Building a Partnership with Health Plans: The Minneapolis and St. Paul Controlling Asthma in American Cities Experience

Jill Heins-Nesvold, Angeline Carlson, and Janny Brust

INTRODUCTION

Coordination and cooperation among multiple health plans serving a metropolitan area can support the overall provision of key services and enhance individual health plan efforts beyond what each health plan could accomplish alone. Such cooperation often addresses disease surveillance, and feedback for physicians or public health campaigns—for example, promoting immunization.^{1,2} Asking health plans to examine or change their policies when working on public health projects appears less common. This case study describes collaboration between a community-based asthma coalition and the health plans providing coverage for children in Minneapolis and St. Paul, Minnesota.

METHODS

In October 2001, the Minneapolis and St. Paul Controlling Asthma in American Cities Project (CAACP), which is administered by the American Lung Association of Minnesota, received a 2-year Centers for Disease Control and Prevention (CDC) strategic planning grant to develop a comprehensive public health approach to improve outcomes for children with asthma in Minneapolis and St. Paul. A diverse coalition representing community, public health, and healthcare professionals; social service agencies; schools; policy leaders; and Minnesota-based health plans developed a community asthma action plan, which CDC then funded with a 5-year implementation grant.

Health plans partnered with the CAACP on three levels. A representative from the Minnesota Council of Health Plans³ (MCHP), the trade association of Minnesota's health plans, participated in the planning process and also served as a co-principal investigator, co-chair of the leadership team and co-chair of 3 workgroups. All health plans in the state contributed in creating an inventory of asthma-related services. In addition, 13 representatives from the 4 largest health plans in the Minnesota and St. Paul metro area participated in strategic planning and implementation workgroups or served on the project leadership team.

Heins-Nesvold is with the American Lung Association of Minnesota, St. Paul, MN, USA; Carlson is with the Data Intelligence, St. Paul, MN, USA; Brust is with the Minnesota Council of Health Plans, St. Paul, MN, USA.

Correspondence: Jill Heins-Nesvold, American Lung Association of Minnesota, St. Paul, MN, USA. (E-mail: Jill.heins@alamn.org)

Recruitment and Participation

Health plan participation was obtained through a formal commitment by the MCHP to be an active partner in planning and implementation of the CAACP. Individual and organizational members of the coalition also built on existing relationships to engage health plan administrators. Of the 7 health plans serving residents within the Minneapolis and St. Paul city limits (the target area of the CAACP), 4 participated actively in the coalition. They represent 85% of the market share in the area, 498,506 out of the area's 584,735 residents.⁴ Two of the 4 health plans, Metropolitan Health Care and UCare, are 100% publicly subsidized programs. The other 2 health plans, Medica and HealthPartners, have a combination of publicly funded and commercial products.

Collaborative Activities and Products

CAACP's initial baseline assessment of asthma-related resources and needs in the project area indicated that information about asthma-related healthcare benefits offered by Minnesota-based health plans was unclear. The assessment found that physicians needed help navigating coverage for asthma medications, services, and devices. Consequently, during the first year of implementation, the CAACP commissioned an inventory of health plan pharmacy benefits for children enrolled in commercial (privately insured, self-insured) and publicly subsidized programs (Prepaid Medical Assistance Program, General Assistance Medical Care, MinnesotaCare). Coalition members representing the MCHP on the Community Health Committee identified contacts for each of the 7 plans serving the metropolitan area. All plans in the state participated in a telephone-based survey conducted by a CAACP external evaluator.

In preparation for the telephone survey, health plan contacts received a draft grid containing available information on pharmacy benefits for children with asthma for all plans. In this way, health plan contacts had the opportunity to verify their own plan's information and review the policies and procedures of other health plans. They were asked to confirm or correct information, which included their policy and mechanism for providing reimbursement for spacers, peak-flow meters and nebulizers, and their policy for providing extra inhalers to be kept at school. CAACP distributed the final grid to area clinics and pharmacies. The corrected grid helped healthcare providers avoid making numerous phone calls to reach the appropriate person for accurate information about benefits, billing issues, and special authorizations for services.

RESULTS

CAACP developed positive, productive partnerships between a community coalition and the health plans in Minnesota and among the health plans themselves. Through these partnership activities, the health plans connected with the community and collaborated with 60 community organizations around a specific disease need, in this case asthma, in new ways. In addition, through participation in the CAACP coalition, health plans satisfied a Minnesota legal mandate that requires nonprofit health plans to develop and submit to the Minnesota Departments of Health and Human Services a public health collaboration plan every 4 years.

Some of the collaboration's other outcomes include the following:

- Four plans simplified their procedures for obtaining asthma devices and services.

- One plan funded the development and printing of clinical education materials.
- One plan provided funding for 6 healthcare clinics to participate in an initiative to improve the organization, flow and quality of services for children with asthma.
- One plan's analysis of its administrative data identified healthcare providers and clinics most in need of quality improvement.
- Two plans contracted with and paid local school districts to provide, through their school health offices, disease management services for students who had been seen in the emergency department for asthma.
- Two plans funded community-based asthma education classes for minority (African American, Hispanic, Hmong, and Somali) parents.
- Two plans disseminated information about CAACP through their newsletters and websites.

Eighteen months after funding ended, 3 of the 4 health plans continued to collaborate with the ongoing coalition. Staff changes within the fourth health plan restricted participation, which might resume when the position is filled. The pharmacy benefits grid has been updated 3 times, most recently in December 2009.

DISCUSSION

Minnesota's health plans are required by law to be nonprofit and to provide a written collaboration plan every 4 years, detailing how they will meet identified public health objectives.⁵ While Minnesota is the only state with this requirement, health insurers in other states also work to further common public health goals. For example, America's Health Insurance Plans, a national association representing nearly 1,300 member insurance companies, provides programs and collaboration tools to promote tobacco cessation, obesity prevention, and immunization.⁶ The Minnesota collaboration can serve as a model to encourage similar participation by other health insurers and their states.

Health plan involvement in the health coalition from the initial planning stages, as members of working groups and management teams, benefited all Minneapolis/St. Paul CAACP participants. The collaboration connected working groups and management teams to those who knew about available health insurance coverage, dispelled myths about such coverage, and gave health plans feedback on those aspects of their policies and procedures that health providers and plan participants found challenging and which the health plans could then modify. CAACP's successful collaboration with health plans provides a template for other community organizations seeking to engage health plans in their work. The pharmacy coverage summary is available on the MCHP website (www.mnhealthplans.org/tools/pharmacy_coverage.cfm).

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DISCLAIMER

The findings and conclusions in this manuscript are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention.

REFERENCES

1. Burwen DR, Sylvester CC, Patow CA. Developing a community health promotion agenda for a managed care organization. *Health Promot Pract.* 2006; 7(1): 86–94.
2. Mays GP, Halverson PK, Stevens R. The contributions of managed care plans to public health practice: evidence from the nation's largest local health departments. *Public Health Rep.* 2001; 116(Suppl 1): 50–67.
3. Minnesota Council of Health Plans. *Minnesota Council of Health Plans*; 2010. Available at: http://www.mnhealthplans.org/about/council_facts.cfm. Accessed January 28, 2010.
4. MDH Health Economics Program analysis of HMO annual reports, 2008. *Minnesota Department of Health*; 2010. Available at: <http://www.health.state.mn.us/divs/hpsc/hep/chartbook/section7.ppt>. Accessed January 25, 2010.
5. Minnesota Health Information Clearinghouse: Action Plans and Collaboration Plans. *Minnesota Department of Health* 2010. Available at: <http://h1n1resource.net/clearinghouse/clactcoll.htm>. Accessed January 25, 2010.
6. AHIP. *America's Health Insurance Plans*; 2010. Available at: <http://www.ahip.org/content/default.aspx?bc=31>. Accessed January 25, 2010.