MINNESOTA COUNCIL of HEALTH PLANS

Minnesota's Health Plans Improving Quality, Reducing Costs, Adding Value

Three key ingredients are needed to create and sustain health care coverage for all Minnesotans. The ingredients are:

1. Control health care costs
2. Improve health care quality
3. Ensure everyone has access to coverage and care

Minnesota's health plans are working on many initiatives to help slow rising costs and improve the care Minnesotans receive. The initiatives outlined here have saved more than $335 million dollars in health care costs while improving the quality of life for Minnesotans.

Here are a few of the success stories.

Preventing Behavioral Health Related Crises

Overview

HealthPartners experience with increasing demands for behavioral-related crisis care in its medical group and at Regions Hospitals

Strategy

Prevent depression by mirroring the approach HealthPartners developed to prevent and treat diabetes, heart disease and other chronic conditions. HealthPartners works to proactively prevent depression for members who are at risk and to offer support to members with mild, moderate, severe and complex cases of depression. A team within HealthPartners uses claims data and a software program to identify members at high risk of having a behavioral health crisis in the next year.

Results

More than 130,000 HealthPartners members have received services through the program. A 2006 comparison of health care use among individuals identified for the high-risk component of the program with that of individuals with similar conditions in a control group found that, those in the program saw a:

- 26 percent increase in outpatient behavioral health visits.
- 9 percent decrease in the number of behavioral health-related emergency room visits.
- 18 percent decrease in inpatient hospital days for behavioral health-related stays.

Per-member, per-month spending for patients in the program was 22 percent less than patients in the control group. This program resulted in medical care saving of $1.5 million in 2005 and $3 million in 2006.

Next Steps

HealthPartners is using this expertise to improve behavioral health care, including work with the DIAMOND initiative.

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Promoting Appropriate Use of Prescriptions

Overview

Pharmacy costs continue to be a major component of health care spending. Medica's Pharmacy Services manages the drug formulary — and the high cost of drugs — while continuing to give members access to needed medications.

Strategy

Medica's formulary management strategy is to promote use of lower-cost drug options whenever evidence supports their clinical effectiveness. Changes to the Medica formulary are made on a regular basis but only after thoughtful review and input from community physicians and pharmacists. Generic substitution involves replacing brand-name drugs with generic alternatives when possible. This results in the least-expensive copayments for members and an overall savings in health care costs.

Managing the formulary in spring of 2007 involved removing the brand-name cholesterol-lowering drug Lipitor from the preferred drug list, while maintaining three generic and two branded alternatives on the formulary.

Results

Use of generics plan-wide has increased by nearly 14 percent, from 51.5 percent in 2004 to 65.4 percent in 2007. At an estimated $8.2 million in savings per percentage-point increase during those three years, this initiative alone has meant a cost savings of $113 million in that time span: $29 million in 2005, $36 million in 2006, and $48 million in 2007.

The change in the formulary that moved Lipitor from the preferred drug list amounts to an estimated first-year savings of $10.3 million.

Overall, the work of Pharmacy Services has moderated Medica's pharmacy trend in recent years, slowing from a year-over-year growth rate of 4.9 percent in 2005 to 3.4 percent in 2007.

Next Steps

Medica's ongoing pharmacy-related activities continue to address utilization and cost issues on behalf of Medica members and employer groups. The goal is to save them money without compromising care.

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Increasing Quitline Referrals

Overview

Tobacco use in the U.S. results in more than 440,000 premature deaths and $75 billion in excess annual medical costs. National guidelines confirm that practitioner interventions work, yet practitioners often fail to connect patients with evidence-based treatments, such as tailored counseling. Blue Cross led and funded a controlled study that demonstrates a pay-for-performance program significantly increases quitline referrals.

Strategy

The project objective is to assess the impact of financial incentives on practitioners' use of a fax referral to phone-based quit-smoking counseling. Telephone coaching for smoking cessation is available to all Minnesota residents for free. Individual clinics in a large Minnesota health care system were randomly assigned to receive information only or information plus financial incentives encouraging quitline referral. The measurement: the proportion of smokers referred to quitline services.

Blue Cross led development of the Minnesota Clinic Fax Referral Program supported collaboratively by Clear Way Minnesota[SM], HealthPartners, Medica, Metropolitan Health Plan, MMSI, Preferred One and UCare. The program is a single fax number that receives fax referrals from clinics and then triages the referrals to the quitline appropriate for each patient's health plan coverage. Referred patients receive up to three outbound calls over a two-week period to enroll in counseling services.

Blue Cross modified existing contracts with intervention clinics to provide incentives for referring tobacco users to quitline services. Clinics referring 50 tobacco users to quitline services between Sept.1, 2005, and June 31, 2006, received a $5,000 bonus. All patients referred counted toward the total, regardless of health plan coverage.

Results

The incentive program substantially increased the rate of physician referrals to tobacco quitline services and it went statewide in 2007. During the project, intervention clinics generated 1,483 referrals compared to 441 referrals received from control clinics. While this study did not track patient-level health care costs, a recent Blue Cross analysis of the short-term costs found that average annual health costs for smokers exceed those of non-smokers by $1,900 per smoker per year. Other studies have found that current and former smokers are less productive than never smokers — $1,420 per smoker per year less productive for current smokers and $935 per smoker per year less productive for former smokers.

Next Steps

Blue Cross will continue to offer incentives to clinics that choose to register for the program and participate in Blue Cross' pay-for-performance program.

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Better Diabetes Care Through Incentives & Guidance

Overview

After successfully implementing a disease management for Medicaid members with diabetes in 2004, UCare established a similar program for Medicare Advantage members in 2005. In 2006, approximately 3,500 Medicare Advantage members with diabetes were enrolled in the program, representing 53 percent of the program's total participation. Individuals eligible for both Medicare and Medicaid comprise 13 percent of the program's enrollment.

Strategy

UCare analyzes claims on a regular basis to identify all members with diabetes, and it categorizes them as "low risk" or "at risk" based on their use of recommended care. A member is considered low-risk if he or she has had two HbA1c tests, a cholesterol test, a retinal eye exam, screening for kidney disease, and two visits to a primary care physician or endocrinologist for diabetes care within the past year. Members are placed in the "at-risk" group if they are missing one or more of these tests or visits.

UCare sends members of the "low-risk" group educational brochures and newsletters about diabetes and recommended care, as well as a phone card with 100 free minutes. In addition, members in both the "low-risk" and "at-risk" groups can access UCare's toll-free Diabetes Message Line at any time to ask non-urgent diabetes-related questions. UCare nurses return calls to the Message Line within one business day.

In addition to the educational materials, members in the "at-risk" group receive customized Diabetes Care Reports on an annual basis that list all of the lab tests and visits recommended for diabetes care; the date of their most recent visit or screening; and a check box with the designation "needed" or "done" to indicate whether they have had the lab test or visit as recommended in the past year. UCare also provides vouchers for members to take to doctor visits along with the customized reports. Members are encouraged to discuss the reports with their doctors and have doctors sign the vouchers upon members' completion of all of the recommended services for diabetes care. Each member who mails a signed voucher to UCare receives a $10 Target gift card.

A fourth component of the program is used when a UCare member is hospitalized or visits the emergency room (ER) for diabetes-related care. UCare sends a report to the member's primary care clinic about the visit or admission, along with a list of the medications the member has taken for diabetes and other health conditions in the past two months. The report encourages the clinic to follow up with members to ensure effective diabetes care.

In January 2008, UCare added health coaching and case management to the programs. A nurse specializing in complex care follows up with all members who have ER visits or hospital stays for diabetes care. During these conversations, nurses ask about factors that contributed to the medical emergency and whether members are facing barriers to treatment. In addition, nurses provide members with information about the condition and about effective diabetes care. They help "at risk" members access diabetes-related preventive care services, and they coach them on diet, exercise, and medication issues to help them maintain blood sugar levels within recommended ranges. The nurse also helps members with complex needs (e.g., those with multiple chronic conditions) connect with UCare's case management nurses or social workers.

Results

Overall, the results below are attributed to the program's activities:

- 31 percent of members with diabetes in the "at risk" group in 2006 moved to the "low-risk" category in 2007.
- Inpatient admissions among members with diabetes fell from 2.8 percent in 2004 to 1.1 percent in 2006.
- Diabetes-related emergency room visits by members with diabetes declined from 2.8 percent in 2004 to 1.7 percent in 2006.

Among members in the "at-risk" group who responded to a 2006 satisfaction survey:

- 87 percent said that the program's Diabetes Care Reports were helpful to them.
- 81 percent said that since receiving the reports, they were more aware of their diabetes care.
- 89 percent said they were satisfied with the program's educational mailings.

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Investigating Fraud and Claims Errors

Overview

Medica's Special Investigations Unit (SIU) investigates health care fraud committed against the health plan. Minnesota and federal law require all health plans to refer suspected fraud to law enforcement. Minnesota law also requires that health plans have an SIU to investigate allegations of fraud involving employees, officers and directors.

Medica's Claims Analysis and Recovery (CAR) Unit audits paid claims and pre-payment of high-dollar claims, analyzing them for payment accuracy. CAR identifies claims processing issues and initiates necessary remedies to ensure accurate claims payment.

Strategy

The Medica SIU pursues cases from referrals from many sources, including members, law enforcement and Health Licensing Boards, as well as through a software tool that his designed to help identify possible fraud. Where fraud or abuse is identified, the SIU pursues recovery of dollars that may have been paid. The majority of cases investigated relate to providers, members and employers (enrollment fraud).

Top areas of SIU-related savings are:

- Group or member cases
- Chiropractic or physical therapy
- Personal care assistants (resulting in 6 felony convictions)
- Specialty providers
- Interpreter services

Top areas for claims recovery are:

- Contractual agreements with providers
- Incorrect provider numbers
- Duplicate payments
- Coordination of benefits issues
- Unbundled charges

Results

Since its inception, the Medica SIU has saved Medica purchasers $20 million. Just in the past year, SIU saved $5 million while investigations have resulted in several successful criminal prosecutions.

Since its beginning seven years ago, Medica's CAR Unit has saved $67.5 million overall for overpayments that aren't fraud-related.

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Paying for High Quality Care

Overview

HealthPartners launched its pay for performance program in 1997, making it one of the first in the nation to have a program. HealthPartners started this program to drive quality improvements by providing financial incentives and begin to transform the payment system to reward improved health outcomes rather than the volume of procedures.

Strategy

Provide a financial incentive to encourage medical groups to reach goals related to improving the quality of care and containing costs. These goals are set by the medical group, as well as the health plan.

HealthPartners Partners in Quality initiative rewards providers for meeting quality measures for primary, specialty and hospital care. Measures include optimal diabetes care, generic drug prescribing, preventive care and tobacco cessation. In 2007, HealthPartners rewarded providers with $21 million in payments.

Results

Improved quality

- HealthPartners members with diabetes suffer 100 fewer heart attacks, 140 fewer amputations and 740 fewer eye complications each year compared to the 1994 baseline.
- 92 percent of members were asked about tobacco use; 70 percent of smokers received help quitting. Tobacco use fell to an all time low of 13 percent. Children's exposure to second hand smoke fell from 23 percent to 6 percent.
- Improved care for members with cardiovascular disease and diabetes has helped reduce the number of deaths from heart disease by 4,000 across the state.
- The number of children who are up to date on preventive services increased from 55 in 2003 to 75 percent in 2005.

Reduced costs

- The use of generic drugs increased from 45 percent in 2002 to 68 percent in August 2007. The average cost difference between brand and generic prescriptions is $150. Every 1 percent increase in the generic rate decreases costs for HealthPartners members by $7 million annually.

Next Steps

Take part in the community discussion to standardize pay for performance measures so that continued improvements in quality can be realized.

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Free Generic Drugs

Overview

Up to 80 percent of all prescriptions could be filled using generics. It is estimated that $20 billion in generic saving went untapped in the United States in 2004. Blue Cross and Blue Shield of Minnesota (Blue Cross) member utilization of generics is currently at 60 percent.

Strategy

In 2006, Blue Cross created a program that allows members to pay nothing out-of-pocket for generic drugs. The huge cost gaps that exist between generics and brand name drugs presented excellent opportunities to achieve savings by encouraging consumers to use safe, effective generic medications. Blue Cross has now experienced that every 1 percent increase in an employer's overall generic use rate can translate into a 1 percent reduction in drug costs. Blue Cross modeling shows that most self-insured employer groups implementing a free generics program will reach a breakeven point when their generic utilization rate rises 5 to 10 percent, for example from 55 to 65 percent. At that point, the money spent on absorbing the full cost of their covered population's generic drugs will be fully offset by the money not spent on brand-name drugs.

Members see immediate cost savings. By eliminating the economic barrier of prescription drug therapy, members are also more apt to follow recommended drug therapy. Members of most Blue Cross fully-insured plans, and members of some large self-insured plans, began paying nothing out of pocket for generic drugs beginning July 1, 2006.

Results

Blue Cross fully insured groups, where the benefit is widely available, experienced a 4.9 percent increase in generic use in 2006. The entire Blue Cross program to increase generic use showed $91 million in savings in 2006; some of the savings attributed to the free generics program.

Next Steps

Blue Cross will continue the free generics program with enhanced communication to members. A growing number of self-insured groups are expected to choose this benefit in the next couple of years.

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Improving Care for Children with Asthma

Overview

Review of utilization data of UCare members with asthma indicated that high risk children are using the Emergency Department as their primary medical home and not seeing their primary care provider for ongoing care. Unfortunately, a main barrier was members with wrong or missing phone numbers. The mobility of the Medicaid population creates demographic information that is often inaccurate. Because of the challenge to reach these members, previous phone-based outreach to Medicaid beneficiaries with asthma had limited success. This partnership program seeks to reach children in school, where they spend most of their time during the week.

Strategy

To improve care for low-income children with asthma, UCare Minnesota partnered with school nurses to implement the Saint Paul Public Schools Asthma Program for children ages 5-18 on a pilot basis during the 2005 – 2006 school year. The Asthma Emergency Department Follow-up Partnership with the St. Paul Public Schools allows the school nurse to be notified if a child was hospitalized or had an emergency visit for asthma. The school nurse follows up with the UCare member and parent or guardian at school. The nurse assesses the student's health status, provides face-to-face education and directs the student back to their primary care provider.

Results

As part of the program, UCare uses utilization data and partners with most hospitals in the Minneapolis-St. Paul metropolitan area so that hospital staff members notify UCare when asthma complications send members in the targeted age group to the hospital or emergency department. UCare then contacts the nurse at the child's school to initiate outreach. Through the program, the school nurse will help the student and their parent learn about and manage asthma. The nurse will assess the child's asthma, provide asthma education, ensure the child takes his/her controller medications appropriately, discusses the use of an asthma action plan and helps the child understand conditions that trigger symptoms. The nurse also encourages follow-up care with the child's doctor. In their communications with physicians and families, nurses emphasize the importance of scheduling a physician visit within 30 days of the child's hospital admission or emergency department visit. Students who had an emergency visit or inpatient stay in the past year are offered an additional school nurse follow-up visit in the spring.

During the 2007 – 2008 school year, UCare and the St. Paul Public Schools expanded the asthma program to offer UCare members with asthma a preventive or proactive school nurse visit during the school year. Between September and December 2007, claims showed that seven children were referred to the program, although the claims data was incomplete as this analysis was written. Children will continue to be referred as needed and UCare will continue to track the program's effectiveness.

Contact

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Medication Therapy Management

Overview

As part of Medicare's Part D program, HealthPartners designed a program to minimize complications from drug interactions in elderly members.

Strategy

In 2006, HealthPartners implemented its Medication Therapy Management program to minimize adverse drug events, reach optimal therapeutic outcomes and decrease overall health care costs connected to "drug related problems." This program is designed for Medicare Part D enrollees who take medications for specific chronic conditions.

Clinical pharmacists meet with patients for a one-hour initial visit and for half-hour on subsequent visits whenever necessary. The service is available at 42 pharmacies and clinics.

Results

1, 924 Medicare Part D enrollees participated in 2006. On average, two drug therapy problems were identified for each patient. Problems included:

- Dosage too low (25 percent of patients)
- Adverse drug reaction develops (23 percent of patients)
- Needs additional therapy (19 percent of patients)
- Needs different drug therapy (15 percent of patients)
- Unnecessary drug therapy (10 percent of patients)
- Dosage too high (5 percent of patients)
- Non-compliance (2 percent of patients)

These problems can result in medical complications that also incur costs such as:

- Clinic outpatient visit, a $170 per visit average
- ER visits, a $780 per visit average
- Hospital admission, a $9,500 per admission average

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Fitness Center Discounts

Overview

Physical activity can help people live longer, healthier lives. Regular physical activity reduces the risk of heart disease, stroke, hypertension, diabetes, colon cancer and osteoporosis. Yet only half of adults in Minnesota are even moderately physically active.

The Centers for Disease Control and Prevention (CDC) recommends that adults get 30 minutes or more of moderate-intensity physical activity most—preferably all—days of the week. If all adults in Minnesota achieved that recommendation, we could expect to see 30 percent fewer cases of heart disease, stroke, colon cancer and osteoporosis.

Strategy

Make it easier for members to get active. Blue Cross implemented the BluePrint for Health™ Fitness Center Discount program in 2005 to give eligible members who work out at a registered fitness center 12 times a month a $20 discount on their fitness center membership fee. Blue Cross has signed on 1,900 fitness centers to participate in the program.

Results

Those who used a fitness center at least eight times a month for at least nine months in the study year had:

- Claims costs 17.8 percent lower than non-participants, after adjusting for health status.
- Emergency room visit rates which were 38.7 percent lower than non-participants.
- Hospital admission rates which were 41.4 percent lower than non-participants.

The study demonstrates that incentive programs like these could ultimately help people live healthier and decrease the need for health care services. The program is one of the most popular member benefit offerings provided by Blue Cross. The study also showed that it is important to have convenient locations for fitness centers because proximity to a fitness center has a direct relationship to whether or not people use their fitness center discount benefit.

Next Steps

Blue Cross will continue to offer the fitness center discount program to its members.

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Preventing Falls in Older Adults

Overview

Every year, falls in and around the home lead to ER visits and hospitalizations. The cost associated with these services is correspondingly high**.** FirstPlan is using an evidence-based strategy to identify individuals at risk for these preventable accidents.

Strategy

FirstPlan develop a comprehensive geriatric evaluation – the Functional Daily Living Skills Assessment (FDLS) –and has been using it since January 2005. The assessment evaluates an older adult's physical and cognitive functions, nutrition status, depression risk, pharmacy/medication management and caregiver health. This is done through a combination of standardized tests, "triggers" and actual performance or simulation of the person's daily tasks. Physical therapists and occupational therapists complete the assessment, working as part of a team with a physician/nurse practitioner, pharmacist, nurse, patient and care providers.

In addition, an evaluation of available community-based services showed the need for an exercise program designed for individuals who were identified as "high risk" for a fall. To bridge this gap, a Balance Class was implemented in both a clinic and assisted living facility setting.

Results

More than 250 older adults have been evaluated. At least five people who were screened were individuals whose physician and/or family members believed that the individual needed care in a skilled nursing facility. Thanks to this strategy, the five individuals were not moved to a facility. Family members received further education and community and volunteer services increased. All combined, these five individuals have lived 43 months without a decline in their health. Based on FirstPlan claims data, the net health care dollars saved is $362,479.

The projected cost savings associated with participation in the Balance Class is between $4,592 to $20,762 per person, depending on the level of care that was required.

Next Steps

1. Identify and pursue a way to allow billing for the assessment and reimbursement for professionally supervised Balance/Fall Risk Reduction Classes.
2. Offer a comprehensive geriatric assessment as part of a care team as a model of care for adults, age 65 and over, to selected individuals.

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Health Management: Improving Care, Managing Costs

Overview

Medica's Health Management division helps ensure that Medica members receive the right care at the right time in the most efficient manner. Through multiple member-focused programs as well as provider-focused programs, the aim is the same: Promote appropriate, evidence-based care that results in efficient delivery of health care services.

Medica conducts health improvement activities for its members that involve the entire continuum of care, from wellness to population health to disease management to complex-care support. Overall, Medica Health Management focuses on clinical quality improvement as well as cost containment, with multiple programs and activities underway to help slow the rate of rising health care costs.

Strategy

Two key programs that exemplify this area's approach are the radiology management program, new in 2006-2007, and predictive modeling, which Medica conducted as a pilot in 2006 and is planning as a broader outreach program starting in 2008.

After initiating a voluntary pilot program in 2006, Medica launched its High-Tech Imaging Program in 2007 across its service area to ensure that evidence-based care is provided for Medica members at the point of service whenever CT, MRI and PET scans are requested. The program was intended to reduce inappropriate and unnecessary services, which amount to a wasteful cost for members and health plans, as well as to reduce harmful radiation for members.

In 2006, Medica conducted a pilot for managing high-risk members using predictive modeling, identifying gaps in care for members who may need additional care for certain health conditions, such as low-back pain, migraines, and mental health issues — all conditions which have serious health implications if left untreated. Members choose to enroll in the program and are actively participating.

Results

High-Tech Imaging: For the first three months the High-Tech Imaging Program was mandatory, there was a 10 percent reduction in utilization. Annualized, the program resulted in savings of approximately $8.4 million in 2007.

Predictive Modeling: Through targeted outreach that linked these nearly 800 identified members in the pilot with health coaches and involved the members setting specific goals for their health, Medica was able to reduce unneeded utilization and expenses by $3,756 per year for participants. When this program becomes fully implemented beginning in 2008, and Medica targets the top 5 percent of its membership for participation, this program could generate overall savings of $15.2 million based on expected participation.

Next Steps

Going forward, Medica will continue to focus on health improvement for its members while helping to reduce excess cost in the health care system.

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HealthPartners 10,000 Steps

Overview

The average American takes about 3,000 to 5,000 steps a day. About one in four Americans get almost no physical activity. Research shows that an average person who takes 10,000 steps daily can achieve the results of the 30 minutes of moderate-intensity physical activity that recommended by the Surgeon General to maintain health.

Strategy

HealthPartners 10,000 Steps program combines using a pedometer with an online motivational program that is based on techniques established in behavioral science. For example, it includes simple, yet continuous reminders to keep with the program. Participants receive daily e-mails that make it easy for walkers to click on a link to log their steps and learn way to increase steps. HealthPartners 10,000 Steps program was one of the first pedometer walking programs in the U.S. The program is open to everyone.

Results

Research shows that after eight weeks in the program, most participants increase their activity by about 3,000 steps or more a day. Nine out of 10 said they get there by adding steps in small increments throughout the day rather than scheduling a time for continuous exercise. In addition, a recent study found that the average walker lost an average of nearly seven pounds without changing his/her diet. After eight months, nine out of 10 who participated in the program said they now achieve the recommended level of physical activity on most days.

Next Steps

The program is now available internationally.

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Preventive Health: Taking care for the long run

Overview

Medica strives to improve and maintain member health. It does this through care management and disease management programs for acute and chronic care needs, but also through various preventive health programs, designed to actively engage members so that they take care of their health. Two Medica fitness programs — one for commercial members and one for seniors — have demonstrated that doing so pays big dividends in the long run. Another preventive health activity reminds members to see their doctor for routine checkups.

Strategy

The fitness program Fit Choices℠ by Medica is geared at Medica commercial members. In this program, members used LifeTime fitness clubs for exercise. The program involves a discounted club membership for using facilities at least eight times per month.

Through the SilverSneakers® fitness program for seniors, Medica Medicare members are encouraged to get active to improve their overall physical health; the program provides participating members with a free full membership to specific fitness clubs. This membership gives them access to all amenities of these facilities as well as exercise classes customized to the Medicare population.

Medica's three-year-old Checkup Checklist program uses personalized health reminders each year to target its members who need routine-health checkups, as determined by claims data. By doing so, Medica helps its members maintain their health by giving them an easy-to-use "snapshot" of preventive health needs. This focus on prevention helps patients get the care they need while helping to reduce long-term health care costs.

Results

Fit Choices: A study of the program showed that members who started a regular exercise routine had a significant 33.6 percent decrease in medical costs after just two years in the program. This translated into a reduction of $4.3 million in year two for participants compared to a control group.

SilverSneakers: This program has a measurable impact: Members who attended class an average of once per week generated a savings among participants of $441 each year on health expenditures. Those who attended class three or more times per week brought about a savings among participants of nearly $2,300 per year.

Checkup Checklist: Studies have indicated that, as a result of this work, 21.6 to 27.2 percent more Medica members received preventive exams than those not prompted by the customized reminders. The Checkup Checklists also result in increased numbers of members seeking needed immunizations and cancer screens.

Next Steps

Prevention is a key to minimizing significant health problems for patients. Medica is committed to helping its members achieve lasting good health.

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PreferredOne Web-Based Health Care Shopping Tools

Overview

As members pay out more of their own health care dollars for consumer-driven high deductible medical plans, the need for additional information and tools to help make wise spending decisions increases.

Strategy

PreferredOne offers Web-based tools that consumers can use for the following:

- Overall Cost Rankings For PreferredOne Hospitals – inpatient and outpatient, low to high
- Reprice My Claims – reprice existing claims with other PreferredOne providers
- Select And Compare Primary Care Clinic Costs – view a cost comparison for frequently performed service
- Imaging Providers – view cost comparisons for MRI, CT and PET/CT scans
- View Specific Costs For Providers – by clinic for common medical conditions, by hospital for common inpatient admission diagnoses and by hospital outpatient/surgical center for common outpatient procedures
- Ask A Physician A Medical Cost Question – submit medical cost questions to a PreferredOne physician
- Health Account Statement – create medical/dental/Rx claim history statement sorted by name and date.

Results

The website hosts 3,000 to 4,000 unique member visitors each month.

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Colorectal Cancer Screening

Overview

Colorectal cancer ranks second as a cause of cancer related deaths. Both men and women are equally at risk. The good news is that this cancer is very manageable if it is detected early.

Strategy

Metropolitan Health Plan's (MHP) work to improve colorectal cancer screening has been very successful in getting members to use fecal occult blood test kits at home and mail the results to their doctor. This gives the doctor a chance to "sell" a colonoscopy to the member or otherwise open a dialogue on the subject of this cancer. The project offers a Target gift card to those members who use the kit at home.

Results

In the three years of the project from 52 to 238 members per year responded to the offer. HEDIS rates improved by 11 to 20.2 percent.

Next Steps

MHP will transition this active project into the overall Total Member Care process, a process that focuses on using any member contact as a conduit for a comprehensive discussion of preventive care programs. Every member contact (as age appropriate) will include a reference to the colorectal cancer screening although the gift card incentive will sunset.

Contact

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Breast Cancer Screening

Overview

The National Cancer Institute (NCI) states that breast cancer is the second most prevalent form of cancer and the second leading cause of cancer deaths for American women. The NCI estimates that each year, more than 210,000 women in the United States learn that they have breast cancer and according to the American Cancer Society (ACS) it is estimated that 40,970 women will die from breast cancer in 2006.

Improvement in this clinical area was targeted because the topic reflects Metropolitan Health Plan's Medicaid population as to disease prevalence and the risks of disease.

Strategy

MHP set out to obtain and sustain a 5 percent absolute increase in the compliance rate for annual mammograms for female (Prepaid Medical Assistance Program) PMAP members between the ages of 40 and 64.

Results

Since implementing a targeted outreach program 225 women have been screened. Recently, MHP received a letter from a 64 year-old woman who hadn't had a mammogram in five years. She had received the informational breast cancer awareness packet and was inspired to schedule a mammogram.

Next Steps

MHP is in the middle of the quality improvement cycle on this project and will continue to contact the women in the appropriate age group to encourage their pledge to perform a monthly self-examination and to schedule a mammogram. MHP is also surveying the respondents to better understand the role of the gift incentive and the decision to obtain a mammogram.

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Pneumonia Vaccines

Overview

Metropolitan Health Plan (MHP) is promoting the pneumococcal vaccine to its senior population, recognizing that this simple one-time vaccine can protect members from severe illness and death.

Strategy

The project provides vaccination data to the Minnesota Senior Health Options care coordinators, and suggests various methods of ensuring that all of our MSHO members have received the pneumococcal vaccine. Also, all vaccination data are submitted into the state-wide immunization registry, for future reference and reporting needs.

Results

We have completed our first measurement year and are very pleased with the success of this project. MHP's measure went from a baseline rate of 18 to 34 percent. If we included the members who had a documented immunization but for which MHP did not receive a claim (such as those members who chose to pay for an immunization at a community event), the rate would be over 45 percent.

Next Steps

MHP is continuing to work with the Minnesota Visiting Nurses Association to immunize seniors and to send the immunization information to the Minnesota Immunization Improvement Collaborative.

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Improving Depression Care in the Nursing Home

Overview

The Minnesota Senior Health Options (MSHO) Depression project was a collaboration of three health plans, including Metropolitan Heath Plan (MHP), Medica and UCare. The goals were to increase the screening rate for depression among members who live in nursing homes, as well as increase the rate of follow-up clinical assessments within 60 days for positive screens.

Strategy

MHP worked with the MSHO care coordinators first by providing educational sessions on depression screening and tools for use in the nursing home. Then the care coordinators worked with the nursing homes to identify the unscreened patients and helped arrange for treatment for those members whose screening indicated the presence of depression. By teaming the care coordination process with the nursing home staff, there was an increased focus on the member's overall mental health and real improvement was demonstrated.

Results

The results showed the screening rate increased from 8 percent at baseline to 36 percent, 28 percent, and 41 percent for the subsequent implementation and re-measurement periods. The rate of clinical assessments following a positive screen also increased from 57 percent at baseline to subsequent measures of 71 percent, 71 percent, and 62 percent. In the conclusion of this project, approximately 83 percent of all members were screened for depression at least once in the nursing home, but not within 60 days.

Next Steps

Achieve a 100 percent screening rate and a follow-up plan with nursing homes and care coordinators.

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