associates member survey, our service quality improved in the following areas:

- The Plan Rating for commercial members improved by one percentage point from 2017, although the increase was not statistically significant. The rating falls in the 50th percentile nationally, while other Minnesota commercial plans place in the 33rd and 25th percentiles.

- In the most recent J.D. Power member survey, HealthPartners is the highest-scoring Minnesota commercial plan by a substantial amount. We have an especially strong performance in Coverage and Benefits, Claims Processing and (out-of-pocket) Costs. We have a lot of value in using these results as a complement to CAHPS results and other feedback sources in our efforts to improve member satisfaction.

- The Specialist Rating increased noticeably over the previous year and its placement in the 75th percentile is well above other Minnesota commercial plans.

- While our Customer Service result exceeds both the national average and all Minnesota plans, it is noteworthy that the score declined from the previous year in both the CAHPS and J.D. Power surveys. According to the J.D. Power survey, lower member ratings of promptness in speaking with a rep are key to the overall decline. This finding is corroborated by longer hold times in Member Services operational metrics.

- Our lowest result, based on percentile rankings, is Coordination of Care. Our result of 77.9% is in the 10th percentile. This rating is based on a single survey question asking how well one’s doctor seemed informed about care received from other doctors. Our care group has a plan to improve their scores, which will positively impact the plan’s result.

- Our score for Plan Information on Costs held steady but improved to the 50th percentile when compared nationally. Making meaningful cost information accessible to members at the times
they need it is our top priority in our Experience work plan. In 2019, our efforts are focused on two initiatives.

- CMS named HealthPartners a 4.5-star plan for both Cost and Dual Special Needs Plan (MSHO). In addition, our Medicare plan received 5 stars in CAHPS. For MSHO, our CAHPS results earned 4.5 Stars overall (5 or 4 stars in 7 of 8 measures and 3 Stars in Getting Prescription Drugs).

- The Medicare Cost plan declined one Star on Rating of Drug Plan, an anticipated shift given changes in generic drug costs made in 2017. On the other hand, three measures in MSHO gained a Star (Rating of Health Care, Getting Care Quickly and Getting Needed Care) due to initiatives such as Your Best Care Option and an incentive payout for specialists achieving scheduling goals of 14 days or less.

- CAHPS results for State Public Programs remain at the state average for most CAHPS measures. Scores for Families & Children (F&C)-MA, MNCare and SNBC are consistent with the Minnesota averages for most CAHPS measures. Families & Children scores higher than the MN Average in Rating of Health Care, MNCare scores higher in Customer Service and SNBC scores higher in Getting Care Quickly. All scores are significantly higher than their respective MN Averages. As part of Your Best Care Option, Member Services and CareLine staff have been working to help members more effectively access the care they need (i.e., virtuwell, convenience clinics, urgent care and ERs). Additionally, both the website and mobile app have been strengthened in this area as well. MSC+ scores lower than the MN Average in Getting Care Quickly, mostly due to a decline in access to specialists.

- CMS named HealthPartners a 4.5-star plan for both Cost and Dual Special Needs Plan (MSHO). In addition, our Medicare plan received 5 stars in all CAHPS measures. For MSHO, our CAHPS results earned 5 or 4 stars in 7 of the 8 measures, Getting needed care remains an area of focus.

- The Medicare Cost plan made significant gains in Rating of Prescription Drug Plan. In both Freedom and MSHO, we improved the Rating of the Prescription Drug Plan from 4 Stars to 5 Stars. We added Pharmacy Navigator staff to assist members; improved communications to both members and providers about preferred alternative medicines, and grandfathered more members who are stable on existing prescriptions.

- CAHPS results for State Public Programs remain at the state average for most CAHPS measures. Scores for Families & Children (F&C)-MA and MNCare are consistent with the Minnesota averages for all CAHPS measures, with Families & Children rating higher in Rating of Health Care, Plan Rating and Customer Service. Member Services and CareLine staff has been working to help members better understand their options for accessing care (i.e., virtuwell, convenience clinics, urgent care and ERs) and the mobile app has been strengthened in this area as well. SNBC has a lower Rating of Personal Doctor and Doctor Communication and F&C has a lower rating in Shared Decision Making than the state average. We want to be more active in providers discussing with the patient any reasons not to take a medicine (e.g., interactions, alternative treatments).

- Results from our Member Experience survey reinforce that perceptions of value have a strong influence on the Plan Rating—or overall member experience. This includes members’ opinions about whether their plan offers a good value and keeps their health care costs reasonable. We are continuing to work on increasing perceptions of plan value by offering practical information and
strengthening cost information for members. Value also is related to Plan Information on Costs, from the CAHPS survey.

- MSHO supplemental benefits are provided free of charge to members to support good health and safety outside of their standard benefit set. In 2018 we were able to expand the set of supplement benefits to include:
  - Activity tracker to track steps and calculate calories burned
  - Pedaler to strengthen and tone leg and arm muscles and increase joint range of motion
  - Blood pressure monitor and first aid kit
  - Falls prevention kit—includes medicine box, non-slip bath mat and tape for stairs, as well as educational materials on preventing falls/staying safe in the home
  - Smoking cessation - hypnotherapy to support members to quit smoking
  - Health education classes—tools & guidance from professionals for better eating, activity and thinking.
Complaints, Grievances and Appeals

Description

Member Services works with members to answer their inquiries and resolve their complaints, grievances and appeals. All member contacts are documented in our customer service system. From here, reports are created for the organization to identify opportunities and make improvements.

Individual departments receive system-generated reports with complaint detail pertaining to their areas on a daily, weekly, monthly and quarterly basis. The data is reviewed for trends, follow-up and service recovery opportunities. Year-end report summaries with trends and analysis are presented to the Health Plan Service Quality Council and the Experience Council. The data is used by these groups in the development of their annual plans. The following data is used to create specific member experience improvement initiatives and analysis. Results here are also used with other information in creation of the Service Initiatives report.

Results and Outcomes

Commercial Complaint and Appeal Results

<table>
<thead>
<tr>
<th></th>
<th>Calls Answered</th>
<th>per 1,000</th>
<th>Verbal Complaints</th>
<th>per 1,000</th>
<th>1st Level Appeals*</th>
<th>per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>1,091,938</td>
<td>1,284</td>
<td>57,146</td>
<td>67.2</td>
<td>3,837</td>
<td>4.51</td>
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<tr>
<td>2017</td>
<td>1,295,245</td>
<td>1,498</td>
<td>58,577</td>
<td>67.8</td>
<td>3,854</td>
<td>4.46</td>
</tr>
<tr>
<td>2018</td>
<td>1,281,738</td>
<td>1,439</td>
<td>60,808</td>
<td>68.3</td>
<td>3,985</td>
<td>4.48</td>
</tr>
</tbody>
</table>

*Includes DRT: Appeals. Written Complaints & Inquires, Reconsideration & Withdrawn Requests

Trends and Analysis of Commercial Complaint and Appeal Data

- Calls answered were down while the Commercial member complaint and appeals received per thousand increased very slightly over 2017. However, due to appeal reconsiderations and withdrawals, the actual number of appeals reviewed decreased significantly.
- The percent of first level appeals that become second level appeals is increasing from 7% in 2016 to 11.5% in 2018.
- Non-clinical appeals dropped significantly in 2018, especially for benefits, network, plan limitations/exclusions and membership.
- While the volume of clinical appeals was down, their percent of total appeals (over non-clinical) increased significantly.
- The overall number of pharmacy appeals was reduced due to a new enhanced reconsideration process for pharmacy issues implemented in August 2018. Denied prior authorizations are...
reviewed again if there is new information provided by the requesting physician. 62% of the reconsideration requests were approved. The ones denied moved on to the full appeal process.

- Pharmacy appeals account for 43% of all clinical appeals.
  - Biologics for auto-immune disorders are 25% of all pharmacy appeals. They are high cost with robust criteria for coverage.
  - Weight loss drug, Saxendra, is the second request by volume.
  - 52% of all expedited appeals are for clinical pharmacy.
  - 19% of all pharmacy appeals are expedited.

- Individual members have the highest per 1,000 appeal rate but their percent of overall appeals has dropped.

- Ongoing appeal trends:
  - Genetic testing and Pharmacogenetic testing appeals increased
  - More third party appeals
  - Misunderstanding of what is covered as preventive
  - More pressure from members: high expectations, not accepting the answer, calling repeatedly
  - Enrollment appeals: individual plans termed for non-payment; members struggling to pay premiums.
  - Cost of Care. Pre-service estimates are difficult, especially facility claims.
  - Quality of care. Members expect more (time spent, definitive dx, best outcomes) based on cost of their care.

- New appeal trends:
  - Luxury facility denials for BH care
  - Non-contracted surgery center appeals
  - More U & C disputes from OON providers

- Verbal complaint trends are similar to the above appeals trends with the addition of:
  - CDHP: FSA Substantiation Issues continue. Members frustrated that we don’t link up claims from their medical plan to any debit card transactions. Denial letters are vague and don’t give a reason why the charge is ineligible or what specifically is missing.
    Overpayments: It is inconvenient to mail cash/check, they would prefer to do it over the phone or online.
  - Claims; 901 Insurance letters and claims being denied continues to be a high volume of calls. Needing a lot of OI information. Members don’t like having to get exact retirement date, disability date, etc.
  - Dental: Confusion from members on claims for members with the embedded pediatric benefit under medical and also a comprehensive dental plan.
  - Premiums/Affordability: Members complain that they have high premiums and still have high DD as well so it’s perceived as little or no coverage. Affordability of prescriptions: Prescription drug coverage- Affordability on high DD plans. Members can’t afford the high cost medications they need to take on a regular basis.
Non-Clinical Appeals (N=1,537) No Medical Decision Required

Clinical Appeals (N=1,672) Medical Judgment Required

2018 Quality Improvement Annual Evaluation 184
Medicare and Medicaid Complaint and Appeal Results

<table>
<thead>
<tr>
<th></th>
<th>Calls Answered</th>
<th>Oral Complaints</th>
<th>1st Level Appeal and Written Grievances</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>per 1,000</td>
<td>per 1,000</td>
<td>per 1,000</td>
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<tr>
<td>2016</td>
<td>296,868</td>
<td>4100</td>
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<tr>
<td></td>
<td></td>
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<td>7.7</td>
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<tr>
<td>2017</td>
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<td>7095</td>
<td>1481</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7.2</td>
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<tr>
<td>2018</td>
<td>409,891</td>
<td>11207</td>
<td>2004</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8.7</td>
</tr>
</tbody>
</table>

Increase in call volume:

- Call volume increased from 2017 to 2018 due to Medicare Cost plan transition. Robust communication from local news outlets, health plans, and CMS (Centers for Medicare and Medicaid Services) for ~360,000 Medicare Cost members across the state of Minnesota started in summer 2018 and continued through year end. HealthPartners had a well-planned communications strategy which prompted members to take action and ask questions in 2018 when they still had time to make health plan changes for January 2019. This thoughtful preparation reduced potential member confusion and phone calls in early 2019.

Trends in 2018 Medicare oral complaints:

- Total grievances increased from 2017 to 2018 in four main categories: Membership, Customer Service, Pharmacy Benefits, and Quality of Care. (Two of these broke into the top six categories for 2018: Membership and Quality of Care.)
- Increases in the Membership complaint category resulted from legislation requiring the Medicare Cost Product (including HealthPartners Freedom plans) to close in select Minnesota counties effective January 1, 2019. 63,115 HealthPartners Medicare plan members were affected by this Medicare Cost plan transition. Trends include:
  - Member anxiety/dissatisfaction regarding their Cost plan being termed.
  - Member concern about status of enrollment applications they submitted, and coordination between brokers, health plans and CMS. Members wanted faster processing of applications.
  - Timeliness concerns from members who expected to receive materials sooner than they did.
- Customer Service (health plan) complaint categories increased in 2018. Market disruption due to Medicare Cost Transition resulted in significant increased staffing needs. Training and onboarding new member service representatives is a lengthy process; full maturity and effectiveness in position is not reached until representatives reach one year of experience.
- Pharmacy Benefit complaints increased from 936 in 2017, to 1360 in 2018.
  - Most pharmacy benefit complaints were rooted in dissatisfaction about member cost for drugs. Beginning January 1, 2018 our Medicare individual plan formulary changed to a cost-driven tier system. This resulted in some members seeing a change in out of pocket drug costs.
  - Dissatisfaction regarding Part D vaccines: Shingrix (shingles vaccine) was in high demand through the year and is a two injection series. Two injections result in members...
experiencing the Part D vaccine process and member cost-sharing twice. Later in 2018, there was also a known shortage of Shingrix.

- Quality of Care grievances increased in 2018. Highest rates of dissatisfaction regarding Quality were in the “Technical Competence” category. Technical Competence concerns include member perception of inappropriate/ineffective care, misdiagnosis, or harm to patient.
  - An increase of 97 Quality complaints for Medicare members was spread throughout 2018, but rates were highest in 2nd quarter for Medicare Cost members and in 4th quarter for Medicare Advantage members. Medicare Advantage membership growth during 3rd and 4th quarters contributed to the trend. New member experience with the plan and value network correlate with higher rates of Quality complaints.

- Previous categories of Website and Durable Medical Equipment dropped out of the top six complaint categories in 2018.
  - Website complaints did gain slightly in 2018 (253), but were outpaced and replaced by Quality of Care complaints (415). Medicare members do tend to express dissatisfaction when website changes occur, but with the volume of changes and website traffic regarding Medicare Cost Transition, the minimal increase of 16 complaints between 2017 and 2018 is notable.
  - Durable Medical Equipment complaints fell by 23 in 2018 due to more stable coverage criteria compared to our Medicare alignment work in 2017.

**Trends in 2018 Medicaid oral complaints:**

- Total complaints increased from 2017 to 2018 in three primary categories: Customer Service, Pharmacy Benefits and Quality of Care. Network Customer Service complaints decreased significantly from 2017 to 2018.
- More than half of Pharmacy benefit complaints were regarding the prior authorization process. This was driven by new guidelines and authorization requirements for opioid medications, and changes to the formulary. There was also dissatisfaction due to member disruption when CVS Pharmacy was removed from the retail pharmacy network in early 2018.
- Quality of Care grievances increased in 2018. Highest rates of dissatisfaction regarding Quality were in the “Technical Competence” category. Technical Competence concerns include member perception of inappropriate/ineffective care, misdiagnosis, or harm to patient.
  - An increase of 80 Quality complaints for Medicaid members was spread through 2018. Although Special Needs Basic Care (SNBC) plan membership is a small percentage of our Medicaid population, SNBC members consistently file higher rates of quality complaints per 1000 members than other HealthPartners Medicaid groups. SNBC members typically use more healthcare services than other Medicaid members which correlates with higher rates of Quality complaints due to increased interaction with healthcare providers.
- Network Customer Service complaints decreased in 2018 as a result of the stable HealthPartners Medicaid membership with HealthPartners plan providers.
- The previous category of Ridecare dropped out of the top six complaint categories in 2018. Ridecare complaints did gain slightly from 81 in 2017, to 104 in 2018. Ridecare member experience improvements likely slowed the growth rate of complaints in this category.
Top Medicare Oral Complaints by Category

Top Medicaid Oral Complaints by Category
Trends for Medicare and Medicaid Appeals (Appeal definition is any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive).

- With the increase in membership the overall number of appeals has increased. In the last few years there has been a noticeable increase in the number of pharmacy appeals for both Medicare and Medicaid. On the Medicare side, the increase can be attributed in part to the fact that Pharmacy Administration (PA) cannot look at a request more than one time. Under CMS regulations, if PA receives new information – they have to forward the request to appeals, as a redetermination, even if the information would change the outcome of the request. This requirement is different than all other products and adds complexity and time for members to receive decisions. It also increases the number of appeals.
  
  o In 2018 there were 828 pharmacy appeals. 735 of these were requests for drugs, 93 were for medical injectables. The requests for drug coverage were approved 57% of the time. In most cases we received additional information that the member now meets criteria.
    ▪ 30% of the requests for drugs were expedited.

  o Trends
    ▪ In Q1 we had an increase in the number of requests for tiering exceptions due to changes in the benefit;
    ▪ Changes in the Medicaid coverage for opioids: New criteria allowed for prescribers to only allow a 7 day fill;
    ▪ Formulary changes to popular drugs for both Medicaid and Medicare;
    ▪ Member Services received additional training to help them to better identify and forward coverage determination requests to Pharmacy Administration;

  o In 2018 appeals for injections in a doctor’s office was moved from Medical Coverage category to the Pharmacy category to better align with the department handling the reviews. The number of injections increased from 59 in 2017 to 93 in 2018. The most commonly appealed injections are botox, prolia, and remicade.
    ▪ 22% of the requests for injectable appeals were expedited.

- Appeal requests of denied medical coverage requests has increased as well. The two largest categories are back procedures (B2) and requests for DME items (74). In the DME category, the most common request is for wheelchairs- both manual and electric. In most cases for medical coverage requests, when the outcome is approved it is because we received additional information that the member now meets criteria for the service.

- Dental also had an increase in the number of appeals. Appeals for dental are primarily for orthodontic requests for public program members; 48% of dental appeals were for coverage of orthodontia services. The public programs guidance for coverage of orthodontia services is based on medical necessity and strict criteria. Consequently a large number of requests are denied and subsequently appealed. Upon appeal we upheld the original decision 73% of the time. We also had 38 appeals for prosthetics. In most cases the member is asking for an exception to the frequency limit or their condition is changed.

- Appeals for office visits has also increased in 2018. These appeals include services the member received during an office visit which have not been covered under their benefits, cost sharing appeals and appeals for services that were as a result of a billing issue with the provider.

- Another trend in 2018 was the continued increase in the number of expedited appeals. In fact, from 2017 to 2018, the number of expedited appeals increased by 55% (expedited appeals must be resolved within 72 hours).
Trends for Medicare and Medicaid Written Grievances (Grievance Definition - Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken).

- There was a slight increase in Pharmacy grievances. Most of these are related to member cost sharing concerns or general dissatisfaction with their benefit in general.
- Membership grievances increased slightly as well due to members upset about changes to the Cost product and having to change plans.

Top Medicare and Medicaid Appeals by Category

![Bar chart showing trends for Medicare and Medicaid appeals by category]

Top Medicare and Medicaid Written Grievances by Category

![Bar chart showing trends for Medicare and Medicaid written grievances by category]
Monitoring the Utilization Management Program

Processes and Staffing

HealthPartners Utilization Management Program activities and initiatives encompass medical, pharmacy, and behavioral health services. Components fall within five major categories:

1. Improving systems of care (e.g., networks and approaches to delivery of care)
2. Providing decision-making support
3. Supporting utilization management at a member-specific or population-specific level
4. Performance measurement and analysis
5. Specific initiatives that are designed, developed, and implemented to improve performance results

Licensed nurses, behavioral health professionals, and registered pharmacists work under the supervision of board-certified physicians for all non-medically necessary case decisions. Associate Medical Directors make denials of coverage for which coverage policy criteria is not met. They consult with external specialty physicians as appropriate. The Medical Directors, Associate Medical Directors, the Senior Directors of Behavioral Health, Disease and Case Management, Pharmacy, and Quality Utilization Improvement are collaboratively responsible for the development of new programs, initiatives, and the ongoing oversight of the day-to-day operations.

We continuously update decision-making criteria with evidence-based information regarding current best medical practices, (e.g., practice guidelines, technology assessments) and cost-benefit considerations. When appropriate, recommendations are made to modify contract language regarding benefit coverage determinations. Staff review and update coverage policy criteria used for the prior authorization programs annually and The Medical Policy, Pharmacy, and Behavioral Health staff and Medical Directors Committee are responsible for the coverage policy criteria development and implementation process. Newly developed or revised criteria are also reviewed by network primary care physicians and/or specialists to ensure criteria input regarding community standards of practice. The coverage policy criteria serve as the criteria for authorization decision for HealthPartners Prior Authorization List. State and federal regulatory requirements, criteria and coverage guidelines for CMS and DHS managed care programs are incorporated into the development of HealthPartners Medical Coverage Criteria. Please see Appendix 3 for decision trend data.

Inter-rater Reliability Testing

We conduct inter-rater reliability evaluations annually for all Utilization Management review staff to ensure consistent application of coverage criteria and benefits. In 2018, we surveyed:
### Staff type | Number of hypothetical cases
---|---
Non-physician medical reviewer (34) | 10
Physician reviewer (7) | 4 medical
| 10 pharmacy
Behavioral health reviewer (13) | 4
Pharmacy reviewer (25) | 10

<table>
<thead>
<tr>
<th>Area</th>
<th>Survey response rate</th>
<th>Consistency rate</th>
<th>Follow-up Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>100% (34/34)</td>
<td>83%</td>
<td>Reviewed cases that had any variance in responses during team meetings to support staff alignment.</td>
</tr>
<tr>
<td>Behavioral health</td>
<td>100% (13/13)</td>
<td>100%</td>
<td>None</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>94% (30/32)</td>
<td>*2 pharmacists write the questions and are not included in the testing</td>
<td>86%</td>
</tr>
</tbody>
</table>

### Satisfaction with the Utilization Management Process

Annually, HealthPartners collects and evaluates data on member and provider experience with Utilization Management (UM) processes and takes action when appropriate. Monitoring metrics include the annual Provider Satisfaction Survey, HEDIS/CAHPS 5.0H survey results, and member complaint and appeal data.

### 2018 Goals

- Sustain a “Strongly Agree”, “Agree”, or “Neither Agree nor Disagree” response rate of 80% or greater for the following provider survey measures:
  - Coverage decision letter was stated in easily understandable language
  - Decision letter gave directions for contacting our medical reviewer to discuss decision
- Sustain a “Strongly Agree”, “Agree”, or “Neither Agree nor Disagree” response rate of 65% or greater for ease of use of online criteria by evaluating options to deliver easy to use online criteria
- Continue to monitor and institute actions to improve timeliness of access to medical reviewers
• Continue to evaluate, update, and develop coverage criteria policies (including a dedicated focus on genetic testing requests) with input from providers and evidence based medicine to support safe and effective care for our patients and members.

• Continue to monitor, evaluate, and institute appropriate actions to address member and practitioner experience with the UM process, as needed.

Assessment of Effectiveness

Provider Experience with the UM process

We mailed the Provider Survey in April 2018 to 740 providers and their office managers who had requested prior authorizations in the past 15-month period. The number of completed surveys was 62, for an adjusted 9% response rate. Trended performance demonstrates consistent performance against goals for provider satisfaction with the UM process in all but 1 of the 6 measures.

Progress Towards Goals

HealthPartners updated the survey questions in 2017 to be more meaningful and easier to respond to, making 2018 the first year for trends.

Quantitative Analysis

<table>
<thead>
<tr>
<th>Pharmacy Prior Authorization Process: (% Strongly agree + Agree + Neither agree nor disagree)</th>
<th>2017</th>
<th>2018</th>
<th>Goal Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>I or my staff are able to find prior authorization criteria online</td>
<td>51%</td>
<td>47%</td>
<td>Not Met</td>
</tr>
<tr>
<td>Coverage decision letter was stated in easily understandable language</td>
<td>76%</td>
<td>76%</td>
<td>Not Met</td>
</tr>
<tr>
<td>Coverage decision letter gave directions for how to access a medical director or clinical pharmacist</td>
<td>75%</td>
<td>77%</td>
<td>Not Met</td>
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</table>

<table>
<thead>
<tr>
<th>Medical Prior Authorization Process: (% Strongly agree + Agree + Neither agree nor disagree)</th>
<th>2017</th>
<th>2018</th>
<th>Goal Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>I or my staff are able to find prior authorization criteria online</td>
<td>65%</td>
<td>45%</td>
<td>Not Met</td>
</tr>
<tr>
<td>Coverage decision letter was stated in easily understandable language</td>
<td>76%</td>
<td>79%</td>
<td>Not Met</td>
</tr>
<tr>
<td>Coverage decision letter gave directions for how to access a medical director</td>
<td>74%</td>
<td>73%</td>
<td>Not Met</td>
</tr>
</tbody>
</table>

\(\downarrow\) = 2018 score is lower than 2017 score at a statistically significant level (p≤0.05)
Qualitative Analysis

- All letters faxed to practitioners, facilities, or vendors already include information on how to contact a medical director. Practitioners are also able to call Member Services if they have questions or need assistance with contacting a medical director
- Medical Policy has been working to improve use of plain language to ensure content is easily understandable for the member and balance that with clinical validity for the practitioner

Member Experience with the UM process

HealthPartners conducts an annual assessment of member satisfaction to support continuous improvement in member experience with utilization review activities across medical, behavioral health and pharmacy programs. Member experience measures used are those suggested by NCQA.

HealthPartners Market Insights and Medical Policy Departments compared key questions from the CAHPS and MA-PD CAPHs surveys. Morpace, Inc. statistically analyzed the CAHPS 2018 survey, which was administered between February and May 2018. Health Care Financing Administration conducted the MA-PD CAPHs 2018 survey, which was administered between March and June 2018. In 2018, Minnesota DHS conducted the Medicaid CAHPS survey between June and August. These results are compared to the state’s benchmark for each enrollee type. Arrows indicate a statistically significant difference compared to the 2018 National Standard or the 2018 MN State Average. Arrows (↑ and ↓) indicate statistical significance in scores compared to 2018 HealthPartners.

Commercial Products: 2018 UM Member Satisfaction Results
Administered by HealthPartners

<table>
<thead>
<tr>
<th>Questions that measure UM satisfaction levels for:</th>
<th>Group Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HealthPartners</td>
</tr>
<tr>
<td>How often get appointment to see a specialist as soon as needed? (CAHPS 5.0)</td>
<td></td>
</tr>
<tr>
<td>(Q25)</td>
<td>87%</td>
</tr>
<tr>
<td>How often get needed care, tests or treatments. (CAHPS 5.0)</td>
<td>94%↑</td>
</tr>
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</table>

Medicare Products (Cost & Risk): 2018 UM Member Satisfaction Results
Administered by HealthPartners

<table>
<thead>
<tr>
<th>Questions that measure UM satisfaction levels for:</th>
<th>Medicare Freedom® (Cost) Plan</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>HealthPartners</td>
</tr>
<tr>
<td>Easy to get appointment with specialist (CAHPS 5.0)</td>
<td></td>
</tr>
<tr>
<td>(Q35)</td>
<td>89%</td>
</tr>
<tr>
<td>How often get needed care, tests or treatments. (CAHPS 5.0)</td>
<td>94%</td>
</tr>
</tbody>
</table>

Medicaid: MNCare Adults and F&C: 2018 Utilization Management Member Satisfaction Results
Administered by Minnesota DHS

<table>
<thead>
<tr>
<th>Questions that measure UM satisfaction levels for:</th>
<th>MNCare Adults</th>
<th>Families &amp; Children (F&amp;C)-MA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HealthPartners</td>
<td>MN State Ave</td>
</tr>
</tbody>
</table>
Easy to get appointments with specialists. (CAHPS 5.0) | Q25 | 75% | 81% | 81% | 84% | Q25 | 76% | 83% | 77% | 82%
How often get needed care, tests or treatments. (CAHPS 5.0). | Q14 | 83% | 92% | 90% | 91% | Q14 | 88% | 92% | 91% | 89%

Medicaid: SNBC: 2018 Utilization Management Member Satisfaction Results
Administered by Minnesota DHS

| Questions that measure UM satisfaction levels for: | SNBC |  |
| --- | --- | --- | --- | --- |
|  | HealthPartners | MN State Ave |  |
| Easy to get appointments with specialists. (CAHPS 5.0) | Q25 | na | 79% | 81% | 82% |
| How often get needed care, tests or treatments. (CAHPS 5.0). | Q14 | na | 83% | 88% | 87% |

na = HealthPartners SNBC plan not eligible for measures.

Medicaid: MSHO and MSC+ 2018 Utilization Management: Member Satisfaction Results
MSHO Administered by CMS and MSC+ Administered by Minnesota DHS

| Questions that measure UM satisfaction levels for: | MNSHO | MN Senior Care Plus (MSC+) |  |
| --- | --- | --- | --- | --- |
|  | HealthPartners | Nat’l Ave | HealthPartners | MN State Ave |
| Easy to get appointments with specialists. (CAHPS 5.0) | Q25 | 92% | 85% | 92% | Q25 | 80% | 82% | 77% | 80% |
| How often get needed care, tests or treatments. (CAHPS 5.0). | Q14 | 99% | 91% | 94% | 91% | Q14 | 89% | 87% | 88% | 88% |

The first survey for both HP-UPH and WI Marketplace products was in 2018, but an insufficient number of responses made reporting ineligible for both. However, our Marketplace products are substantively similar in benefit design and administration to our commercial group products. Therefore we will use the commercial group product results to understand our performance for Marketplace products.

Product Trends for Ease of Getting Appointments/Required Care

- For Commercial group adult members, 2018 CAHPS results are consistent with the National Average for both utilization process management process measures. Getting needed care, tests or treatment is trending lower and is statistically significantly lower than HealthPartners 2016 score.
- For Medicare Freedom® (Cost) Plan members, rates for getting needed care, test or treatment is higher in 2018 than the National Average at a statistically significant level. HealthPartners score on this measure is higher than the National Average since 2013. The score for access to specialty appointments is slightly lower than the National Average but not at a statistically significant level.
- MSHO 2018 CAHPS results are higher than the National Average for getting care, tests and treatment at a statistically significant level. The score for specialty appointment access is slightly higher than the National Average. Scores for both measures are trending noticeably higher than last year.
- For Commercial group adult, Medicare Freedom® (Cost) Plan and MSHO members, no other significant trends were noted in the 2018 CAHPS Survey and no opportunities for improvement are identified in the results.
- 2018 Medicaid CAHPS Survey performance shows no statistically significant differences compared to the Average benchmarks. Scores for both MinnesotaCare (MNCare) measures are steady after last year’s significant gains. 2018’s specialty access score for Families and Children-Medical

2018 Quality Improvement Annual Evaluation 194
Assistance (F&C-MA) is trending slightly lower, while getting care, test and treatment is steady. Special Needs Basic Care (SNBC) trends higher in both measures over last year’s nascent measurement. Minnesota Senior Care Plus (MSC+) is trending slightly lower for specialty access but is steady for getting care, tests and treatment.

**Analysis**

**Access to Care**

There is little indication that HealthPartners members are experiencing specific plan-related barriers for getting care, although the erosion of commercial group members’ score warrants monitoring and is likely related to health care affordability rather than specific HealthPartners utilization policy changes.

**Specialty Access**

HealthPartners recognizes that specialty appointment demand in Minnesota is robust, and our own care groups and contracted clinics have taken steps to improve specialty scheduling and patient flow through continued development and enhancement of online scheduling systems.

**Referrals**

Referrals to specialists are not required for the majority of our products. HealthPartners’ comprehensive networks ensure that our members are able to receive the care they need within their designated network. On the few occasions when this is not possible, our utilization management and customer service teams work with the referring provider to find a specialty provider that meets the member’s specific health care needs.

**Focused Network Access Management**

The In Network Benefit Request policy addresses requests for reimbursement of out-of-network care at in-network benefit levels. To be considered for this level of reimbursement, a clinician with knowledge of the member’s current clinical condition and care needs will submit sufficient documentation for the plan to determine whether treatment for the member’s current condition is available within the member’s plan network.

**Appeals**

**Spine**
Sacroiliac joint injections, radiofrequency ablative (RFA) denervation procedures, and spinal fusions represent our largest categories of spine-related appeals. An average of 14 spine-related appeals were received per quarter in 2018. See Appendix 3 for a breakdown of spine-related appeals.

**Pharmacy**
There were 1,527 Pharmacy Appeals in 2018. Top medications are reviewed each quarter, and coverage issues are reported back to the Pharmacy Review Committee. See Appendix 4 for detailed breakdown of
pharmacy appeals. A large volume of pharmacy denials are overturned due to additional information. This has led to increased provider outreach for complete information with the initial request.

**Investigational Services**

See Appendix 4 for detailed breakdown of appeals for investigational services. Per analysis of data contained in Appendix 4, significant trends in appeals associated with investigational services are most likely due to a continued high volume of requests for genetic testing and medical devices. In addition to directly initiating appeals, developer/manufacturers are also providing standardized appeal templates to service providers and encouraging them to submit appeals on the behalf of the member. Additionally, coverage guidelines for Cologuard changed in April of 2017. Cologuard was a high volume appeal category; however, appeals for services received before that date tapered off and ceased entirely in 2018.

**Genetic Testing**

Given the rapidly expanding genetic testing market, growth in direct to consumer (DTC) marketing of genetic tests, and our organization's multiple efforts to ensure appropriate use, this has become a category of increasing appeals. This growth in genetic test appeals is consistent with the increase in genetic testing PA requests. HealthPartners continues to address this by developing coverage criteria policies that support safe, effective, and evidence based use of these tests. Increasingly, developer/manufacturers are aggressively pursuing direct to member marketing and are initiating a high volume of appeals on behalf of the member. For example, one of the specific genetic tests driving this is Genesight pharmacogenetic testing for behavioral health indications.

**Online Access to Criteria**

The low performance results specific to provider satisfaction with online access to criteria is likely due to the fact that the criteria are not available within the Electronic Medical Record but instead are available on our website, and providers may not know where to find it. We believe our movement to increased use of electronic PA which are drug specific will help improve this satisfaction.

For non-pharmaceutical PA, we have had an electronic PA submission process since 2012 that has only realized modest use by providers (approximately 17% of PA submissions.) Access to online non-pharmaceutical PA criteria is very intuitive and easy to use, so it may be that provider offices do not know where to access it.

**Barrier Analysis**

**Provider Survey Responses and Response Rate:**

The survey response rate fell 5 percentage points between 2017 and 2018 (from 14% to 9%). This may be due to physician time constraints and prioritization of patient care over administrative work. Office managers may complete the survey for several physicians. MMA lobbying focused on PA and the AMA physician survey may also contribute to a general lack of interest or motivation to provide feedback. If physicians have received other surveys, there may be a sense of survey fatigue.

2018 Quality Improvement Annual Evaluation  196
Public Perception:
It is likely that the legislative discussions and media coverage regarding proposed legislation specific to PA had an influence on several aspects of provider satisfaction, such as the access to online criteria and timeliness of decisions. As stated earlier in the analysis section, we have had electronic PA submissions capability for years by being HIPAA 278 transaction ready for many years based on federal requirements; however, we have had no provider trading partners interested in using functionality. We have also had our more intuitive web submission option since 2012, though with limited provider use (about 17% of PA submissions.)

Pharmaceutical electronic PA (ePA) solution has been available since January 2016 and is currently used for over 65% of requests. This has helped reduce the turnaround times and should result in improved satisfaction in the next few years as the systems become more sophisticated and faster.

New Technology Direct to Member Marketing:
As new technologies are striving to increase market share, we see an impact on member requests for specific services, increased expectations of coverage, and third party vendors appealing on the member’s behalf. We expect this will always be a dynamic within the healthcare market, especially as we strive to ensure evidence based coverage, as vendors are often marketing new technologies once they receive FDA approval, but before the quality evidence regarding effectiveness, safety, and effect on health outcomes is available.

Impact of Triple Aim strategies:
As we strive to improve health, experience and affordability, some of our initiatives can initially meet provider and member resistance as we are attempting to influence patterns of care and use of specific services. Effective utilization management spans the continuum of care and services, and we use it at selected leverage points to improve the safety, quality, value and/or utilization of care. It may involve either or both consumer and provider engagement support services.

Systems and processes for both operational and administrative functions are designed and continuously improved to support effective and appropriate care delivery and utilization management initiatives.

Resource limitations specific to timeliness of decisions:
All organizations are faced with recruitment and retention challenges. We have increasing rates of retirement and interest in part time positions, increasing competition between employers based on salary and benefits. This means we are more challenged with having sufficient resources to support increasing volumes of reviews. The increasing volumes are related to prior authorization program changes and additional complexity related to expansion to other regions and changes to other lines of business.
Spine Program:
HealthPartners Spine Program continues to evolve in order to leverage our capabilities to improve health, member experience and affordability. While it is evidence based and promotes safe and effective care, it continues to affect both member and provider satisfaction.

HealthPartners is committed to collaborating with our provider network to provide the right care at the right time and in the right setting for our members.

- HealthPartners continues to utilize the Medical Spine Consult Program which is designed to ensure access to appropriate specialists following a consult with a HealthPartners designated Medical Spine Center. Accessing the right healthcare provider at the right time ensures spine surgeons and neurosurgeons are only being seen when medically appropriate to the member’s specific condition. This process helps to eliminate inappropriate use of specialists which increases access for patients who are appropriately referred.

Identified Opportunities for Improvement/Actions

In 2018, HealthPartners continued and enhanced our strategies and initiatives to support and improve member and provider experience.

- **Support for Members and Providers:**
  In 2016, HealthPartners implemented New Technology Coverage Alerts for services not covered to ensure that member facing staff has the appropriate talking points to address member concerns. This service continues and was expanded in 2017 to our provider groups and on HP.com blog postings.

- **Ease of use of online criteria:**
  In order to assist our providers in determining if prior authorization is necessary for medical items and services and to improve access online criteria, we are building an application to help providers. Work will continue into 2019 and is targeted to be completed in 4th quarter 2019.

- **Electronic authorization function:**
  Utilization of the online prior authorization application for submission of medical PA continues to increase. This method ensures only minimally necessary information is collected to make a coverage decision and hopefully saves provider office time in collecting pertinent clinical information to submit a request.
• **Pharmacy E-Prior Authorization:**
HealthPartners continues to work with our vendors to support ePA. As of March 2019, we are receiving over 60% of prior authorization requests via ePA. EMR vendors are still making enhancements to their system functionality in order for providers to take advantage of this capability. We are also working to facilitate auto-adjudication of requests (i.e., eliminate manual intervention). Once in place, electronic submissions that meet defined criteria will be automatically processed, further reducing turnaround time. We are also rolling out Real Time Pharmacy Benefit Check, which provides more specific Formulary coverage information within the electronic medical record in 2019.

**2019 Goals**

- Sustain a “Strongly Agree”, “Agree”, or “Neither Agree nor Disagree” response rate of 75% or greater for decision letters being stated in easily understandable language
- Sustain a “Strongly Agree”, “Agree”, or “Neither Agree nor Disagree” response rate of 65% or greater for ease of use of online criteria by evaluating options to deliver easy to use online criteria
- Continue to evaluate, update, and develop coverage criteria policies with input from providers and evidence based medicine to support safe and effective care for our patients and members
- Continue to monitor, evaluate, and institute appropriate actions to address member and practitioner experience with the UM process, as needed
Affordability Initiatives

Description
HealthPartners Triple Aim affordability approach is built on a strong foundation of programs designed to reduce overuse and misuse of resources and to improve the value of services provided to our members. We systematically identify new opportunities and enhance our programs to capture cost savings. In 2018, we had 44 affordability strategies. Systematic focus on high-cost cases confirmed that the top cost drivers continue to be transplant, neonatal intensive care, oncology, and specialty pharmacy.

Goal
Each year we establish an affordability target that is based upon a projection of the upcoming year’s claims to reduce the expected Total Cost of Care (TCOC) by 1-2 percent. The 2018 one to two percent TCOC goal was $61 to 122 million. We identify and implement new affordability strategies and objectively calculate the value and return on investment (ROI) of HealthPartners medical management programs, services and networks.

Initiatives/Interventions
A major focus of our claims cost savings strategies is the Triple Aim approach:
- Affordability initiative identification
- ROI analysis

Affordability Initiative Identification Process
HealthPartners has developed a multi-disciplinary affordability council and trend management team to systematically identify short and long-term opportunities and implement strategies for claims cost savings. Each year, this team develops an annual plan that outlines new claims trend management focus areas. Concurrently, they continually identify and evaluate new opportunities. The team has implemented a “Phase Gate” approach, which incorporates SBARs (scope and situation, potential claims cost savings opportunity, and potential strategy options) to assure an efficient process to support execution of ideas to generate intended results. Initiatives are closely monitored, including ongoing barrier analysis. Initiative leads create an overall timeline for each phase through feasibility and monitor progress to the timeline.

Key Focus Areas
Improve health. Examples: new program development and expansion of our health and well-being efforts
- Developed health personalization platform which leverages data we have about each member to provide a personalized experience, surfacing the most relevant health and well-being activities and health plan resources to meet the individual member’s need

Engage members/patients. Example: enhanced engagement strategies for medical and behavioral health disease and case management programs
Developed and implemented a personalized navigation program focused on benefit navigation and maximization for our most complex, highest risk members using in-person interventions such as home visits and bedside visits.

Improve payment. Examples: re-contracting, fraud and abuse

- Expansion of our approach to leveraging proprietary Usual and Customary (U&C) fee schedules to manage out-of-network costs.

Increase appropriate use and efficiency. Examples: appropriate use of the Emergency Department, new technology support, medical policy

- Genetic testing is a continued focus across our enterprise to improve the overall experience and quality of care received by our members, through partnerships across our health plan and care delivery system. Genetic testing for neurological and developmental conditions was a focus area in 2018. Coverage policy language was expanded and clarified to ensure appropriate utilization of genetic testing for these conditions. Policy language was also standardized across all 10 policies to ensure efficient and consistent coverage determinations for genetic testing.

**Barrier Analysis**

The primary barrier is limited opportunities for identification of new ideas and/or new big ideas. Additional barriers include payment reform challenges, mandated benefit requirements and limited comparative effectiveness research of best evidence-based care to guide plan benefits, plan coverage and provider selection.

**Gaps in Care**

Health and Care Engagement has developed a systematic process for affordability ideation. Quarterly updates are provided based on competitor analysis, purchasers and consultants, contracted vendors, trend management, leader insights from conferences and CMS webinars. We also monitor, review and compile national best practices work to ensure a shared understanding of innovative work that is occurring across the country.

**Results/Outcomes**

We successfully identified and implemented new affordability strategies in 2018. We met the 2018 savings goal by realizing $61.9 million in saving last year. Examples of achieved results include the following:

- Complex and Inpatient Case Management services were successful in preventing inpatient admissions and reducing readmissions that resulted in reducing health care costs by $32.9 million.
- Behavioral Health Case Management services were likewise successful in preventing inpatient admissions and reducing readmissions that resulted in reducing health care costs by $10.7 million.
- Our disease management programs that focus on the core chronic diseases of diabetes, asthma, coronary artery disease, chronic obstructive pulmonary disease and heart failure reduced
costs by $13.0 million. Additionally, our cancer disease management program led to a savings of $1.8 million.

- Medication Therapy Management program resulted in a savings of $3.1 million.

Additionally, existing programs received a formal ROI evaluation and were determined to meet the expectations for the specific type of program.

Examples of current ROI’s:

<table>
<thead>
<tr>
<th>Program</th>
<th>ROI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Disease Management</td>
<td>3.0:1</td>
</tr>
<tr>
<td>Cancer</td>
<td>2.0:1</td>
</tr>
<tr>
<td>Behavioral Health Case Management</td>
<td>2.7:1</td>
</tr>
<tr>
<td>Complex Case Management</td>
<td>2.8:1</td>
</tr>
<tr>
<td>Medication Therapy Management</td>
<td>2.5:1</td>
</tr>
<tr>
<td>Inpatient Case Management</td>
<td>2.7:1</td>
</tr>
<tr>
<td>Behavioral Health Utilization Management</td>
<td>4.3:1</td>
</tr>
<tr>
<td>Medical PA Program</td>
<td>5.2:1</td>
</tr>
<tr>
<td>Rx Prior Authorization</td>
<td>15.1:1</td>
</tr>
</tbody>
</table>
Medical Coverage Policy Development

Description

Medical Coverage Policy develops written coverage criteria to provide consistent information, clinical criteria and interpretation of coverage. These criteria serve as the basis for authorization decisions of certain medical procedures, behavioral health services, pharmaceuticals, devices and other benefits, including items on the HealthPartners prior authorization list.

Goal

- Promote best care, affordability and experience while reducing overuse and misuse of health care services.
- Ensure members have equitable access to care that is safe, effective and has been proven to have a positive effect on health outcomes.
- Ensure coverage policies support integrity of coverage and authorization program decisions, including aligning with the most current reliable scientific evidence and consideration of scientific advances, expert opinion, or changes in current standards of medical practice.

Initiatives/Interventions

Implement strategies to support best care, affordability and experience:

- Routine monitoring of literature and horizon scanning is performed to identify new or updated evidence on key topics.
- The New Technology Committee assesses new technologies to determine if they are investigational/experimental and forwards their consensus recommendation to the Medical Director Committee or its policy development subgroup for coverage consideration and to applicable business units (e.g. Provider Relations and Network Management or prior authorization program) for strategy development.
- New or revised policies are approved by the Medical Director Committee and brought to the coding committee for implementation and alignment of claims edits. This includes incorporating analysis of new technology and new applications of existing technologies.
- Implementation of coverage policies in collaboration with medical directors, quality and utilization improvement, contracting, claims, member services, product and benefits with a specific focus on alignment with coding and claims payment.
- Focus on strategic topics such as spine, genetic testing/genetic therapies, transplants, gender dysphoria services, mental health parity, and investigational services.
- Annual or periodic review is performed on all commercial, Medicare and Medicaid policies.
Development of employer specific policies to support employer group variances as required with exploration of additional employer specific needs through cross functional collaborative project.

Barrier Analysis

- Rapidly emerging new technologies and FDA approvals.
- Absence of sufficient evidence on some topics to make an adequate determination
- Absence of sound and/or varying understanding of codes and inconsistent and variable coding practices among providers (e.g. genetic testing).
- Multiple competing priorities of policy development to meet requirements for new technologies, Medicare/Medicaid policies, revision of policies, affordability topics and changes to policies to better support prior authorization programs.
- Complexity of managing multiple communication channels to ensure consistent messaging regarding complex coverage policies and criteria.
- Payment liability for non-covered claims (provider versus member). Typically unless the coverage policy requires prior authorization or is investigational/experimental, the claim is denied to member liability, resulting in a dissatisfying member experience.
- Significant variation in employer specific contract benefits, language and exclusions.

Opportunities for improvement:

- Routinely assess for and implement policy development process redesign to be maximally efficient, credible, and scalable.
- Facilitate improvement of the claims edit implementation process to ensure accurate edits that support current coverage policy determinations and align with policy effective dates.
- Ongoing assessment of system needs for accurate and efficient coverage policy implementation.
- Identify opportunities to address complexity of verbiage within key medical coverage policies.
- Continuous focus on new and emerging technologies and changes in medical practice to ensure accurate coverage policy positions and attention to affordability opportunities.

Results/Outcomes

New Technology Committee:
• New Technology Committee membership further expanded membership to include a broader scope of specialties and now includes physicians with expertise in cardiology, oncology and ophthalmology.

• A comprehensive flow diagram was developed to demonstrate the process by which topics originate and move through the committee to an actionable outcome as well as the committee’s inter-relationship with other departments. The diagram is used as an educational tool to help new members and internal customers better understand the committee’s work. It has also been valuable to assist colleagues in explaining the New Tech process to external customers.

• Committee leaders collaborated with leaders from Provider Relations and Network Management to develop a better understanding of how our work is related and how we can best partner to achieve successful management of new technology services.

• The committee continues to improve the timing of topics moving through the committee so that they can be appropriately addressed via policy and/or the claims process, thus ensuring correct medical management and claims payment/non-payment. This is evidenced below by the number of topics which have been added to either the Investigational Services-List of Non-Covered Services policy or other existing policy, or closed for review.

• In 2018, the New Technologies Committee reviewed 105 topics: This included 12 new topics, 14 watch list items and 79 items on the Investigational services-list of non-covered services. Of these, eight topics were added to the Investigational services-list of non-covered services policy. For one topic, the assessment indicated that evidence had evolved to the degree that the health plan should provide coverage.

• New Technology Committee and Medical Director Committee continue to support stewardship and green initiatives by conducting paperless meetings.

**Coverage Policy:**

• 32 new clinical coverage criteria were developed including *Chimeric antigen receptor/genetically engineered T-cell receptor (CAR-T) therapy*. Ongoing evaluation of policies that do not require prior authorization to determine the relevance to current standard of care, evidence, cost and claims history, resulted in 37 policies being retired.

• Annual review was performed on 268 coverage policies resulting in revising coverage criteria for 115 policies.

• Due to 2018 regional expansion into North Dakota and South Dakota, an extensive review of state mandate language in comparison to existing coverage policies was completed resulting in a 2 new policies and 9 policy revisions in order to align with state requirements.
• In depth analysis of preventive care services coverage and claims payment approaches. This included analysis of current coverage policy, payment policies/approaches and member contracts in comparison to the required coverages according to USPSTF A and B rated recommendations, healthcare.gov preventive care polices for adults and children and the HRSA.gov guidelines for women. Results will continue to inform payment and contractual approaches in 2019.

• In depth analysis of vitamin D testing usage and cost to determine value and appropriateness of testing, driving future coverage policy development for 2019.

• New transplant prior notification requirement implemented for transplant pre-consultations to better support members with the initiation of care and benefit coordination.

• New coverage criteria and prior authorization requirements developed for endovenous laser ablation therapy.

• Fact Sheets summarize current evidence regarding a procedure/device when there is no coverage policy. They are used to aid medical directors in making coverage decisions. As a result of the 2017 process improvement project, a Fact Sheet is only created when there is a specific request for coverage that requires a decision by a Medical Director. Fact Sheet usage is monitored monthly to assess volume of requests and opportunities for policy revision or creation to include the topic. In 2018, 101 Fact Sheets were identified as no longer having value and were archived.

• Partnership with sales to develop informative talking points to effectively capture the work of medical coverage policy, new technology committee and genetic testing projects.

• Evolution of the genetics coverage and strategies, as addressed in Genetics Program chapter.
Genetics Program

Description

Genetics-based laboratory testing and personalized medicine is at the cusp of rapid growth. Genetic testing expense alone is projected to reach $15 to $25 billion nationally by 2021. The emergence of practicable large scale genomic sequencing and the rapid development of gene therapies and other personalized and targeted therapeutics will drive this growth even further.

Goal

HealthPartners is now transitioning from a genetic testing program primarily focused on laboratory genetic counselors and health plan payment and coverage, to a comprehensive Genetics Program comprising the health plan, care group, laboratory, and research institute. The Genetics Program is intended to serve as a framework to support evidence-based clinical practice, medical coverage policy, contracted laboratory networks, access to genetic counseling, and knowledge resources to support strategy development.

Initiatives/Interventions

The Genetics Program was started with a multi-faceted organizational structure to drive the goals and objectives of the overall program. The program committee structure is composed of the Genetics Steering Committee, a Genetics Leads group, and the Genomics/Personalized Medicine (G/PM) advisory group. Genetics advisory groups are formed as needed under medical director leadership and serve to inform the steering committee, the health plan Medical Director Committee, and the health plan Pharmacy and Therapeutics Committee. Additional workgroups are formed on a strategy-specific basis, as needed.

These committees and groups have led an integrated effort to move the program from its original small, focused structure to a fully comprehensive program encompassing all areas of the organization.

**ECRI**

We contracted with ECRI, a knowledge-based genetic testing vendor, to provide the most current and comprehensive information regarding genetic testing and the appropriate use of each test. The information they provide augments the knowledge of the genetic counselors in choosing the most appropriate test for our patients and informs our coverage policy development.

**Medical Coverage Policy**

The Medical Coverage Policy team has created multiple new genetic testing coverage policies as a result of the recommendations of multiple Clinical Advisory Groups. These coverage policies are continuously reviewed to ensure alignment with evidence-based care and community practice patterns. In addition, the Medical Coverage Policy team has produced alert documents outlining the health plan’s position on specific genetic tests and a white paper to highlight the role of laboratory genetic counselors. These resources are critical to the health care process, work to inform our
members about coverage, and ensure that our members and patients receive not only the correct tests, but also the tests that are covered by their health plan.

**Advisory Groups**

Advisory Groups comprising medical professionals from across the Twin Cities area and beyond have provided input and usage recommendations for our genetic testing coverage in the areas listed below. Our members and patients benefit from the knowledge of these multi-disciplinary teams with expertise in very specific genetic conditions and disorders:

- Molecular Profiling and Cancer Markers
- Developmental & Autism Spectrum Disorders
- Pharmacogenetics
- Neurodegenerative disorders
- NIPS (Noninvasive Prenatal Screening)
- Carrier Screening
- Cardiology / Vascular Conditions
- Neuromuscular Disorders & Ataxia
- Clotting/bleeding Disorders
- Gastrointestinal disorders
- Cancer Predisposition
- Vision and Hearing Disorders

**Concert Genetics**

We utilize a contracted vendor, Concert Genetics, to provide us with market analytics consultation. This vendor completes comprehensive analyses of our claims data twice annually to provide us with actionable insights on medical policy, reimbursement, payment integrity, and laboratory contracting to guide us in the effective management of genetic testing. As a result, we have successfully renegotiated contracted rates within our genetic testing laboratory network; welcomed select new laboratories to our network to meet members’ needs for specialized genetic tests; proactively addressed possible payment integrity concerns; and developed evidence-based coverage positions on emerging tests and market trends that are impacting our members and patients.

**Contracted Laboratory Network**

The health plan’s Provider Relations and Network Management department maintains genetic testing laboratory contracts to ensure cost-effective and consistent pricing for covered tests. This work includes the identification of opportunities for enhancement of our contracted network through developing new relationships with select high-value laboratory partners. This contracted network allows us greater control over our resources, while providing access to the genetic tests our members and patients need.

**EMR Orders**
For the HealthPartners family of care providers, orders for genetic testing are electronically routed to the Laboratory Genetic Counselors for their review and consultation. This ensures that our genetic counselors are engaged in the selection of tests and in advising providers, in order to support optimal patient care.

**Laboratory-based Genetic Counselors**

Regions and Methodist hospitals have two laboratory-based Genetic Counselors to provide real-time genetic counseling to patients, and provide guidance to physicians and healthcare providers who may not have in-depth knowledge or experience with the complexities of genetic testing. The Genetic Counselors provide a singular focus for information that is both current and appropriate for the patient’s specific needs. When questions arise regarding genetic tests, they are the one-stop resource for the best advice and feedback.

**Communications**

We engage with communications consultants to expand the knowledge base of genetic testing across the organization. Provider and employee newsletters have included articles about real families with genetic concerns, as well as information about the role of genetic counselors and how to engage them in the process of genetics care. Many effective methods exist to share genetic testing information and highlight available resources to assist with navigating this complicated area, including member- and patient-facing blog posts and information sheets available at the point-of-care. Increasing awareness improves the organization’s knowledge, and ultimately improves care and understanding for our members and patients.

**Research**

To remain at the forefront of supporting evidence-based genetics care and treatments for our patients and members, the Genetics Program is partnering with leaders and investigators at the HealthPartners Research Institute. This partnership keeps us apprised of new developments in genetics care at the national level and within our local community, such as a large National Cancer Institute cohort study that will be open to our patients and members, as well as the beginnings of a biorepository to be housed within HealthPartners.

**Genomics/Personalized Medicine (G/PM) Advisory Group**

A new Genomics/Personalized Medicine (G/PM) Advisory Group is now part of HealthPartners’ comprehensive model of care delivery.

While currently in the beginning stages of program development, proposed goals for the G/PM Advisory Group include the following:

– Optimal stewardship of our resources, including pursuit of a contracted relationship with a telehealth vendor specializing in genetic counseling to facilitate access to this critical service for our patients and members.
Prioritization of access and coordination of genetics care for members affected by the Tier One diseases identified by the Association for Molecular Pathology: Lynch syndrome, hereditary breast and ovarian cancer syndrome, and familial hypercholesterolemia.

**Barrier Analysis**

The barriers to improved care cover a wide range of issues that complicate program management. Patient and member experience and quality of care are impacted in multiple ways as outlined in the table below.

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Impact to Patients</th>
<th>How this has been addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall complexity of tests in a rapidly changing environment:</td>
<td>The patient may not receive the right test at the right time for the right condition.</td>
<td>• Laboratory Genetic Counselors assess tests and provide feedback to health care providers</td>
</tr>
<tr>
<td>-10 new tests are added every day</td>
<td></td>
<td>• Implemented timely review of test orders through the use of Epic tools.</td>
</tr>
<tr>
<td>-Genetic/molecular tests have nearly tripled from 27,000 to 75,000 over just a few years</td>
<td></td>
<td>• Utilization of ECRI, a knowledge-based genetic testing vendor.</td>
</tr>
<tr>
<td>The evolution of test coding and a lack of specificity.</td>
<td>The potential for the patient to be billed for an inaccurate test.</td>
<td>• We are using a data analytics vendor, Concert Genetics, to analyze claims for possible misuse of codes or tests, identify over-pricing of tests, and detect possible fraudulent activity.</td>
</tr>
<tr>
<td>There are only a few hundred billing codes in existence today for the thousands of available tests.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The increased use of multi-gene testing panels and large scale genetic sequencing, which may include unnecessary tests.</td>
<td>The potential for the patient to be billed for unneeded tests.</td>
<td>• We are using a data analytics vendor, Concert Genetics, to analyze claims for possible misuse of codes or tests, identify over-pricing of tests, and detect possible fraudulent activity. • Utilization of ECRI, a knowledge-based genetic testing vendor.</td>
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<tr>
<td>Lack of practitioner knowledge about the most appropriate tests; lack of practitioner access to genetic testing knowledge resources, including Genetic Counselors and/or literature.</td>
<td>The patient may not receive the right test at the right time for the right condition.</td>
<td>• Laboratory-based Genetic Counselors assess test orders and provide feedback to health care providers • Created Genetic Testing Formulary documents, which help establish a baseline of our current genetic test requests and guide providers when ordering tests.</td>
</tr>
<tr>
<td>Direct-to-consumer marketing of genetic tests that may not be appropriate for a patient’s particular situation.</td>
<td>Patients may have tests that are unnecessary or provide confusing results and which may be very expensive.</td>
<td>• On-going assessment of new tests and trends in the market • Increasing awareness through multiple communication channels • Joined a national group forum at Seattle Children’s Hospital, PLUGS (Pediatric Laboratory Utilization Guidance Services). Membership in this group is about sharing best practices.</td>
</tr>
<tr>
<td>Advocacy web sites that encourage genetic testing which may not change the care plan or the outcome of a disease/condition and are based on limited clinical evidence. The development of genetic tests has outpaced related treatments.</td>
<td>Patients may have tests that are unnecessary and possibly very expensive; the testing may not drive improved care.</td>
<td>• On-going assessment of new tests and trends in the market • Increasing awareness through multiple communication channels. • Participation in a national group forum established at Seattle Children’s Hospital, PLUGS (Pediatric Laboratory Utilization Guidance Services). Membership in this group is about sharing best practices. • Utilization of ECRI, a knowledge-based genetic testing vendor.</td>
</tr>
</tbody>
</table>

**Measures of Success**

The Genetics Program has supported a triple-aim approach, specifically optimal member and patient care experiences and enhanced overall quality and affordability of care, as a result of the following:

- Successfully developed a cross functional genetics approach and committee oversight structure dedicated to promotion of the best patient/member experience and affordability goals, including:
  - Provision of strategic direction related to genetics care;
- Identification of key champions and areas affected by new genetics initiatives;
- Monitoring and managing to prevent the overuse and misuse of genetic testing, while concurrently supporting best use of genetics services; and
- Maintenance of a high level of awareness of genetic-related issues, market trends, and new technology developments.
- Expansion of scope to include partnership with the HealthPartners Research Institute.

- Successfully created new laboratory Genetic Counselor roles to review genetic test orders for our HealthPartners and Park Nicollet medical groups and guide physicians to the right genetic tests for the right conditions or disorders, reduce inadvertent ordering errors, and eliminate unnecessary testing. They also verify that the appropriate testing laboratory is selected to ensure patients and providers receive actionable results.
  - As of December 2018, the laboratory genetic counselor program shows approximately $2.9M in total cost avoidance savings since program start (up $1.4M from 2017), with an average cost savings per test order of $1841 in 2018 (up $1000 per test from 2017). We will continue to monitor these metrics and others on an ongoing basis to understand the long-term impact of our initiatives.

- Successful operational implementation of efficient genetic test ordering processes. This centralized process routes all genetic testing orders to the laboratory Genetic Counselors. In turn, they provide timely review and real-time decision support to our clinicians, prior to a test being collected, performed, or sent out to an external reference laboratory. This simple-to-use service allows clinicians to use a personalized medicine approach to select the test that best fits the clinical need of an individual patient. The After Visit Summary script provides next steps for the patients and supports a positive patient and member experience.

- Successful health plan trend mitigation and cost savings of approximately $2.5M over three years, with the three-year trend reduction of $0.39 PMPM from 2015-2018 as a result of clinical coverage criteria, selective use of prior authorization, and targeted laboratory contracting.
  - From 2017-2018, we first experienced a flattening of this trend and then a slight increase of $0.06 PMPM.
  - Utilization decreased by 15% from 2015 to 2016, by 6% from 2016 to 2017, and increased by 10% from 2017 to 2018.
  - Analysis to understand the increase in trend is underway.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Allowed</th>
<th>Allowed PMPM</th>
<th>Allowed per Service</th>
<th>Services Per 1000</th>
</tr>
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<tbody>
<tr>
<td>2015</td>
<td>$13,977,638</td>
<td>$1.44</td>
<td>$613.16</td>
<td>28.23</td>
</tr>
<tr>
<td>2016</td>
<td>$12,146,881</td>
<td>$1.17</td>
<td>$582.11</td>
<td>24.12</td>
</tr>
<tr>
<td>2017</td>
<td>$10,539,237</td>
<td>$0.99</td>
<td>$522.70</td>
<td>22.78</td>
</tr>
<tr>
<td>2018</td>
<td>$11,484,080</td>
<td>$1.05</td>
<td>$501.36</td>
<td>25.06</td>
</tr>
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</table>

**Areas for Focus: 2019**
HealthPartners has recognized the emerging trend in genetic testing and personalized medicine throughout the last five years. Over the past three years we have implemented multifaceted strategies to promote the optimal use of these services, including laboratory network contracting solutions; medical coverage policies; medical management strategies; and care delivery programs. Looking ahead to 2019 and beyond, we will continue to innovate strategy in this space, inclusive of:

- Capturing ordering/referring provider data in our claims system for efficient delivery to our data warehouse to enhance our capacity for pattern recognition, evaluation, and monitoring;
- Identifying opportunities to enter into contract agreements with additional specialized genetics laboratories to ensure alignment with market rates and a diverse and comprehensive portfolio of laboratory partners to serve our patients and members;
- Continuously maintaining medical coverage policies and developing medical management strategies to ensure we are covering evidence-based applications of emerging forms of genetics care;
- Pioneering the use of effective tools and technologies within our care delivery system and health plan to guide our patients, members, and their healthcare teams to the most affordable genetic testing laboratories to meet their unique needs, such as:
  - Providing contracted laboratory network information in an easy-to-access online link alongside medical coverage policies;
  - Promoting our organization’s laboratory genetic counseling services to optimize the ordering processes within our own care delivery system; and
  - Seeking greater understanding of diverse models of genetics care, including virtual and telephonic genetic counseling services;
- Engaging with our patients, members and their healthcare providers over diverse mediums, such as blog posts and targeted educational communications; and
- Utilizing the upcoming benchmarking data for the full year of 2018 to identify additional opportunities for targeted initiatives and overall strategy development in genetic testing and personalized medicine.
Organizational Structure

Genetics Committee Structure

Genetics Steering Committee
* Meets Quarterly
  * Plan
  * Care Group (Laboratory, Primary & Specialty Care)
  * Research

Genetics Advisory Groups
* Meets monthly
* Ad hoc, as needed

Genomic/Personalized Medicine Advisory Group
* Meets quarterly

Related committees informed by Genetics Advisory Groups
* Medical Director Committee
* P & T Committee

Periodic Initiatives Meetings
* Ad hoc, as needed
  * Concert Genetics
  * Genetic Health Information Network Summit Workgroup
  * Oncology GT Gold Pass
Practitioner Credentialing

Description

HealthPartners reviews and evaluates the qualifications of licensed independent practitioners to help assure that care and services are provided to enrollees by competent professional staff and in an appropriate and safe environment.

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Size</td>
<td>44,693</td>
<td>62,446</td>
<td>70,368</td>
<td>74,900</td>
<td>NA</td>
</tr>
<tr>
<td>Non-delegated</td>
<td>20,898</td>
<td>24,062</td>
<td>27,850</td>
<td>26,155</td>
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<tr>
<td>Delegated (regional network only)</td>
<td>23,795</td>
<td>38,384</td>
<td>45,518</td>
<td>48,745</td>
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Initial Applications (all practitioner types)

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number processed</td>
<td>2528</td>
<td>2702</td>
<td>2899</td>
<td>3016</td>
<td></td>
</tr>
<tr>
<td>Percent completed in 30 days</td>
<td>80%</td>
<td>46%</td>
<td>25%</td>
<td>34%</td>
<td>90%</td>
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<tr>
<td>Average turn-around time in days</td>
<td>27</td>
<td>41</td>
<td>46</td>
<td>40</td>
<td>30</td>
</tr>
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</table>

Recredentialing Applications (all practitioner types)

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>Goal</th>
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<tr>
<td>Number processed</td>
<td>4515</td>
<td>6110</td>
<td>8165</td>
<td>6448</td>
<td></td>
</tr>
<tr>
<td>Percent completed within 36 months</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Network Strategies

A key element of the HealthPartners quality strategy is our partnership with our entire network of care delivery systems. Our provider partnership model is based on shared accountability for provider success. HealthPartners’ approach is to partner with providers to have shared accountability for their success. HealthPartners is an integrated organization which includes care delivery so we are uniquely positioned to successfully partner with providers. We design our supports, data tools, care delivery support and payment arrangements based on our in-depth knowledge of the challenges facing providers and how to improve the triple aim for patients. We meet providers where they are, and ultimately embed contracts with arrangements regarding clinical outcomes, shared savings and patient experience.

Our strategy is collaboration through true partnership. We provide data tactics including data production, data analysis and data application to translate data into action. Shared accountability for provider success includes:

- Care delivery enhancements
- Care model redesign
- Smart referrals and clinical partnerships
- Early adoption of new innovation.

The success of these programs relies on determining the right incentives for clinic participation, the ability of HealthPartners to provide accurate and timely data and our flexibility to meet providers where they are.

Key network strategies for maintaining and improving the high quality of care our members expect include Total Cost of Care arrangements, our Partners in Excellence (PIE) program, high value networks and Centers of Excellence.

Goals

The goals for the quality network strategies are to collaborate with our clinical providers to ensure all care provided to our members meets the triple aim of high quality care with a positive member experience and affordability.

Description

Total Cost of Care

The Total Cost of Care Report supports the Triple Aim goals by creating a more complete picture of the drivers of health care costs, which can be used to identify opportunities within individual practices. TCOC is a comprehensive reflection of a providers resource use, intensity, appropriateness, and efficiency built around the services a provider group’s patients receive and the clinics, specialists and hospitals in which they receive the services.

HealthPartners schedules annual or biannual meetings with TCOC providers to identify potential opportunities where costs and utilization could be reduced. These opportunities are provider specific based on overall population served, cost of services and practice patterns. HealthPartners provides individual level data to clinics via our Patient Management Application tool developed to support clinics in their approach to population health management and meeting quality expectations.
Challenges related to TCOC include organization staffing limitations such as having resources available for telehealth and other technological services. Additionally, TCOC is currently only built for commercial populations. There is increased interest in getting the data for other patient populations and being able to see different cuts of data based on clinic locations.

In 2019 HealthPartners will update the TCOC platform and will include data for all product types and allow the provider better visual data looks and better manipulation. It will also house our other already established tools to help with care coordination and pharmacy costs. In 2018, over $25 million was saved through TCOC arrangements.

**Partners in Excellence (PIE)**

The Partners in Excellence program forms the basis for HealthPartners’ financial and public recognition for medical or specialty groups achieving high levels of performance on the Triple Aim of exceptional clinical quality, patient experience, and affordable care. Financial rewards are based on medical, specialty or pharmacy group performance as measured by Minnesota Community Measurement. For those measures that do not have a corresponding MNCM measures, we utilize HealthPartners Clinical Indicator measurement set, and HealthPartners Consumer Choice Satisfaction survey.

The awards are made at an annual event and it is a way to provide public recognition of improved performance and sharing of best practices in addition to financial recognition. In November 2018, HealthPartners recognized over 50 health care providers as part of our Annual Partners in Excellence event. The event celebrates providers across the Upper Midwest who are doing meaningful work to improve health, experience and affordability for the patients and communities they serve. Awards recognize medical, specialty, pharmacy and hospital providers who contract with the HealthPartners health plan.

There are four kinds of awards:

1) The Pharmacy Award recognizes pharmacy groups based on four performance measures.
2) The Medical Award recognizes medical and specialty groups. Silver Award winners receive high scores in patient experience and quality. Gold award winners meet the full Triple Aim, achieving high scores in affordability as well as patient experience and quality.
3) The Innovation in Health Care Award recognizes health care organizations that design and implement innovations for a condition, or for the care delivery model/process.
4) The Preventive Care Recognition Award recognizes major process changes that result in persistent, sustainable improvement for preventive care screening.
The measures used in the PIE program are established measures that are endorsed nationally or generally accepted national or regional standards. We draw on a range of established measures that are accurate, valid and reliable from a variety of sources for a robust overall rating methodology. The scoring methodology is transparent, clearly communicated and consistent which avoids or minimizes subjectivity and ensures accuracy and validity.

- Partners in Excellence Program results:
  - In 2018, three groups received HealthPartners’ sixth annual Preventive Care Recognition Award for major process changes that resulted in persistent, sustainable improvement for preventive care screening that addressed the health of population served.
  - The Preventative Awards recognized seven applicants overall, representing all levels of the health delivery system that made significant quality improvement to the populations they care for.
  - 2018 Partners in Excellence recognized 46 primary care groups, 85 specialty care groups and 26 pharmacies for achieving quality targets.
  - In 2018 five Innovation in Health Care Awards were given for designing and implementing progressive approaches for a condition or for the care delivery model/process. Twenty-six applicants overall were recognized, representing all levels of the health delivery system that made transformational changes.

Centers of Excellence (COE)

HealthPartners operates COE’s on the premise of identified providers for a specific service who provide exceptionally high quality care through outcome measurement, demonstration of cost efficient care, and provide members an exceptional experience. COE requires consistent review of outcomes by all participants and medical policies which are fully developed to ensure all criteria is met for each procedure. HealthPartners currently recognizes COE for Transplant and Weight Loss Surgery. We monitor the expectations of this program closely and approve only those providers who meet accreditation, volume and outcome requirements.

- Weight Loss Surgery – Data is compiled from Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).
  - Benefit coverage for Weight Loss Surgery is a significant issue facing both members and providers when the service is requested but the member’s benefit does not include coverage.
  - Primary focus for 2019 will be to ensure COE participants have a tool in place to measure post-operative psychosocial well-being. This will be a criteria going into place 01/01/2020 for providers to participate in the network.

- Transplant - Data is compiled from Scientific Registry of Transplant Recipients (SRTR)
  - HealthPartners has been working through improvements in UM management (prior notification process) for transplant.
  - 2018 was year of significant learning to identify the measurement tools that can be used for outcome based measurement for the network. This work will continue in 2019.

High Value Networks
The goal of High Value Procedure Designations is to help ensure members receive the best value for their health care dollars. To that end, specific high volume and/or high cost surgical procedures are analyzed to identify variation in cost and quality, in order to designate facilities that are high quality and cost effective at a procedure level.

The following table shows the procedures that are evaluated on quality and cost for High Value Designations, and the number of locations in each designation:

<table>
<thead>
<tr>
<th>Cardiac Care</th>
<th>Cardiac Ablation</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cardiac Catheterization</td>
<td>14</td>
</tr>
<tr>
<td>Orthopedic Care</td>
<td>Arthroscopic knee surgery</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Arthroscopic shoulder surgery</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Back surgery</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Carpal tunnel surgery</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Hip replacement surgery &amp; revision</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>Knee replacement &amp; revision</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>Rotator cuff surgery</td>
<td>9</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>Tonsil and/or adenoid surgery</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Tympanostomy surgery</td>
<td>12</td>
</tr>
<tr>
<td>Other</td>
<td>Cataract removal</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Cholecystectomy</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Hernia repair, inguinal</td>
<td>9</td>
</tr>
</tbody>
</table>

Cost - Cost performance is measured in terms of an index, or costs compared to the 13 county metro average for each procedure. In order to achieve High Value designation for a procedure, facilities must demonstrate cost-effective performance that is better than the 13 county metro average for the procedure. An index greater than 1.0 reflects cost performance that is worse (or more expensive) than the metro average, where an index less than 1.0 reflects cost performance that is better (or less expensive) than the metro average. The facility, provider, and any associated ancillary costs during the procedure episode can impact the procedure-specific total cost index (TCI).

Quality - In order to be designated as High Value, hospitals with an overall quality rating must have achieved either a 3 or 4 star overall quality rating in the quality assessment.
Clinical Consultations

HealthPartners offers consultative services through the Quality Improvement and Compliance (QIC) Department to clinic groups to support their quality improvement initiatives. Clinics may choose technical assistance on clinic processes, or they may benefit from analysis of data specific to their clinic.

- A Registered Nurse from the QIC is available to consult with medical groups about their quality improvement processes and assist with interpreting data. This can be especially helpful for small clinics or smaller systems without a fully developed QI department.
- Plan medical directors and quality improvement staff meet with network providers during consultations, round tables and Quality Connections Forums.
- HealthPartners provides a claim based Registry Report to our contracted clinics on a quarterly basis. These reports are available to be viewed on line through a secure login to the Provider Portal. The report includes data on preventive services and chronic disease. The Registry Reports program aligns with measures as defined by HEDIS codes. The reports provide aggregated claims information to primary care and specialty providers to support and assist improvement process efforts in care delivery and care coordination with patients.
Barrier Analysis

- Clinic systems may feel they “don’t have time” to participate in awards programs and consultative meetings that they see as non-clinical activities. Common reasons for this reluctance include:
  - Provider non-compliance with evidence-based guidelines.
  - Payment system for volume rather than quality of outcomes
  - Insufficient resources to support adoption of recommended initiatives or staff training
- Clinic systems and practitioners may be unaware of consultant services offered through HealthPartners
- Tools provided such as the Registry Report seem duplicative and not value added to reports clinic systems already has in place.

Quality Connections Forums

Quality Connections Forums is a strategy to share best practice for quality improvement initiatives across our provider network. We convene quality improvement and other representatives from clinics to meet for relationship building and to share successes, learnings, best practices, experiences and results. The stated purpose of the group is to share and learn so that we can take action to benefit our patients and our organizations as we mutually strive to achieve high performance results on publicly reported measures.

Quality Connections Forums are held three times per year to engage HealthPartners provider groups in quality initiatives to improve publicly reported measures. This group has grown from 5 provider groups in 2012 to 16 in 2018. The meetings offer clinics a forum to share improvement projects, discuss what was successful and challenges experienced as well as results of QI initiatives. Sharing tested strategies provides opportunities for the provider groups to use tested interventions for quality improvement. In 2018, topics discussed included pain management and issues related to opioids, Annual Wellness Visits, Osteoporosis and strategies to close gaps in care.
# Delegation 2019

## Description

HealthPartners gives other entities the authority to perform certain functions on its behalf. Oversight of the contracted entity is performed to ensure the delegated functions are performed according to HealthPartners expectations.

<table>
<thead>
<tr>
<th>Delegated Entity</th>
<th>Delegated Functions</th>
<th>Initial Delegation Date</th>
<th>Last Audit Date</th>
<th>Status</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altru Health System</td>
<td>Practitioner Credentialing</td>
<td>January 1998</td>
<td>6/18/2018</td>
<td>Interim file audit due January 2019</td>
<td>On-going monitoring Reviewed and approved at Quality Review Committee. CAP reported to DHS</td>
</tr>
<tr>
<td>Aspirus Network</td>
<td>Practitioner Credentialing</td>
<td>November 2006</td>
<td>6/25/2018</td>
<td>On-going monitoring</td>
<td>Reviewed and approved at Quality Review Committee</td>
</tr>
<tr>
<td>Aurora Health Care</td>
<td>Practitioner Credentialing</td>
<td>August 2017</td>
<td>8/23/2018</td>
<td>On-going monitoring</td>
<td>Reviewed and approved at Quality Review Committee</td>
</tr>
<tr>
<td>Avera Health</td>
<td>Practitioner Credentialing</td>
<td>September 2002</td>
<td>NCQA accredited health plan – Policy and Procedure and CMS File Review 6/15/2018</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>BayCare Health System</td>
<td>Practitioner Credentialing</td>
<td>October 2017</td>
<td>8/13/2018</td>
<td>Ongoing Monitoring</td>
<td>Reviewed and approved at Quality Review Committee</td>
</tr>
<tr>
<td>Becker County</td>
<td>Case and Disease Management (SNBC)</td>
<td>July 1, 2016</td>
<td>1/4/2019</td>
<td>Ongoing Monitoring</td>
<td>Information submitted to Gov Programs Sr Manager of Monitoring and</td>
</tr>
<tr>
<td>Organization</td>
<td>Service Type</td>
<td>Date</td>
<td>Submission Date</td>
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<td>Notes</td>
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<tr>
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<td>-----------------</td>
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<td>Bellin Health</td>
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<td>September 2017</td>
<td>6/15/2018</td>
<td>Ongoing Monitoring</td>
<td>Reviewed and approved at Quality Review Committee</td>
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<tr>
<td>Blue Sky, Inc.</td>
<td>Case and Disease Management (SNBC)</td>
<td>July 1, 2016</td>
<td>1/4/2019</td>
<td>Ongoing Monitoring</td>
<td>Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit &amp; Compliance</td>
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<tr>
<td>Bluestone Physician Services</td>
<td>Case and Disease Management (SNBC and MSHO/MSC+)</td>
<td>July 1, 2016 for SNBC and October 1, 2017 for MSHO/MSC+</td>
<td>1/4/2019</td>
<td>Ongoing Monitoring</td>
<td>Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit &amp; Compliance</td>
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<td>Carlton County PHHS</td>
<td>Case and Disease Management (SNBC)</td>
<td>July 1, 2016</td>
<td>1/4/2019</td>
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<td>Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit &amp; Compliance</td>
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<tr>
<td>CIGNA Behavioral Health</td>
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<td>NCQA accredited health plan –</td>
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<tr>
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<td>End Date</td>
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</tr>
<tr>
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<td>July 1, 2016</td>
<td>1/4/2019</td>
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<td>Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit &amp; Compliance</td>
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<td>Cook County PHHS</td>
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<td>1/4/2019</td>
<td>Ongoing Monitoring</td>
<td>Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit &amp; Compliance</td>
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<tr>
<td>Doctor on Demand</td>
<td>Practitioner Credentialing</td>
<td>April 2016</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<td>Essentia East – St. Mary’s Duluth Clinic Health System</td>
<td>Practitioner Credentialing</td>
<td>March 2000</td>
<td>8/21/2018</td>
<td>On-going monitoring</td>
<td>Reviewed and approved at Quality Review Committee</td>
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<tr>
<td>EyeMed Vision Care</td>
<td>Practitioner Credentialing (optometrists only)</td>
<td>April 2008</td>
<td>10/1/2018</td>
<td>On-going monitoring</td>
<td>Will be reviewed at Quality Review Committee Meeting 12/17/2018 for approval</td>
</tr>
<tr>
<td>Fairview Health Services</td>
<td>Practitioner Credentialing</td>
<td>January 1999</td>
<td>9/26/2018/ NCQA certified</td>
<td>On-going monitoring</td>
<td>Reviewed and approved at</td>
</tr>
<tr>
<td>Provider</td>
<td>Service/Process</td>
<td>Start Date</td>
<td>Date</td>
<td>Monitoring Status</td>
<td>Notes</td>
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<td>----------------------------------</td>
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<td>-------------------</td>
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<tr>
<td>Fulcrum/eviCore</td>
<td>Utilization Management</td>
<td>January 2008</td>
<td>10/27/2018</td>
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<td>Fulcrum Health</td>
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<td>July 2018</td>
<td>5/23/2018</td>
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<tr>
<td>Guild Inc.</td>
<td>Case and Disease Management (SNBC)</td>
<td>July 1, 2016</td>
<td>1/4/2019</td>
<td>On-going Monitoring</td>
<td>Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit &amp; Compliance</td>
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<tr>
<td>Gundersen Health System</td>
<td>Practitioner Credentialing</td>
<td>January 2017</td>
<td>4/26/2018</td>
<td>On-going Monitoring</td>
<td>Reviewed and approved at Quality Review Committee</td>
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<tr>
<td>Health Plus</td>
<td>Practitioner Credentialing</td>
<td>9/5/2018</td>
<td>9/18/2017</td>
<td>On-going monitoring</td>
<td>Reviewed and approved at Quality Review Committee</td>
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<tr>
<td>Independent Lifestyles Inc</td>
<td>Case and Disease Management (SNBC)</td>
<td>July 1, 2016</td>
<td>1/4/2019</td>
<td>On-going Monitoring</td>
<td>Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit &amp; Compliance</td>
</tr>
<tr>
<td>Entity</td>
<td>Service Provided</td>
<td>Start Date</td>
<td>End Date</td>
<td>Status</td>
<td>Information Submitted to</td>
</tr>
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<td>Koochiching County PHHS</td>
<td>Case and Disease Management (SNBC)</td>
<td>July 1, 2016</td>
<td>1/4/2019</td>
<td>On-going Monitoring</td>
<td>Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit &amp; Compliance</td>
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<td>Lutheran Social Service of MN</td>
<td>Case and Disease Management (SNBC)</td>
<td>July 1, 2016</td>
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<td>Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit &amp; Compliance</td>
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<td>Mahnomen County Case and Disease Management (SNBC)</td>
<td>July 1, 2016</td>
<td>1/4/2019</td>
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<td>Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit &amp; Compliance</td>
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<td>Marshall County Social Services</td>
<td>Case and Disease Management (SNBC)</td>
<td>July 1, 2016</td>
<td>1/4/2019</td>
<td>On-going Monitoring</td>
<td>Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit &amp; Compliance</td>
</tr>
<tr>
<td>Mayo Clinic Rochester Practitioner Credentialing</td>
<td>January 1996</td>
<td>7/16/2018</td>
<td>On-going monitoring</td>
<td>Reviewed and approved at Quality Review Committee</td>
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<tr>
<td>Mayo Clinic Health Practitioner</td>
<td>November</td>
<td>7/31/2018</td>
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<tr>
<td>System</td>
<td>Credentialing</td>
<td>Year</td>
<td>Date</td>
<td>Monitoring</td>
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<td>Mayo Clinic Health System – Eau Claire</td>
<td>Practitioner</td>
<td>February 2004</td>
<td>3/21/2018</td>
<td>On-going</td>
<td>Reviewed and approved at Quality Review Committee</td>
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<tr>
<td>System – Franciscan Healthcare</td>
<td>Credentialing</td>
<td>January 2008</td>
<td>4/26/2018</td>
<td>On-going</td>
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<tr>
<td>Medimore</td>
<td>Practitioner</td>
<td>September 2015</td>
<td>7/23/2018 Interim Audit Due 2/2019</td>
<td>On-going</td>
<td>Reviewed and approved at Quality Review Committee</td>
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<tr>
<td>Mercy of Iowa City PHO</td>
<td>Practitioner</td>
<td>March 2017</td>
<td>3/22/2018</td>
<td>On-going</td>
<td>Reviewed and approved at Quality Review Committee</td>
</tr>
<tr>
<td>Midlands Choice</td>
<td>Practitioner</td>
<td>September 2016</td>
<td>5/30/2018</td>
<td>On-going</td>
<td>Reviewed and approved at Quality Review Committee</td>
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<tr>
<td>Midlands Choice</td>
<td>Organizational Facility Assessments</td>
<td>4/1/2018</td>
<td>NA – Initial assessment completed in 2018</td>
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<td>Reviewed and approved at Quality Review Committee</td>
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<td>Organization</td>
<td>Service Provided</td>
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<td>Minnesota Stroke Association</td>
<td>Case and Disease Management (SNBC)</td>
<td>July 1, 2016</td>
<td>1/4/2019</td>
<td>On-going Monitoring</td>
<td>Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit &amp; Compliance</td>
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<tr>
<td>MultiPlan (aka PHCS)</td>
<td>Practitioner Credentialing (optometrists only)</td>
<td>January 2007</td>
<td>NCQA accredited in credentialing - Policy and Procedure Review 8/1/2018</td>
<td>NA</td>
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<td>Norman County PH</td>
<td>Case and Disease Management (SNBC)</td>
<td>July 1, 2016</td>
<td>1/4/2019</td>
<td>On-going Monitoring</td>
<td>Information submitted to Gov Programs Sr Manager of Monitoring and Compliance and to VP of Internal Audit &amp; Compliance</td>
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<td>Oakleaf Medical Network</td>
<td>Practitioner Credentialing</td>
<td>March 2006</td>
<td>3/22/2018</td>
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<td>Reviewed and approved at Quality Review Committee</td>
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<td>Olmsted Medical Center</td>
<td>Practitioner Credentialing</td>
<td>January 1997</td>
<td>8/29/2018</td>
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<td>Reviewed and approved at Quality Review Committee</td>
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<td>Paramount</td>
<td>Practitioner Credentialing</td>
<td>September 2015</td>
<td>7/25/2018</td>
<td>On-going monitoring</td>
<td>Reviewed and approved at Quality Review Committee</td>
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<td>Polk County PHHS</td>
<td>Case and Disease Management (SNBC)</td>
<td>July 1, 2016</td>
<td>1/11/2019</td>
<td>On-going Monitoring</td>
<td>Information submitted to Gov Programs Sr Manager of Monitoring and Compliance</td>
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<tr>
<td>Organization</td>
<td>Type</td>
<td>Date</td>
<td>Period</td>
<td>Status</td>
<td>Information Submitted To</td>
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<td>Roseau County Social Services</td>
<td>Case and Disease Management (SNBC)</td>
<td>July 1, 2016</td>
<td>1/4/2019</td>
<td>On-going Monitoring</td>
<td>Gov Programs Sr Manager of Monitoring and to VP of Internal Audit &amp; Compliance</td>
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<tr>
<td>Sanford Health</td>
<td>Practitioner Credentialing</td>
<td>January 2000</td>
<td>NCQA accredited health plan - Policy and Procedure and CMS File Review 5/17/2018</td>
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<td>ThedaCare</td>
<td>Practitioner Credentialing</td>
<td>September 2017</td>
<td>9/6/2018</td>
<td>On-going monitoring</td>
<td>Reviewed and approved at Quality Review Committee</td>
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<td>MedImpact</td>
<td>Network and Claims Processing</td>
<td>January 2008</td>
<td>9/2017</td>
<td>On-going monitoring</td>
<td>Reviewed and approved at Pharmacy Quality Committee</td>
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<td>Source</td>
<td>Type/Activity</td>
<td>Start Date</td>
<td>End Date</td>
<td>Frequency</td>
<td>Monitoring</td>
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<td>Fulcrum</td>
<td>Network</td>
<td>May 1995</td>
<td>6/2018</td>
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<td>VGM, Inc. (Homelink)</td>
<td>Network</td>
<td>January 2014</td>
<td>4/24/2018</td>
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<td>monitoring</td>
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<td>SourceHOV</td>
<td>Data entry of paper claims</td>
<td>1991</td>
<td>5/23/2018</td>
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<td>Bolger</td>
<td>Marketing/Fulfillment</td>
<td>April 2012</td>
<td>7/2018</td>
<td>Annual</td>
<td>Packet &amp; Onsite Audit are reviewed and approved by Marketing</td>
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<td>University of Iowa</td>
<td>Practitioner Credentialing</td>
<td>June 2015</td>
<td>7/17/2018</td>
<td>NCQA certified CVO</td>
<td>On-going monitoring</td>
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