



Michigan Association of Health Plans

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MAHP Pinnacle Awards recognize best health care improvement practices in Michigan

The Michigan Association of Health Plans has recognized 13 programs developed by seven health plans around the state for their outstanding contributions to increasing efficiency and patient care, helping lower costs and increase service to Michigan residents.

“The Pinnacle Awards are among the most important ways health plans can ensure best practices are recognized and adopted in our state. Michigan health plans are nationally recognized as leaders in quality and efficiency. Displaying these outstanding programs to all of our members ensures that Michigan residents get the best possible care at the lowest possible cost,” said Rick Murdock, executive director of the Michigan Association of Health Plans.

The awards were presented at a reception Sept. 29 at the Lansing Center in Lansing. Health Alliance Plan took home three awards; Priority Health and Midwest Health Plan each won two. Health plans submit important new programs to a MAHP judging panel that includes health care experts, lawmakers and the news media.

Full details on each winner are available at www.mahp.org. Below is a brief description of winning program.

Business/Operational Performance – Commercial: Grand Valley Health Plan for “Improving Member Access to Cost Information”: In today’s growing world of deductibles, co-payments, and increased patient cost sharing, Grand Valley Health Plan developed and implemented a plan to increase member satisfaction by ensuring they are presented with and have access to plan information and costs they may be responsible for.

Business/Operational Performance – Medicaid: Midwest Health Plan for “Green Light Go”: Midwest Health Plan initiated ‘Green Light Go!’ to improve member satisfaction with access to care and reduce the administrative burden of referrals. The goal was to streamline the health services authorization process by eliminating referral requirements for routine services within the Midwest network. A color-coded authorization grid was developed listing common procedures and the required plan authorization/ notification. Green services meant “Go!” requiring no referral or plan notification. Yellow services indicated “Proceed with caution” as some services might require plan notification. Red services meant “Stop” because they are not a benefit.

The plan realized a reduction in staff time in the health services and claims departments, and eliminated printing costs for referral forms. The program also reduced time for patients to receive services.

Clinical Service Improvement – Commercial: Priority Health for “Spine Centers of Excellence”: Spine surgery rates in West Michigan are higher than the national average for both commercial as well as Medicare populations. Surgery is not always superior to conservative care. When multidisciplinary spine centers are employed and when patients are fully informed of all the treatment options, surgery rates can be reduced without affecting patient outcomes.

Using this evidence, Priority Health developed its Spine Centers of Excellence. The program seeks to ensure patients understand all options when both surgical and nonsurgical treatment options are relevant. For cases in which surgery is clearly indicated, patients are not required to be seen in a spine center. In all other cases, patients are required to see a physiatrist. After consultation, the patient and referring physician can continue care with the rehabilitation physician or consult a surgeon.

Honorable mention: Priority Health for "Patient Centered Medical Home Pilot": The patient-centered medical home (PCMH) initiative is designed to transform primary care and make it more accessible, cost effective and patient-based. The Priority Health pilot demonstrated the value of specific attributes of the PCMH: access, care coordination and patient engagement. The emphasis is on primary disease management and improving quality for diabetic patients.

Initial indicators show the pilot practices performing better than the network on clinical and cost measures with approximately \$2 million dollars in savings in the first six months.

Clinical Service Improvement – Medicaid: Midwest Health Plan for "Caring for Culture – Caring for Women”: Midwest Health Plan initiated the Caring for Culture – Caring for Women project in 2007 to address low rates in a number of female health measures. With a culturally diverse membership, Midwest focused on reducing cultural and linguistic issues and barriers to improve rates. Midwest hired a dedicated nurse to send mailings, make courtesy calls to women and to enroll pregnant women in Rosebud, a program that assigns a nurse to work with patients. To reduce cultural barriers, MHP hired additional Arabic and Spanish speaking customer services representatives, and MHP also worked with providers in the Dearborn area to ensure the practices had female Arabic Medical Assistants (MA) and office staff.

Chronic Disease Management – Commercial: Health Alliance Plan for “Improving Antidepressant Medication Compliance”: Sixty-five to eighty percent of patients diagnosed with depression recover after careful compliance with antidepressant medication (ADM) protocols. To improve ADM compliance, Health Alliance Plan (HAP) developed a member-centric disease management program that promotes informed decision-making by members and physicians. Upon diagnosis of depression, HAP sends a customized letter to the member about the importance of adherence to the medication protocol and specific information about their prescription(s). Physicians receive similar information. HAP also transferred several ADM medications to its maintenance drug list. Now, more members have the option for a 90-day refill of their ADM, and members saw a 45 percent cost savings as a result. Using innovative computer software, HAP tracks medication refills and intervenes quickly when members do not

refill their medication. In 2008, HAP's ADM compliance rose 4.8 percent. Survey responses indicate a positive impact on work attendance and productivity.

Chronic Disease Management– Medicaid: Great Lakes Health Plan for "CardioCom Telehealth": In June 2008, Great Lakes Health Plan (GLHP) added the CardioCom Telescale[®] tool as a component to the newly designed Congestive Heart Failure (CHF) disease management program. This program combines a high tech Home Monitoring Device with experienced cardiac nurses for symptom management, weight monitoring and compliance to medication, diet and physician office visits. Proactive management of daily weight and symptoms can improve the member's quality of life and reduce hospitalizations. Each day, GLHP members use the CardioCom Telescale[®] at home to perform a daily Health Check. A Health Check consists of members answering a series of questions about their current symptoms and measuring their weight. The Telescale[®] is easy to use and is designed for individuals with limited mobility and low-level technical skills.

Care Management for Medicare Populations – Medicare Advantage: Health Alliance Plan for "HAP's In-Home Care Program": Patients suffering from complex chronic illnesses often receive heroic and futile end-of-life care although it is expensive with virtually no expectation of stopping the slide to worsening health and eventual death. HAP's In-Home Care Program (HIHCP) is an alternative for members who qualify for hospice but have chosen not to participate. This unique approach provides both curative and palliative health care services and helps enrollees gently transition to hospice if and when they feel they are ready. More than 700 members have enrolled. Early results show decreased hospital admissions, ER visits, and costs while increasing acceptance and transition to hospice.

Health Care Technology – Commercial: Physicians Health Plan of Mid-Michigan for "My Rx Choices Prescription Savings Program": The My Rx Choices prescription savings program is offered to help reduce the cost of members' prescription drugs by providing lower-cost alternatives. PHP members were informed with mailings, brochures, employee health fairs, employer group demonstrations and worksite videos. The intent of this program is to encourage use of maintenance medications by reducing out-of-pocket prescription costs. Exploring medication options empowers the patient to be an active participant in their health care. The program saved an estimated \$131,562 for 2008 and \$51,234 for the first half of 2009. A team approach is fostered by the health plan, employer, member and doctor working together to establish the most cost-effective medication regimen.

Health Care Technology – Medicaid: Health Plan of Michigan for "The Right Call at the Right Time": Medicaid Health Plans employ different methods to provide outreach and engage their members. Health Plan of Michigan (HPM) wanted to make sure that every interaction with a member was maximized to meet the goal of the member's call while providing a consistent preventive care message. HPM used the Touchstar autodialer system and integrated it with its managed care system. This provides the member with the "Right Call at the Right Time" every time regardless of the department they call.

Community Outreach/Partnerships (Single Plan): Health Alliance Plan for "Senior Splash & Mom's in Motion": Health Alliance Plan (HAP) launched a free water aerobics program at four Detroit recreation centers. Built around the proven health benefits of water aerobics, HAP's

Senior Splash Bash & Moms in Motion program was designed to: increase the number of aquatic educational opportunities available in Detroit; engage seniors and mothers to make positive life choices through aquatic activity; and increase the utilization of each site. The program has expanded to 18 sites in southeast Michigan, and has an average annual attendance of 2,640 adults. The program is providing new resources to struggling recreation programs while creating entirely new opportunities in some communities. In February 2009, Clinton Township reported a 400 percent increase in attendance by seniors during its HAP-sponsored sessions.

Collaborative Community Health Initiatives: Priority Health, United Way and First Steps Kent for “Children’s Healthcare Access Program Pilot”: Children using Medicaid have poorer health outcomes compared privately insured children. These outcomes include significantly higher hospitalization rates, more severe illnesses resulting in hospitalization, more visits to the emergency room and higher rates of respiratory illnesses such as asthma.

Priority Health partnered with First Steps Kent and United Way to form the Children’s Healthcare Access Program (CHAP) in May 2008. The project involves approximately 15,000 children in Kent County who are enrolled in Priority Health Medicaid. Priority Health, Helen DeVos Children’s Hospital, four community medical clinics, four private pediatric practices and numerous human service agencies. The program is taking a comprehensive approach to improving access to care to help children get the care and support they need to stay healthy.

Nursing Award: Karen Meyerson, MSN, RN, FNP-C, AE-C, Jan Roberts, RN, AE-C and Patti Bihn, RN, AE-C for “MATCH Asthma Case Management Program”: The nurse-led Michigan MATCH (Managing Asthma Through Case-management in Homes) program offers in-home asthma case management for children and adults with moderate to severe persistent asthma. The proportion of Michigan adults and children with asthma who have recommended routine asthma visits, asthma education, or have ever been given an action plan falls far below optimal levels. Less than half of children and adults used a long term control medication. For each indicator, the disparity between blacks and whites is significant. Michigan asthma hospitalization rates are significantly higher among black persons than whites. Most disturbing is the racial disparity in asthma mortality. Rates for blacks are three times the rates for whites.

The MATCH case management programs address many of the needs identified above. It is led by nurses (the majority of case managers are nurses), who work closely with health plan representatives to make sure clients and their families receive appropriate and adequate education.

In addition to performing leadership and case management roles, the nurses also market the program in their communities to encourage referrals, and have actively promoted the model in additional high asthma-burden Michigan communities as interest has arisen. Research shows case managed individuals experienced 60 percent fewer emergency room visits, 66 percent fewer hospitalizations, and a shorter length of stay, if hospitalized due to asthma.