

**Appendix 5: Current Performance Improvement Projects Summary**

# PIP NEWS

## 2012

### An Update for Professionals Working to Improve the Health of Patients Eligible for Public Programs in Minnesota

#### Participating Health Plans

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Plus)

HealthPartners

Medica

Metropolitan Health Plan (MHP)

UCare

#### Participating CBPs

Itasca Medical Care (IMCare)

PrimeWest Health (PrimeWest)

South Country Health Alliance (SCHA)

Stratis Health provides support and assistance to the health plans in developing, implementing, and evaluating the PIPs.

## Health Improvement Projects (PIPs)

The Minnesota health plans and county based purchasing plans (CBPs) launch a performance improvement project (PIP) each year to improve the health of the public programs members they serve.

The participating health plans and CBPs develop and promote the performance improvement projects to comply with state requirements and support care coordinators and providers in their efforts to provide quality care in the complex arena of care for people eligible for public programs. Health plans are required to initiate a new performance improvement project each year with a typical cycle of two to four years. The Minnesota health plans and CBPs (“the collaborative”) work together on the PIPs to align quality improvement efforts, provide consistent messages to providers, and collaborate to maximize impact. As such, some PIPs are completed as a collaborative effort across health plans.

This health plan collaborative performance improvement project (PIP) newsletter is designed to describe the current state public program PIPs and provide information about the PIPs that may be helpful for you in your work with public programs members.

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- ♦ Human Papillomavirus (HPV)
- ♦ Preventive Visits
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- ♦ Transitions in Care: Improved Post-Discharge Follow-Up Care
- ♦ Collaboration to Improve Quality of Life for Members with Asthma or COPD
- ♦ Cholesterol Screening Among Members with Diabetes
- ♦ Transitions of Care: Post-Discharge Member Follow-Up
- ♦ Improving Influenza Vaccination Rates
- ♦ Breast Cancer Screening

## Minnesota Public Programs

MinnesotaCare (MNCare)	A publicly subsidized program for residents who do not have access to affordable health care coverage that serves an average of more than 100,000 people each month. It has been critical to helping people leave welfare to work, without losing health care coverage.
Prepaid Medical Assistance Program (PMAP)	A health care program that pays for medical services for low-income families, children, pregnant women, and people who have disabilities in Minnesota. This includes coverage for hospital stays, physician services, rehabilitation services, and preventive care.
Special Needs Basic Care (SNBC)	For people under age 65 who are certified disabled and eligible for Medical Assistance. The program also incorporates Medicare Parts A, B, and D for enrollees who have that coverage. Enrollees have a care coordinator for health care and support services. This program is available in most counties and is administered by DHS and contracted health plans. Enrollees get personal care assistance and private duty nursing services through DHS (fee for service).
Minnesota SeniorCare Plus (MSC+)	For low income seniors ages 65 and older and is provided through the health plan of choice, including a separate plan for Medicare Part D drug coverage, if the person has Medicare. Enrolling in MSC+ is mandatory unless the person is enrolled in the optional Minnesota Senior Health Options (MSHO) program.
The Minnesota Senior Health Options (MSHO)	Combines separate health programs and support systems into one health care package. It is for people ages 65 and older eligible for Medical Assistance (MA) and enrolled in Medicare Parts A and B or who have MA only. People can choose to join MSHO or stay in their current MA program. MSHO enrollees are assigned a care coordinator who will help them get their health care and related support services.

## Collaborative PIPs: Current Implementation

Topic	Timeline*	Populations	Plans
Colorectal Cancer (CRC) Screening**	2011-2014	PMAP, MNCare	Blue Plus, HealthPartners, Medica, UCare
Transitions in Care: improved post-discharge member follow-up care	2011-2014	SNBC, MSHO, MSC+	Blue Plus, HealthPartners, Medica, Metropolitan Health Plan
Blood pressure control for members with diabetes	2010-2013	PMAP, MNCare, SNBC, MSHO, MSC+	Blue Plus, HealthPartners, Itasca Medical Care, Medica, Metropolitan Health Plan, PrimeWest Health, South Country Health Alliance, UCare

\*End date of implementation is estimated. If projects do not meet goals, implementation periods may be extended

\*\*UCare is also reaching the SNBC populations with the colorectal cancer (CRC) screening

In 2011, the collaborative completed projects on aspirin therapy in ischemic heart disease and diabetes mellitus, human papillomavirus (HPV) vaccination, and preventive visits for new members.

In 2011, the CBPs launched organization-specific PIPs targeting the following areas:

- PrimeWest: Post-hospitalization follow-up for (MSHO, MSC+, PMAP), and cholesterol screening for members with diabetes (SNBC)
- IMCare: Asthma and COPD management (all populations)
- SCHA: Breast Cancer Screening (MSHO, MSC+, PMAP), Pneumococcal vaccination (SNBC)

## Aspirin Therapy in Ischemic Heart Disease and Diabetes Mellitus

### Participating Health Plans/CBPs

Blue Plus, HealthPartners, Itasca Medical Care, Medica, Metropolitan Health Plan, PrimeWest Health, South Country Health Alliance, UCare

### Project Timeframe

2008 – 2011 (completed)

This PIP worked to promote awareness of the benefits of low-dose aspirin therapy in eligible MSHO/MSD+ members with a diagnosis of ischemic heart disease and/or diabetes mellitus. Prescriptions were tracked at the health plans through pharmacy claims allowing for measurement and monitoring of improvement. Project interventions included promoting communication between members and their care team regarding the use of aspirin therapy, as well as increasing awareness of Medicaid over-the-counter prescription benefits. Overall, the project promoted awareness of the use of clinical guidelines related to aspirin therapy.

### Findings

As a result of this PIP, providers changed documentation of over-the-counter aspirin prescriptions to improve patient safety. This work has been successful, as the final measurement represents a 15.84% increase over the baseline measurement of 25.93%, well exceeding the 5% improvement goal. As a result of these results, this PIP has now been successfully completed.

David Pautz, MD, FACP, Senior Medical Director, Government Programs, Blue Plus, applauds the success of the project and attributes it to the work of the care coordinators: "Working with care coordinators to encourage and empower patients to talk with their health care provider about the health benefits of aspirin therapy and increasing awareness of over-the-counter benefits for aspirin helped ensure the success of this PIP."

### What Can You Do?

*Care coordinators:* Continue to encourage conversations between patients and providers around low dose aspirin therapy.

*Providers:* Continue to prescribe low dose aspirin when appropriate to your patients.

**For more information about this project, contact: Alisha Ellwood, [alisha\\_ellwood@bluecrossmn.com](mailto:alisha_ellwood@bluecrossmn.com).**

## Human Papillomavirus (HPV)

### Participating Health Plans/CBPs

Blue Plus, HealthPartners, Itasca Medical Care, Medica, Metropolitan Health Plan, PrimeWest Health, South Country Health Alliance, UCare

### Project Timeframe

2008 - 2010 (completed)

The overall project goal was to increase the rate of 11-12 year old females enrolled in PMAP or MNCare who received at least one administered dose of the HPV vaccine. Interventions included targeted materials to parents and guardians, as well as partnerships with physicians, clinics, and other key organizations to increase the awareness of the importance of HPV vaccination in the prevention of cervical cancer.

### Findings to Date

The project exceeded its 5% improvement goal, moving the baseline rate from 23.84% to 32.60%. As a result, this PIP has now been successfully completed. The collaborative has integrated the successful interventions into regular business practices to sustain the improvements made.

### What Can You Do?

*Providers:* Continue to encourage appropriate adolescents to receive the HPV vaccination.

Educational resources are available to download at: <http://www.stratishealth.org/pip/hpv.html>.

For more information about this project, contact: Bethany Krafthefer, [bethany.krafthefer@primewest.org](mailto:bethany.krafthefer@primewest.org).

## Preventive Visits for New Members

### Participating CBPs (collaborative 1)

Itasca Medical Care, PrimeWest, South Country Health Alliance

### Participating Health Plans (collaborative 2)

HealthPartners, Medica, Metropolitan Health Plan, UCare

### Project Timeframe

2009 - 2011 (completed)

Two collaborative groups have been working on increasing the percentage of new members enrolled in MSHO, MSC+, PMAP, MNCare, or SNBC who receive a preventive visit within six months of enrollment.

Collaborative 1 has worked to promote member awareness through providing education and tools to providers and members on the benefits of receiving preventive visits. Clinics have been given information on appropriate coding for preventive visits. The collaborative has also been working to help improve communication between the health care team and members about the importance of a preventive visit. Additionally, the collaborative has provided assistance to members to overcome barriers to receiving a preventive visit, including providing an incentive for those members who complete a preventive visit.

Collaborative 2 has worked to promote the benefits of preventive care to new members through direct education and collaboration with providers, reinforcing the visit can serve to establish and maintain a relationship between the member and their care team.

### Findings

The project has resulted in a small increase in preventive visits for new members according to the measurement criteria for the PIP. Additional data review by the teams indicates that many new members are accessing a primary care physician in the first six months of enrollment. However, coding practices may not reflect the visit included preventive information, or the member was 'new' as they may not have changed providers when they joined a new plan. Additional information to help improve coding of preventive visits and lessons learned through the PIP have been shared with the Department of Human Services and providers. The PIP has now been completed for both collaborative teams.

### What Can You Do?

**Care Coordinators:** Work with members to determine if they are due for a preventive visit. Member materials have been created to assist in having these conversations: <http://www.stratishealth.org/pip/preventive-care.html>

**Providers:** Encourage and provide comprehensive preventative visits for members. Monitor coding to ensure these visits are indicated as preventive when appropriate.

For more information about this project, contact: Bethany Krafthefer, [bethany.krafthefer@primewest.org](mailto:bethany.krafthefer@primewest.org), or Tamara Sippl, [tsippl@ucare.org](mailto:tsippl@ucare.org).

## Blood Pressure Control for Members with Diabetes

### Participating CBPs (collaborative 1)

Itasca Medical Care, PrimeWest, South Country Health Alliance

### Participating Health Plans (collaborative 2)

Blue Plus, HealthPartners, Medica, Metropolitan Health Plan, UCare

### Project Timeframe

2010 - 2013

Two collaborative groups continue to work on improving blood pressure control for members with diabetes enrolled in MSHO, MSC+, PMAP, MNCare, and SNBC. Both are working to increase the proportion of members with diabetes who have blood pressure in control as measured by the Healthcare Effectiveness Data and Information Set (HEDIS) Comprehensive Diabetes Care (CDC) <140/90 mmHg blood pressure measure.

The primary intervention strategy for collaborative 1 is a curriculum designed for members to promote learning by repetition, active participation, and interactive resources for questions or concerns. Members are also encouraged to have discussions with primary care providers. The topics are tailored to meet the unique needs of each population, with all materials emphasizing three key messages:

- Develop a blood pressure management plan with primary care provider
- Establish a blood pressure goal for each member
- Promote self monitoring of blood pressure at home or in the community

Each CBP has established a partnership with a champion clinic, nursing home, and SNBC support organization, taking a systematic approach toward managing blood pressure in patients with diabetes. The partnerships encourage individualized self-management approaches that empower patients. Effective strategies learned through these partnerships will be shared with providers in the CBP networks.

Interventions implemented by collaborative 2 include a variety of member, provider, and care coordinator outreach, including: two member postcards on self monitoring of blood pressure and questions to ask their doctor, member and provider letters encouraging enrollment in health plan medication therapy management programs, provider internet-based training series on four areas of hypertension management, and quality improvement initiatives with health plan partner clinics.

### Findings to Date

Members participating in the collaborative 1 PIP were mailed a survey at the beginning of the project and again after the first year of interventions to gather information regarding blood pressure management knowledge and practices. There was an increase in both the number of members who reported having a conversation with their primary care provider

about blood pressure management and who had established a blood pressure goal. The number of members who report having a blood pressure goal increased by nearly 6% compared to baseline. More members also reported they monitor their blood pressure at home and most indicated they check their blood pressure themselves, although a growing number receive assistance from a family member. Educational materials reminded members of the various types of locations in the community that typically have blood pressure machines available for public use. The number of members reporting they knew where to could go in their own community to check their blood pressure increased by about 5%.

The first measurement period data from collaborative 2 shows an increase in the rate of members with controlled blood pressure. Data from the quality improvement initiatives with the collaborative 2 health plan partner clinics significantly improved in 2010.

### What Can You Do?

**Care Coordinators:** Encourage members to set and monitor progress toward blood pressure management goals.

**Providers:** Encourage development and monitoring of blood pressure goals with all members as appropriate. Providers can refer patients to health plan disease management programs at any time for additional support and education. As part of their benefit coverage, most members can get a home blood pressure monitor through a prescription from their provider; most pharmacies and contracted medical equipment suppliers can dispense any brand or model that is certified for accuracy and best meets the needs of the patient.

**For more information about this project, contact: Alice Laine (collaborative 1), [ALaine@mnscha.org](mailto:ALaine@mnscha.org), or Sally Irrgang (collaborative 2), [sally.irrgang@medica.com](mailto:sally.irrgang@medica.com).**

## Colorectal Cancer Screening

### Participating Health Plans

Blue Plus, Medica, HealthPartners, UCare

### Project Timeframe

2011-2014

The goal of this PIP is to increase the colorectal cancer (CRC) screening rates of members enrolled in PMAP and MNCare at partner clinics by a relative improvement rate (RIR) of 15%. Each health plan is partnering with at least one clinic to promote awareness of CRC screening and improve clinic processes around CRC screening and tracking.

Interventions are specifically focused on the specific needs of the PMAP/MN Care population. Examples of improved clinic processes to improve rates in this population include outreach calls for patients overdue for screenings who had previously scheduled and cancelled. The health plans provide tools to promote CRC screening to patients from diverse backgrounds and are working to understand the role of interpretive services in CRC screening and availability of interpreters at specialty clinics because many CRC screens are completed at a site other than the primary care clinic. Interventions also include providing support for process improvement and technical assistance in the clinic, as well as training clinic staff to better understand and use the current CRC guidelines. Through this work, providers are annually tracking their overall and PMAP/MNCare CRC screening rates (e.g., discrete data collection in the EHR).

### Findings to Date

The measure for this PIP is aligned with MN Community Measurement CRC measure specifications focusing on the PMAP/MNCare subset. All partner clinics reported baseline rates in the fall of 2011.

**What Can You Do?**

*Care Coordinators:* Educate members about the different CRC screening options. Encourage members to have conversations with their providers about the best options for screening.

*Providers:* Know your clinic's CRC screening rate. Look at your process to clarify how you are tracking on every patient regarding whether they've had a CRC screening completed. Develop processes to ensure your clinic/practitioners address the need for CRC screening with every patient.

For more information about this project, contact: Melissa Deuschle, [mdeuschle@ucare.org](mailto:mdeuschle@ucare.org).

## Transitions in Care: Improved Post-Discharge Follow-Up Care

**Participating Health Plans**

Blue Plus, HealthPartners, Medica, Metropolitan Health Plan

**Project Timeframe**

2011 - 2014

This project works to increase the proportion of MSHO, MSC+, and SNBC members who complete a scheduled follow-up clinic appointment after hospital discharge. Success will be measured through claims that show a follow-up visit within 15 days of medical/surgical hospital discharge to home. The goal is to see a 14% relative improvement rate increase over baseline.

Each of the four participating health plans has partnered with a hospital and provider group to test interventions that encourage members to schedule and attend a follow-up clinic appointment after being discharged from the hospital. Interventions with the hospitals include reviewing and revising current processes, procedures, and tools around discharge planning, and improving provider engagement and ownership of the transition from the hospital to home.

**Findings to Date**

Hospital/clinic teams have reported on various evaluation metrics, member transition surveys have been administered, and initial lessons learned have been summarized. Initial feedback has been positive. The first measurement period timeframe (4/2011 - 3/2012) will be collected in spring 2012.

**What Can You Do?**

*Care Coordinators:* Work with members (MSHO, MSC+, SNBC) to ensure members schedule and attend their post-discharge follow-up appointment within 15 days of hospital discharge.

*Providers:* Follow transition and discharge processes to ensure follow-up clinic appointments are scheduled, that members receive adequate discharge instructions, and that necessary steps are taken to promote continuity and quality of care post-hospital discharge.

For more information about this project, contact: Barbara Post, [barbara.post@co.hennepin.mn.us](mailto:barbara.post@co.hennepin.mn.us)



## Collaboration to Improve the Quality of Life for Members with Asthma or COPD

### Participating Health Plans/CBPs:

Itasca Medical Care

### Project Timeframe:

2011 - 2013

For this PIP, IMCare is collaborating with Grand Itasca Clinic & Hospital (GICH) to improve the quality of life of members with asthma/COPD. The study population includes the entire eligible MA/MSHO community population, ages 5 years and older. IMCare sent out a pre & post survey of all asthma & COPD members regarding their quality of life, and provided member education about symptom recognition, symptom control and self-management skills to help improve their quality of life. IMCare has also implemented and taught Pfizer's Beat the Pack smoking cessation program. IMCare has worked with the GICH quality department to send providers report cards of their members that meet defined criteria semi-annually. The goal of this PIP is to increase the percentage improvement in the total combined score of the symptom areas and self-management areas which contribute to the quality of life of our members with asthma/COPD, this is measured by the IMCare Asthma/COPD Quality of Life Member Survey.

### Findings to Date

This PIP was initiated in January 2011. The Quality of Life survey will be resent to members in early 2012 to evaluate impact of the initiative.

### What Can You Do?

*Care coordinators and providers:* Comprehensive high-quality care for those with asthma/COPD requires a collaborative effort. IMCare encourages our collaborative partners to discuss this project with IMCare members with asthma/COPD for whom they provide services; refer members to the smoking cessation program and disease management/case management programs as necessary.

For more information about this project, contact: Leah Huso, [leah.huso@co.itasca.mn.us](mailto:leah.huso@co.itasca.mn.us).

## Cholesterol Screening Among Members with Diabetes

### Participating CBP

PrimeWest

### Project Timeframe

2011 - 2013

The purpose of this PIP is to increase the number of SNBC members ages 18-75 with diabetes who receive a low density lipoprotein-cholesterol (LDL-C), or "bad" cholesterol screening annually. The project will be considered successful when the HEDIS CDC rate for LDL-C screening reaches 85% or above and is sustained for two measurement periods.

Quarterly lists of members who have not received cholesterol screening ("risk lists") are emailed to County Case Managers to track cholesterol screening progress. To better understand issues of health care literacy, PrimeWest and its county case managers/care coordinators will focus on effective communication with members when sending reminders and during

face-to-face visits. PrimeWest communicates the project plan with providers that are secondarily involved, e.g., group homes, primary care provider clinics, care givers, etc. Reminders are sent to the primary care providers of the SNBC members in need of a cholesterol screening in efforts to have reminders placed into member charts.

### **Success/Findings to Date**

Measurement period 1 rates will be available in July 2012.

### **What Can You Do?**

*Providers and Coordinators:* Ensure all members with diabetes receive an annual LDL-C screening.

For more information about this project, contact: Bethany Krafthefer, [bethany.krafthefer@primewest.org](mailto:bethany.krafthefer@primewest.org)

## **Transitions of Care: Post-Discharge Member Follow-up**

### **Participating CBP**

PrimeWest

### **Project Timeframe**

2011 - 2013

The purpose of this PIP is to facilitate coordination and information sharing with contracted focus hospitals to impact the outcomes of discharge planning for members, and to ultimately reduce readmissions. The project will be considered successful when the 30 day readmission rate for PrimeWest Health members discharged reaches a relative decrease of 10.8% from baseline and is sustained for two measurement periods in each population.

The main strategy of this project is to work closely with three focus hospitals to facilitate communication of the discharge date and discharge plan to PrimeWest, ideally to be provided within one day of a member being discharged from the hospital. A second strategy will be to use this information to reach out to members by making personal connections via phone call to let them know that support is available.

Interventions include evaluation of the focus hospital's existing discharge forms and communication practices. Discharged members receive timely follow-up communication related to the discharge plan. Understanding issues of health literacy, PrimeWest and its County Case Managers will focus on effective communication with members. The project plan and the related interventions are shared with those secondarily involved (pharmacies, PCP clinics, care givers, etc.). PrimeWest is tracking discharge and follow-up activities.

### **Findings to Date**

Initial findings indicate that, overall, members are extremely surprised and pleased a PrimeWest nurse took time to call them to see how they were doing. Findings show the majority of members understood their discharge instructions and received a copy of these instructions. Members also scheduled and went to their follow-up visit.

PrimeWest has found there are challenges to receiving a discharge date and legible discharge instructions in a timely manner from the focus hospitals.

### **What Can You Do?**

*Care Coordinators:* Work with members to ensure they received and understand their discharge instructions, and that they've scheduled and attended their follow-up visits.

**Providers:** Support the project by giving health plans timely notification of hospital discharges and giving members clear and understandable discharge instructions that include pertinent information such as:

- Hospital course and treatment
- Discharge medications
- Completed test results
- Pending test results
- Follow-up plans

For more information about this project, contact: Bethany Krafthefer, [bethany.krafthefer@primewest.org](mailto:bethany.krafthefer@primewest.org).

## Improving Influenza Vaccination Rates

### Participating Health Plans

South Country Health Alliance

### Project Timeframe

2011 - 2013

The goal of this project is to increase the number of SNBC members who receive an annual influenza shot.

Interventions are based on the Community Guide for Preventive Services, a model designed to provide population-based interventions to improve targeted vaccination coverage among these high-risk adults. Over the course of the flu season (September through March), all members—referred to as AbilityCare members—will receive up to two educational mailings about the importance of getting a flu shot, along with information about benefit coverage and how to obtain it. Members who don't get a flu shot after the two mailings will receive a follow-up phone call as a reminder, along with assistance for locating a flu shot clinic, scheduling an appointment, or arranging transportation.

All AbilityCare members will also be asked to complete a survey that identifies specific factors that influenced their decision to get the shot or not be immunized. Information gathered through this survey will be used for future intervention strategies and to refresh key messages.

### Findings to Date

This PIP was initiated in August 2011, before the start of the 2011-2012 flu season. Process measures assessing the impact of specific interventions, as well as a review of claims data and calculation of the outcome measure, will be completed during 2nd Quarter 2012.

### What Can You Do?

**Care Coordinators and Providers:** Both Care Coordinators and providers can help to promote flu shot clinics—including those hosted by public health departments—to clients/patients when possible and as appropriate. The flu shot is a covered benefit for SCHA members

For assistance finding a flu shot clinic or scheduling an appointment, members can contact SCHA's Member Services line toll-free at 1-866-567-7242 (TTY: 711) or visit MDH's "Find a Flu Shot Clinic" page:

[http://www.health.state.mn.us/cgi-bin/idepc/fluschedule/fluclinic\\_search.cgi](http://www.health.state.mn.us/cgi-bin/idepc/fluschedule/fluclinic_search.cgi).

## Breast Cancer Screening

### Participating CBP

South Country Health Alliance

### Project Timeframe

2011 - 2013

The goal of project is to increase the proportion of SCHA's PMAP/MNCare, MSHO, and MSC+ members who receive a mammogram.

SCHA is taking a multi-faceted approach to improving compliance with mammography screening guidelines among women ages 42-69 years. As part of this PIP, eligible members are sent educational materials about the importance of breast cancer screenings, along with reminders to schedule a mammogram as they become due for the screening. Women who remain non-compliant are contacted via telephone and encouraged to complete the screening. SCHA also offers a reward to women who have a mammogram and return a voucher signed by a clinician. As part of SCHA's partnership with local public health departments, "risk lists" of members due for a mammogram are distributed to public health staff to provide additional outreach to women, including assistance with scheduling or transportation, as necessary. A survey of eligible SCHA members will also be employed to identify specific factors that either influenced the member to receive a mammogram or factors contributing to their lack of screening.

### Findings to Date

This PIP was initiated in January 2011 and follows HEDIS measurement timelines. Process measures assessing the impact of specific interventions, as well as a review of claims data and calculation of the outcome measure, will be completed during 3rd Quarter 2012.

*Providers and Coordinators:* Support women who are appropriate for mammography to schedule and follow through with screening.

**For more information on this project, contact: Alice Laine, [alaine@mnscha.org](mailto:alaine@mnscha.org).**

## 2012 PIPs

A variety of projects are planned for launch in 2012. A brief summary of the 2012 PIP projects is outlined below.

Topic	Health Plan(s)	Population	Contact	
Reducing Non-Urgent Emergency Department Use in the PMAP/ MNCare Populations: A Partnership with the Minnesota Head Start Association	Blue Plus, HealthPartners, Medica, UCare	PMAP, MNCare	Alisha Ellwood	<a href="mailto:alisha_ellwood@bluecrossmn.com">alisha_ellwood@bluecrossmn.com</a>
Increasing use of Spirometry Testing for the Diagnosis of COPD in the MSHO/MS C+/ SNBC Populations	Blue Plus, HealthPartners, Medica	MSHO, MS C+, SNBC	Anne Wolf	<a href="mailto:Anne.e.wolf@healthpartners.com">Anne.e.wolf@healthpartners.com</a>
Increasing Annual Preventive and Diagnostic Dental Services	Metropolitan Health Plan	MSHO, MS C+, SNBC	Monica Simmer	<a href="mailto:Monica.Simmer@co.hennepin.mn.us">Monica.Simmer@co.hennepin.mn.us</a>
Breast Cancer Screening	UCare	MSHO, MS C+, SNBC	Lindsay Kohn	<a href="mailto:lkohn@ucare.org">lkohn@ucare.org</a>
Colorectal Cancer Screening	Itasca Medical Care, PrimeWest Health, South Country Health Alliance	PMAP, MNCare, MSHO, MS C+, SNBC	Bethany Krafthefer	<a href="mailto:bethany.krafthefer@primewest.org">bethany.krafthefer@primewest.org</a>

## Questions

If you have additional questions regarding any of the initiatives, or would like to suggest topics for future newsletters, please feel free to contact the individuals listed under Plan Contacts. Thank you for all you do to improve quality of care for public programs members.

For more on the PIP work, please visit: <http://www.stratishealth.org/providers/healthplanpips.html>.

## Plan Contacts

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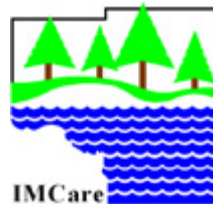
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