

**MSHO/MSD+/SNBC Community & Institutionalized  
Care Coordinator Training:  
Blood Pressure Control for Members with Diabetes  
2010 Performance Improvement Project (PIP)**



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# Agenda

## ■ Part I:

- Introduction
- Keynote Clinical Presentation Dr. O'Connor
- Questions for Dr. O'Connor

## ■ Part II:

- Target Goal by Population
- Project Interventions
- Care Coordinator Expectations
- Care Coordinator Resources
- Questions for Collaborative



# Introduction

## ■ PIP Collaborative Partners

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

## ■ Project Purpose

- Improve blood pressure control in members 18 and older who have diabetes

## ■ Primary Measure

- Increase proportion of members ages 18 through 75 with diabetes below 130/80 mmHg, as measured through annual HEDIS audit.

## ■ Study Populations

- Community & Institutionalized MHSO/MSO+
- Community & Institutionalized SNBC



## Keynote Presentation

### Welcome



Dr. Patrick O'Connor

Senior Investigator,

Health Partners Research Foundation

[http://www.hprf.org/investigators/O'Connor\\_Patrick.html](http://www.hprf.org/investigators/O'Connor_Patrick.html)



## Questions for Dr. O'Connor





## Target Goal by Population

- **MSHO/MSC+ Population:**
  - Increase in percentage of eligible members who attain a blood pressure below 130/80 mmHg by an absolute 4 percentage points above baseline
  
- **SNBC Population:**
  - To be determined based upon reportable 2009 HEDIS data results



## Project Interventions

### ■ Member

- Blood Pressure (BP) self-monitoring cut-off card via direct mail
- Medication management cut-off card via direct mail
- Medication Therapy Management (MTM) services informational letter

### ■ Practitioner and Clinic

- Practitioner Training Series – Set of Three
- Quality Improvement (QI) Toolkit for all clinics
- Customized QI Projects with a subset of clinics



# Project Interventions

- **Long Term Care (LTC) Facility Staff**
  - PowerPoint slide set and toolkit provided (each facility encouraged to hold own in-service)
  - Instructions provided for viewing online Practitioner Training Series
- **Care Coordinator**
  - Training session
  - Resources:
    1. Toolkit
    2. Biannual BP Medication Management Risk List
    3. Translated materials



# Community Care Coordinator Expectations

## If Member Has Diabetes

- **Make “Diabetes” a red flag**
- **Use toolkit talking points:**
  - Discuss the Importance of blood pressure control in diabetes
  - Ask member if they know their most recent blood pressure reading
  - Talk about the blood pressure postcard and encourage member to track their blood pressures
  - Help member identify opportunities for blood pressure checks
  - Tell member to share their blood pressure readings with their practitioner and discuss a blood pressure goal.
  - Encourage member to eat healthy, be active, and to always take their medicines as prescribed.



## Community Care Coordinator Expectations

### **If Member has Diabetes and Hypertension, refer to talking points:**

- Remind member that symptoms of high blood pressure are often silent.
- Encourage member to take questions about their blood pressure readings and medicines to next practitioner appointment.
- Encourage member to discuss self-monitoring with their practitioner.
- Assist member in obtaining a home blood pressure monitor if prescribed by practitioner.
- Encourage members to enroll in Medication Therapy Management (MTM) and/or Disease Management programs offered by the health plan.
- Stress the importance of always taking blood pressure medicines as prescribed.
- Be sure to document your involvement in case notes.



# Community Care Coordinator Expectations

## If Member is on RISK LIST for Potential Noncompliance

- Understand that health plan pharmacy records indicate blood pressure prescriptions have not been filled as anticipated.
- Discuss the following talking points (see Toolkit):
  - Ask member if they have problems getting or taking medicines.
  - Recognize need for prompt follow-up if member is out of medicines or unsure of prescriptions. Encourage member to contact practitioner.
  - Encourage member to enroll in Medication Therapy Management (MTM) and/or Disease Management programs offered by the health plan.
  - Remind member - pharmacist can answer questions about their medicines.
  - Stress the importance of regular blood pressure checks.
  - If member forgets to take their medicines, share tips for remembering.
- Notify practitioner of member's potential noncompliance (see Toolkit).
- Be sure to document your involvement in case notes.



## LTC Care Coordinator Expectations

The responsibilities of LTC care coordinators may differ, with varying degree of staff and member interaction. We ask you to enhance the efforts of this project within the scope of your current role:

- Remember that high blood pressure is a major risk factor for complications in a member with diabetes.
- Be aware that diabetes blood pressure goal is <130/80 for members through age 75. Share that information whenever appropriate.
- If member >age 75, BP goal may vary. Recognize that blood pressure guidelines/standing orders should exist for these residents.
- If you have questions or concerns about BP control for residents with diabetes, share those with LTC staff. You can mention this training as the impetus for your discussion.
- Encourage LTC staff to participate in upcoming presentations on the importance of blood pressure control for residents with diabetes.



## Care Coordinator Resources

- **Care Coordinator Toolkit**
  - Provided at training
- **Member Mailings**
  - Example postcards sent to Care Coordinator by health plan at time of dissemination
- **MTM Communication**
  - Example letter sent to Care Coordinator by health plan at time of dissemination
- **Translated Materials**
  - Distributed at time of completion



## Questions for Health Plan Collaborative





# THANK YOU!

- **Evaluation**—complete here:  
<http://quest.cvent.com/v.aspx?1A%2cQ3%2cf6198a6d-e7db-45de-a3d5-d0bdce7a73b0>
- CEUs can be printed off at the completion of the evaluation.
- Contact your health plan representatives with questions or comments.

*Thank you — Your work helps ensure  
PIP success!*



# PIP Health Plan Representatives

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