Hennepin Health
your community health plan

2021-2023 SNBC Comprehensive Diabetes Care Performance Improvement Project

September 1, 2024

PIP: 2021-2023 SNBC Comprehensive Diabetes Care

Purpose

This PIP is designed to promote health equity and decrease the racial and ethnic disparities for SNBC members living with diabetes by providing information for members to self-manage their diabetes. The PIP is a collaboration of Minnesota Managed Care Organizations (MCOs) ("the Collaborative") that includes Blue Plus, HealthPartners, Hennepin Health, Medica, South Country Health Alliance (SCHA), and UCare. Each participating MCO has established a goal aimed at improving the HEDIS® diabetes care measures of achieving a blood pressure in good control, A1c testing completed, A1c control and completing eye exams, as appropriate, with the focus on disparities relevant to the individual MCO population.

Hennepin Health seeks to improve the health and wellness of SNBC members, ages 18 – 64, diagnosed with diabetes mellitus. The goal is to reduce disparities in health care, increase access to care, and to address social drivers of health. Hennepin Health works with internal SNBC care guide team members, external SNBC care coordination agencies, provider organizations and Accountable Health Model partners (Hennepin County Public Health and Human Services, Hennepin Healthcare, and NorthPoint Health and Wellness Center) to address the individual member social drivers of health and barriers to care to facilitate comprehensive management for members living with diabetes. To be able to reduce the disparities in diabetes, current evidence-based programs are used to address the many factors that influence health, such as access to nutritious foods, options for physical activity through a collaborative approach between both health care and non-health care to improve diabetes and addresses the social and environmental factors that affect vulnerable populations.[11] When the need has been identified, members will be offered diabetic education to encourage self-awareness, self-care, and promote person-centered decision-making around their diabetic management that may lead to improved health outcomes. It has been shown that people who have received diabetes education are more likely to use primary care and preventive services, take medication as prescribed, and control their blood glucose and blood pressure.

Diabetes is the sixth leading cause of death in Minnesota and the leading cause of blindness, kidney failure, and lower-limb amputations. In Minnesota, glaring racial and ethnic disparities in diabetes exist that are reflected in the disease's prevalence, complication and death rates, and preventive care received by those who have diabetes.[1]

The Minnesota Community Measurement 2022 Minnesota Health Care Disparities Report [2] highlights the following key findings related to diabetes:

- Patients who are Black/ African American, American Indian/ Native American, Multi-racial or Native Hawaiian/Pacific Islander have significantly lower rates of optimal care compared to the statewide rate.
- Patients who are Hispanic/Latinx have significantly lower rates of optimal care compared to the statewide rate.
- Patients from Laos, Mexico, or Somalia have significantly lower rates of optimal care compared to the statewide rate.

Disparities happen when the health of a group of people are negatively affected by factors like how much money they earn, their race or ethnicity, or where they live.[3] While Minnesota consistently ranks as one of the healthiest states in the nation, there continues to be wide variation in health care outcomes across and within certain communities. Racial and ethnic disparities in diabetes complications and diabetes-related deaths are made worse by a variety of factors including poor access to diabetes medicines, supplies, and preventive care. Lack of culturally and linguistically appropriate diabetes education materials and support systems, and lack of culturally diverse or culturally competent health care providers further impede effective diabetes management in these populations.[4]

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[1] https://www.health.state.mn.us/communities/equity/ehdi/priority.html
[2] Minnesota Community Measurement 2022 Minnesota Health Care Disparities Report, October 2023: https://mncmsecure.org/website/Reports/Community%20Reports/Disparities%20by%20RELC/2022MY%20Disparities%20by%20RELC_FINAL.pdf
[3] https://www.health.state.mn.us/diseases/diabetes/data/diabetesfacts.html
[4] https://www.health.state.mn.us/communities/equity/ehdi/priority.html

Analysis

This project measured closing disparity gaps by leveraging the HEDIS® diabetes measure set listed below. Each MCO has identified which HEDIS® measure(s) to focus targeted efforts. Hennepin Health chose the following HEDIS® measures to report.

- Hemoglobin A1c Control for Patients with Diabetes (HBD) measure: The percentage of members 18-75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:
    - HbA1c control (<8.0%).
    - HbA1c poor control (>9.0%).
- Hemoglobin A1c Testing for Patients with Diabetes (retired, no longer using since 2022) (CDC)
- Blood Pressure Control for Patients with Diabetes (BPD) measure: The percentage of members 18-75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.
- Eye Exam for Patients with Diabetes (EED) measure: The percentage of members 18-75 years of age with diabetes (types 1 and 2) who had a retinal eye exam during the measurement year or the year prior to the measurement year, if the retinal eye exam is negative for retinopathy.

The 2020 HEDIS® Comprehensive Diabetes Care (CDC) measure is the baseline measurements for this PIP. HEDIS® is retrospective; therefore, HEDIS® 2020 reflects calendar year 2019 activities. The HEDIS® naming convention changed since the drafting of the PIP proposal in 2020, so the measurement year is reflected in the data naming. Therefore, *2021 HEDIS® data* now represents data collected in calendar year 2021. Through the course of this report, *HEDIS® data collected in 2019 will be compared to HEDIS® data collected in 2021, 2022 and 2023. Data in this report that is labeled as 2019 data was labeled as 2020 data in the proposal* in line with the naming convention of the time**.** The pre-implementation year of 2020, which is also the first year of the COVID-19 pandemic, is not reflected in this data. Hennepin Health reported only one year of baseline data (vs multiple years to establish trending) because HEDIS® data specifications change and cannot be retroactively applied to previous years. Also, for the HEDIS® 2022 measurement year (MY), National Committee for Quality Assurance (NCQA) changed the HEDIS® CDC measure by separating the CDC components into individual measures: Eye Exam for Patients with Diabetes (EED), Hemoglobin A1c Control for Patients with Diabetes (HBD), and Blood Pressure Control for Patients with Diabetes (BPD). This report will use the updated terminology. The CDC A1c testing measure was eliminated for MY2021; therefore, Hennepin Health is using the HBD measure to calculate the overall A1c testing rate for SNBC members living with diabetes.

To review health care race and ethnic disparities, Hennepin Health leveraged data available through the DHS Medicaid enrollment application. Hennepin Health used the HEDIS® Diabetes Care – Hemoglobin A1c for Patients with Diabetes (HBD), Blood Pressure Control for Patients with Diabetes (BPD) and Eye Exam for Patients with Diabetes (EED) hybrid data as the entire SNBC eligible population is in the sample. In the hybrid methodology, clinical information is abstracted from the member's medical chart. This information complements the administrative (claims) data as it provides a complete picture of the care and services provided. Hennepin Health has access to the Hennepin Healthcare electronic medical record, Epic®. To minimize the impact of the lack of race, ethnicity, and language (REL) data, Hennepin Health utilized Epic® to obtain REL data for members who are seen at Hennepin Healthcare and NorthPoint Health and Wellness Center. Therefore, our "unknown" race/ethnic rate may be lower than the other MCOs. The matching process is labor intensive and a burden in the analysis process, however. The tables below show the numerators, denominators, and rates for the total population and by racial and ethnicity groups as defined by NCQA HEDIS®.

The measures displayed in Table 1 below are used to monitor the success of the PIP. The CY2019 HEDIS® Diabetes Care HBD, BPD, and EED results will continue to serve as the baseline.

Table 1. HEDIS® Diabetes Care PIP Measures	
Measure	**Description**
HEDIS® Blood Pressure Control (BPD)	The percentage of members ages 18–75 with diabetes (Type 1 and Type 2) and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.
HEDIS® HbA1c Testing (HBD)	The percentage of members ages 18-75 with diabetes (Type 1 and Type 2) who had an HbA1c test performed during the measurement year.
HEDIS® HbA1c Control >9 (poor control) (HBD)	The percentage of members ages 18-75 with diabetes (Type 1 and Type 2) whose most recent HbA1c test performed during the measurement year result is >9 (poor control).
HEDIS® Eye Exam (EED)	The percentage of members ages 18-75 with diabetes (Type 1 and Type 2) who had a retinal or dilated eye exam performed during the measurement year or a negative retinal or dilated eye exam (negative for retinopathy in the year prior to the measurement year.

Hennepin Health is part of an Accountable Health Model (AHM) which includes Hennepin County Public Health and Human Services, Hennepin Healthcare and NorthPoint Health and Wellness as the AHM partners. Both the Collaborative and Hennepin Health have accomplished much in the PIP. As such, there is an opportunity to collaborate on initiatives among the AHM partners. In three years, the goals to improve all four metrics of the HEDIS® Diabetes Care measures for eligible SNBC members were not reached as detailed in following tables and figures below. Data for the HEDIS® Diabetes Care measures for 2019, 2021, 2022 and 2023 are displayed in Table 2.

Table 2. HEDIS® Diabetes Care Rates					
Measure	**Year**	**Numerator**	**Denominator**	**Rate**	**Percent Change From 2019 baseline**
Blood Pressure Control <140/90 (BPD)	2019	149	199	74.5%	-15.0%
	2021	143	203	70.4%	
	2022	148	226	67.3%	
	2023	138	232	59.5%	
HbA1c Testing (HBD)	2019	185	199	90.3%	-5.9%
	2021	186	203	91.6%	
	2022	198	226	87.6%	
	2023	202	232	87.1%	
HbA1c Poor Control >9% (HBD)	2019	64	199	32.2%	4.2%
	2021	54	203	26.9%	
	2022	64	226	28.3%	
	2023	65	232	28%	
Eye Exams (EED)	2019	128	199	64.3%	-7.4%
	2021	109	203	53.6%	
	2022	117	226	51.8%	
	2023	132	232	56.9%	

Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS® CY 2021, CY 2022, CY 2023

Healthcare Disparity Analysis

Hennepin Health is committed to reducing health inequity for all members. In analyzing the data in 2023 compared to 2019, 2021, and 2022, inequities for the HEDIS® Diabetes measures exist. However, conclusions are difficult to draw because of the small denominators. It is also difficult to determine whether the differences are significant. The COVID-19 pandemic has had a significant impact on members accessing health care on a timely basis for the last three years. The pandemic not only exposed but worsened many long-standing barriers for some members to receive care.

Hennepin Health has SNBC internal and external care coordinators who are trusted and knowledgeable frontline personnel. They bridge cultural and linguistic barriers and expand access to coverage and care. They work closely with members who have behavioral/chemical dependency and/or medical conditions to assist members in improving their quality of life. Hennepin Health engaged care coordinators to develop processes to better identify if and what social drivers of health are impacting members' ability to receive timely health care services. In addition, racial disparity gaps between Non-Hispanic White and members of color were monitored for impact. Hennepin Health focused on decreasing other disparities and addressing social drivers to improve the HEDIS® measures and members' health outcomes.

To review health care race/ethnic disparities, race, and ethnicity data available through the member's Medical Assistance enrollment application is use. DHS sends the member's enrollment data, including race and ethnicity, on a monthly basis. In addition, DHS collaborates with the Centers for Medicare and Medicaid Services (CMS) to obtain race and ethnicity data for Medicaid members who choose not to identify their race and ethnicity. In 2022, "multiracial" became available as a category for analysis in the data. Hennepin Health chose not to include this category in the following race data breakdown for two reasons: there is no trend data available, and there is not enough information available to know if the people within the category share any cultural similarities or social drivers. It should also be noted that individuals of Hispanic ethnicity can be of any race; therefore, some individuals may be counted in both the Hispanic and a race category, which may lead to the sum of a measure being a larger number than is presented as the total.

For each measure, Hennepin Health calculated the Index of Disproportionate Under-Representation (IDU) to identify disparity subpopulations in terms of their receipt of evidence-based health care relative to the general Hennepin Health population. The IDU is calculated by dividing the subpopulation's percent of the total denominator by the subpopulation's percent of the total numerator and results over 100% indicate a disparity subpopulation. The following data should be interpreted with caution due to the small sample sizes.

Hennepin Health uses the HEDIS® hybrid methodology in collecting and reporting the diabetes care measures. The number of SNBC members living with diabetes is below the HEDIS® required sample of 411; therefore, the data reflects all eligible SNBC members living with diabetes. The tables below show the numerators, denominators, and rates for the total population and by racial groups as defined by NCQA HEDIS®.

Using 2023 data, racial disparities were identified by race and ethnic group for the various HEDIS® Diabetes Care measures as displayed in Table 3.

Table 3. Race/Ethnic Disparities by HEDIS® Diabetes Care Measures

Measures	Black/ African American	American Indian	Asian/Pacific Islander	Hispanic
HEDIS® Blood Pressure Control <140/90mm HG (BPD)	Yes	Yes	Yes	Yes
HEDIS® HbA1c Testing (HBD)	Yes	Yes	No	Yes
HEDIS® HbA1c Control >9 (poor control) (HBD)	Yes	No	Yes	No
HEDIS® Eye Exam (EED)	No	Yes	Yes	Yes

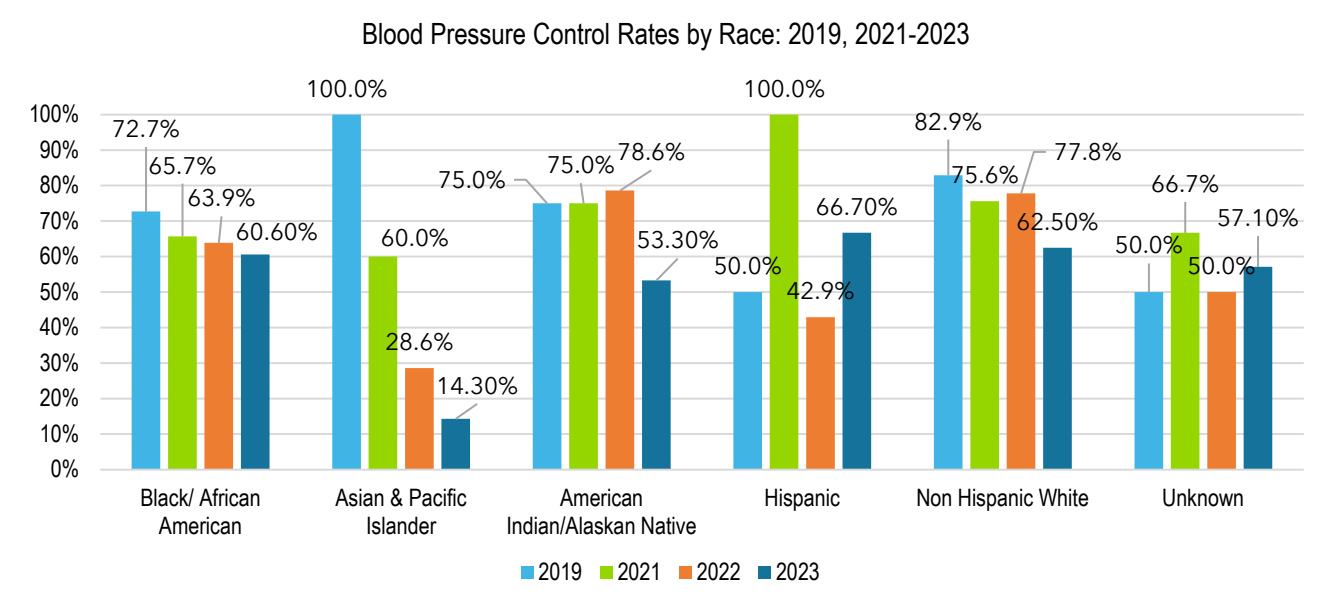
Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS® CY 2022, CY 2023

As shown in Table 4, blood pressure control rates decreased for all races except for the Native Americans who registered a slight increase when compared to rates for the Non-Hispanic White population. The data reflected in Figure 1 provides a visual for the decreased blood pressure control in 2023. The largest rate decreases occurred in both the Asian/Pacific Islander race and Hispanic ethnicity.

Table 4. Race/Ethnic Disparities by HEDIS® Diabetes Care Blood Pressure Control Rates 2023				
Race	**Numerator**	**Denominator**	**Rate**	**Difference Relative to Non-Hispanic White Race**
Black / African American	86	142	60.56	-1.94%
Asian/Pacific Islander	1	7	14.29%	-48.21%
Hispanic	3	7	42.9%	+19.6%
Native American	8	15	53.33%	-9.17%
Non-Hispanic White	30	48	62.50%	0.00%
Unknown	8	14	57.14%	-5.36%
Total	**138**	**232**	**59.48**	**-3.02%**

Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS® CY 2022, CY 2023

Figure 1: Blood Pressure Control Rates by Race, 2019, 2021, 2022, 2023



Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS® CY 2019, 2021, CY 2022, CY 2023

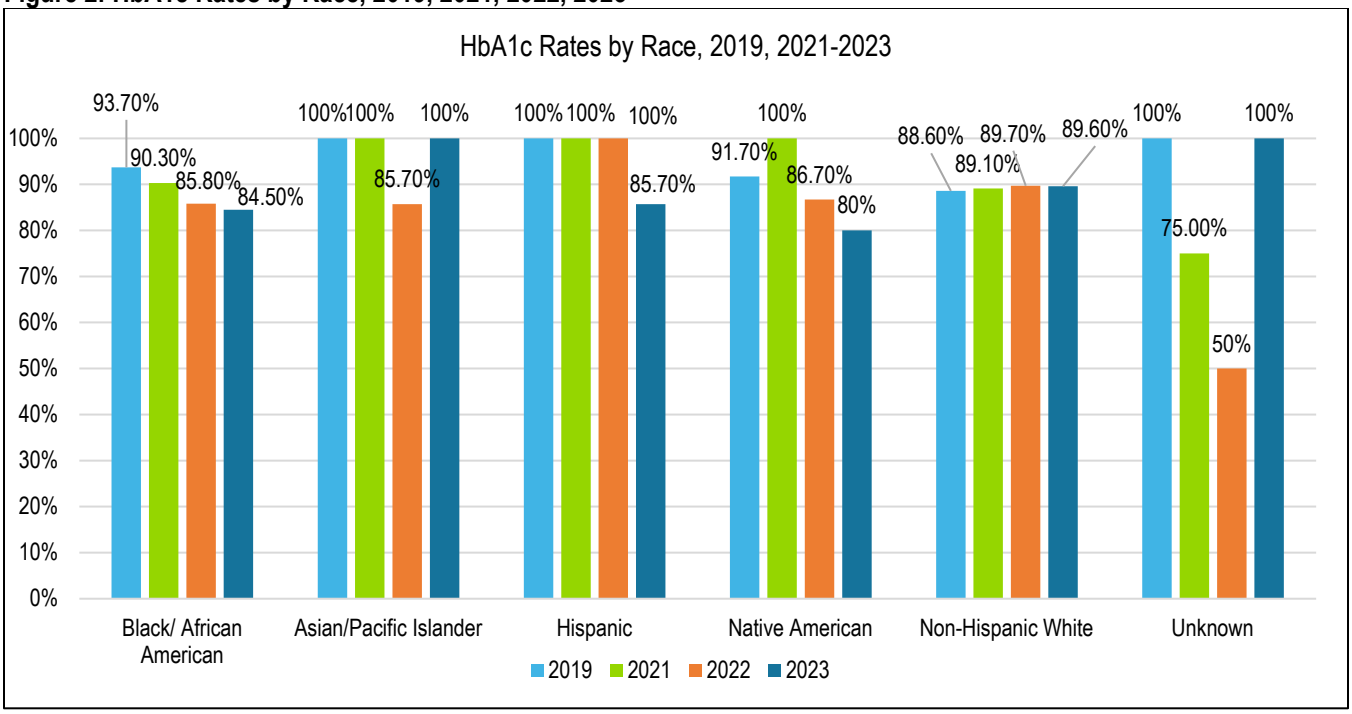
For the HEDIS® Diabetes Care HbA1c testing in 2023, every racial group has lower HbA1c testing rates compared to the Non-Hispanic White population. The Hispanic group rate was 100%, higher than the Non-Hispanic White population; however, the sample size was only 7 (Table 5). Hemoglobin A1c testing rates have stayed the same or declined for every race and ethnic group since 2019 except for the Non-Hispanic White population for whom the rate increased nominally by one percentage point with a denominator size of 48 (Figure 2). For this measure, Black/ African American, Asian and Pacific Islander, and Native American members were all disproportionately underrepresented (IDUs: 102, 102, and 101, respectively). Additionally, testing rates have not improved for every racial group in 2023 compared to 2019 (Figure 2). However, the sample size is small, so it is possible the differences are due to random variation.

Table 5. Race/Ethnic Disparities by HEDIS® Diabetes Care HbA1c Testing Rates 2023				
Race	**Numerator**	**Denominator**	**Rate**	**Difference Relative to Non-Hispanic White Race**
Black / African American	133	142	85.8%	-3.9%

Table 5. Race/Ethnic Disparities by HEDIS® Diabetes Care HbA1c Testing Rates 2023				
Race	**Numerator**	**Denominator**	**Rate**	**Difference Relative to Non-Hispanic White Race**
Asian/Pacific Islander	6	7	85.7%	-4.0%
Hispanic	7	7	100%	+10.3%
Native American	13	15	86.7%	-3.0%
Non-Hispanic White	35	48	89.7%	0.00%
Unknown	1	2	50%	-39.7%
Total	**198**	**239**	**86.5%**	**-3.2%**

Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS® CY 2021 and CY 2022, CY 2023

Figure 2: HbA1c Rates by Race, 2019, 2021, 2022, 2023



Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS CY 2019, 2021 and 2022, CY 2023

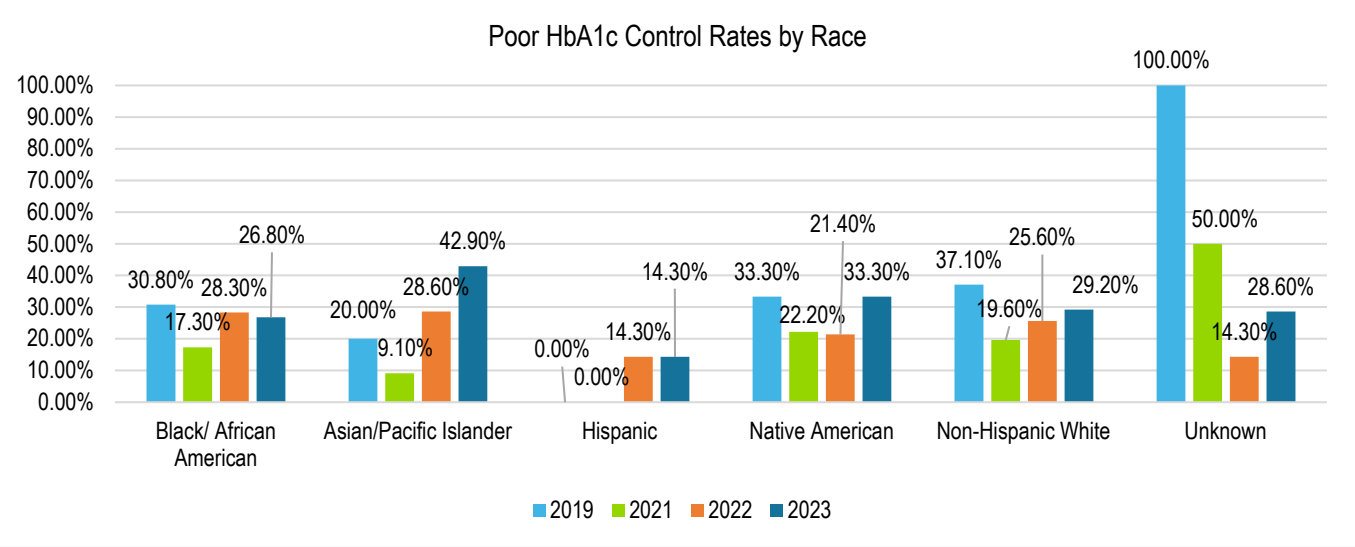
As shown in Table 6, the Poor HbA1c Control (HBD) rates have decreased across the populations except for the Asian and Pacific Islander population for whom it increased by 22.9 percentage points (N=7) when compared to the rates in 2019. This is a positive change, as lower rates for this measure are considered successful. Hennepin Health's Black/ African American members were disproportionately underrepresented in this measure (IDU: 104). Since lower rates are better in this case, being underrepresented is a positive; therefore, the Hispanic, Asian/Pacific Islander, Native American, and Non-Hispanic White members are faring worse in this case.

As demonstrated in Figure 1, the rates of Poor HbA1c Control have decreased across the populations except for the Asian and Pacific Islander population for whom it increased by 22.9 percentage points (N=7). This is a positive change, as lower rates for this measure are considered successful. Black/ African American members were disproportionately underrepresented in this measure (IDU: 104). Since lower rates are better in this case, being underrepresented is a positive; therefore, the Hispanic, Asian/Pacific Islander, Native American, and Non-Hispanic White members are faring worse in this case.

Table 6. Race/Ethnic Disparities by HEDIS® HbA1c Poor Control >9% Rates 2023				
Race	**Numerator**	**Denominator**	**Rate**	**Difference Relative to Non-Hispanic White Race**
Black/ African American	38	142	26.8%	-2.4%
Asian/Pacific Islander	3	7	42.9%	+13.7%
Hispanic	1	7	14.29%	-14.9%
Native American	5	15	33.3%	+4.1%
Non-Hispanic White	14	48	29.2%	0.00%
Unknown	4	14	28.6%	-0.6%
Total	**65**	**233**	**27.9%**	**-0.1%**

Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS® CY 2021, CY 2022 , CY 2023

Figure 13. Poor HbA1c Control by Rates by Race (HBD) (lower is better)



Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS® CY 2019, CY 2021,CY 2022, and CY 2023

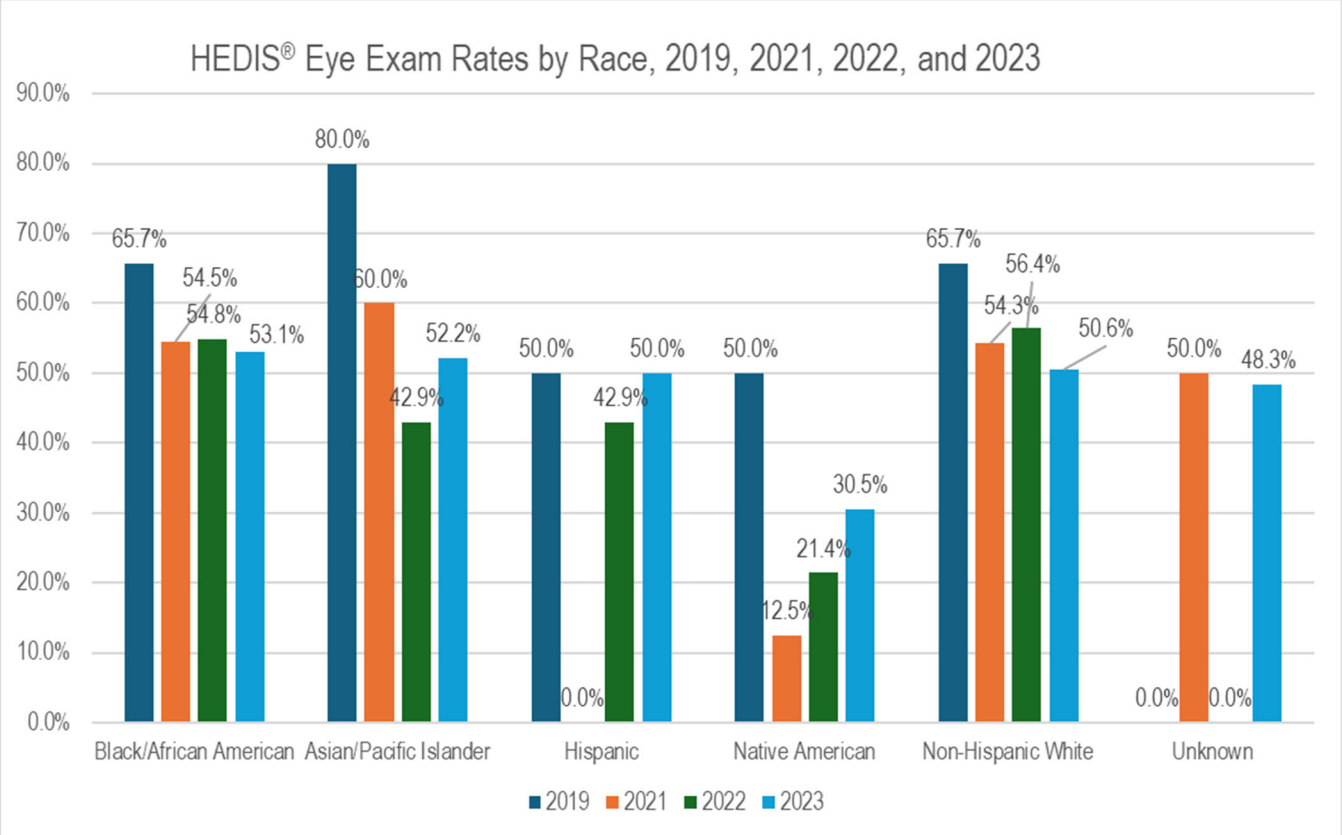
As displayed in Table 7, all populations had a slightly lower eye exam rate, except for the Black/ African American race for whom it increased by 2.23 percentage points, when compared to the Non-Hispanic White population in 2023. While in 2021, rates for the Black/ African American and Asian/Pacific Islander populations were slightly higher compared to Non-Hispanic Whites. Racial disparities were seen in the Hispanic, Native American, and the unknown races when compared to the Non-Hispanic White population. The eye exam rates decreased for all race/ethnic groups in 2023 compared to 2019, as seen in Figure 4 below. However, the sample size for all race/ethnic groups in 2019, 2021, 2022, and 2023 was small, so caution should be used when interpreting the data. This measure is particularly challenging to improve, as Hennepin Health has heard anecdotally, SNBC members do not often prioritize vision care compared to their other health care needs and may not understand the importance of having an annual retinal eye exam.

Table 7. Race/Ethnic Disparities by HEDIS® Eye Exam Rates 2023				
Race	**Numerator**	**Denominator**	**Rate**	**Difference Relative to Non-Hispanic White Race**
Black / African American	86	142	60.56%	+2.23%

Table 7. Race/Ethnic Disparities by HEDIS® Eye Exam Rates 2023				
Race	**Numerator**	**Denominator**	**Rate**	**Difference Relative to Non-Hispanic White Race**
Asian/Pacific Islander	2	7	28.57%	-26.76%
Hispanic		7	50.00	-8.33%
Native American	8	15	53.33%	-5.00%
Non-Hispanic White	28	48	58.33%	0.00%
Unknown	6	14	42.86%	-15.48%
Total	**132**	**232**	**56.9%**	**-1.44%**

Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS® CY 2021, 2022, 2023

Figure 4: HEDIS® Eye Exam Rates by Race, 2019, 2021, 2022, and 2023



Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS® CY 2019, CY2021, CY 2022 , CY 2023

Collaborative Interventions

The Collaborative and Hennepin Health specific interventions focus on reducing racial disparities and improving the rates for the HEDIS® measures. Collaborative interventions include the development of an educational series and resources for members, care coordinators, community health workers, health coaches, and others. Examples of educational topics are nutrition, food disparity, MCO supplemental benefits and motivational interviewing. Some resources that may be developed are outlined below.

- Supplemental benefits for each MCO relevant to diabetes care such as fitness/wellness classes, technology available, healthy diet or cooking classes and weight management classes.

- Access to care coordination or disease management resources for each MCO.
- How to access resources to address social determinants of health as appropriate.
- Transportation services available.
- Incentives for diabetes care.

The Collaborative partnered with the Minnesota Cardiovascular Health and the Minnesota Department of Health (MDH) Diabetes Team. In 2021, the MDH Diabetes Team primarily took the role of supporting the work of the Collaborative by promoting the webinars planned and hosted by the PIP Collaborative. The partnership continued into 2023 as the care coordination webinar series continued. The 2023 webinars focused on improving the comprehensive diabetes care and services for MSHO/MSC+ and SNBC members. This three-year project included ten webinars. There was a total of 4,334 attendees with 2,476 evaluations completed, a 63% completion rate. Topics covered in 2023 were as follows:

1. Meeting the Challenges of Diabetes: Oral Health Considerations for People with Diabetes
2. Meeting the Challenges of Diabetes: Diabetes and Skin Care

Other Collaborative interventions included the provision of tools and resources to MCOs members to improve their overall health as well as their specific health conditions. In the Q4 2021, the MCOs launched a standardized supplemental benefits grid which identifies each MCO's specific support resource information. This tool serves as an information hub for care coordinators and clinicians to find relevant resources and supplemental benefits that enhance and support the care of our members. Moreover, each MCO has or is developing a connection to a community program to help address food insecurity and other social drivers of health. A healthy diet is vital to controlling diabetes and other comorbidities such as high blood pressure and obesity. Consequently, by maximizing other resources, MCOs hope to provide members with options to supplement their diet with healthier alternatives.

The Collaborative continued working with MDH Diabetes and Health Behavior team who promoted the Collaborative's webinars. The Collaborative, in return, agreed to promote a Diabetes Toolkit available on the MDH website.

Hennepin Health specific interventions included member education through Healthwise Knowledgebase®, an online health resource available on the Hennepin Health website. With Healthwise® Knowledgebase, the member can research tests, medications, and treatment. Members can use the interactive personal calculator, watch videos, or read about health-related topics. Information is based on the best, most up-to date medical research and is available in English or Spanish. Hennepin Health is exploring with Hennepin County Public Health and Human Services, Hennepin Healthcare, and NorthPoint Health and Wellness Center potential process improvements to their current diabetic education programs to reduce barriers to receiving this education.

Another Hennepin Health specific intervention included the development and continued use of a diabetes assessment tool to receive input and feedback from members in how they manage their diabetes. The assessment comprises of six areas with a social drivers of health focus. Other interventions included promoting supplemental benefits like YMCA membership and incentive reward program vouchers for HbA1c testing and eye exams. Hennepin Health is collaborating with members living with diabetes who are experiencing food insecurity to identify food sources to best meets their needs. In the continued use of the assessment in 2023, 30 members completed the assessment. Over half of the members expressed an interest in receiving information and resources to improve their understanding of their condition and to better self-manage it. Seventy-seven percent (77%) of members indicated interest to learn more about the best foods to eat to manage their diabetes. Very few members (three) indicated they were having difficulties with equipment such as a blood pressure monitor or glucometer. The majority of members (93%) self-report they take their medications for diabetes every day. Members were reassessed throughout the PIP period to evaluate the effectiveness of the interventions provided to address their unique needs.

Hennepin Health met with the Collaborative twice a month throughout the 2021-2023 PIP implementation. Both Hennepin Health and Collaborative interventions were implemented according to the timeline submitted in the PIP work plan. The Collaborative and MDH collaborated and implemented initiatives to support the PIP. The webinar series developed throughout the past three years will remain on the Stratis' website, allowing individuals to review topics aimed at understanding how diabetes impacts all systems of the body and address knowledge gaps in order to increase access to care.

Recommendations and Next Steps

Beginning in 2024, Hennepin Health will enter into a new PIP cycle focused on members living with cooccurring diabetes and depression. This PIP will acknowledge the importance of psychological assessment as part of diabetes care as a depression diagnosis may be missed due to lack of mental health screening. People with diabetes are 2 to 3 times more likely to have depression than people without diabetes. Only 25% to 50% of people with diabetes who have depression get diagnosed and treated. Treatment/therapy, medicine or both is usually very effective.[2]

Hennepin Health will engage internal SNBC care navigator team members, external SNBC care coordination agencies, provider organizations and Hennepin County Departments (Hennepin County Public Health and Human Services, Hennepin Healthcare, and NorthPoint Health and Wellness Center) to address the impact of depression on the individual member living with diabetes. Social drivers of health and barriers to care will also be identified and addressed to facilitate members meeting their individual goals of success. When the need has been identified, members will be offered diabetic education to encourage self-awareness, self-care, and promote person-centered decision-making around their depression and diabetic management that may lead to improved health outcomes and meeting their goals.

The aim of this PIP is to make year-over-year improvements in the identified measures via the Plan-Do-Study-Act (PDSA) cycle. In line with DHS recommendations (via email on November 3rd, 2023), the focus is shifting from closing racial disparities from all racial/ethnic groups to specifically focusing on the members who are Black/ African American in comparison to the Non-Hispanic White population. In addition, the goal is to see continually improving the diabetes HEDIS® measures for 2024 through 2026 for members living with diabetes and depression. This will be incrementally achieved by engaging the community to address mental health comorbidities and health disparity gaps.

The Index of Disproportionate Under-Representation (IDU) will continue to be used to monitor and identify disparity subpopulations in terms of their receipt of evidence-based health care relative to the general Hennepin Health population, with the hope to see year-over-year improvements.

This project will measure gaps in care by leveraging the NCQA HEDIS® Effectiveness of Care Diabetes measure set, with a focus on members who have comorbidities with diabetes and depression. Each MCO has identified which measure(s) to focus targeted efforts. Hennepin Health is also exploring the feasibility of developing two non- HEDIS® metrics to identify the following.

- Members living with diabetes and depression who have been screened for depression and the screening frequency, using either the PHQ-2 or the PHQ-9 tool.
- Members living with diabetes who have not been identified as having depression and have not been screened for depression.

Acknowledging the complexities that can arise from attempts to directly correlate behavioral modification outcomes with specific interventions, Hennepin Health and the Collaborative, will embark on several interventions with the expectation that as we plan, we will identify the interventions that will resonate more with the members. Using the PDSA cycle, the identified initiatives will be tested, adopted, adjusted, or abandoned, as needed, based on their usefulness to the established target outcomes. The PDSA cycle will continue as lessons learned from previous cycle tests will be repositioned, as needed, and a new cycle will start.

The mechanism of change for clinical quality-based performance improvement is the PDSA cycle of iterative tests of small change. Per the Institute for Healthcare Improvement (IHI), “Testing changes is an iterative process: the completion of each PDSA cycle leads directly into the start of the next cycle. A team learns from the test — What worked and what didn't work? What should be kept, changed, or abandoned? — and uses the new knowledge to plan the next test.” That is, the approach to improvement of extant systems, processes, and workflows is not a theoretical, but rather an applied practice. All interventions are designed to work in tandem to produce procedural, systemic, and ultimately sustainable meaningful change in outcome by making incremental adjustments in the current state until an improved state is achieved. PDSA cycles are considered the best

[2] Minnesota Community Measurement 2022 Minnesota Health Care Disparities Report, October 2023: https://mncmsecure.org/website/Reports/Community%20Reports/Disparities%20by%20RELC/2022MY%20Disparities%20by%20RELC_FINAL.pdf

practice standard in quality for effecting change in extant systems. This is because, in an extant system, we do not have the same ability to control for potentially significant confounding factors in a "X" leads to "Y" due to "Z" causal analysis more typical of a hypothesis testing model. Extant system confounders include regulatory restraints, financial rules, resource allocation, parallel/complimentary process limitations, data availability and validity, and a host of others.

Hennepin Health has SNBC internal and external care coordinators who are trusted, knowledgeable, frontline personnel. They bridge cultural and linguistic barriers and expand access to coverage and care. They work closely with members who have behavioral/chemical dependency and/or medical conditions to assist members in improving their quality of life. They encourage members to schedule visits with the health care provider and receive necessary tests such as HbA1c test and eye exams. Hennepin Health will continue to engage care coordinators to develop processes to better identify if and what social drivers of health are impacting members ability receive timely health care services Lastly, Hennepin Health will continue to partner with external agencies who offer healthy eating and nutrition education sessions to members who are interested in learning on how to eat healthy.

As directed by the Minnesota Department of Human Services (DHS) in May of 2023, the Collaborative is incorporating community informed measures into the PIP processes for MSHO/MSC+ and SNBC members. Specifically, DHS tasked the MCOs with "collecting enrollee input on their interactions with the healthcare system and developing community informed measures for the project, while maintaining that such work takes time and has not been previously attempted in the context of the PIPs"[3]. During the PIP planning process, the Collaborative researched different existing methodologies for community engagement and used the findings to develop a guiding philosophy on how to incorporate this new aspect into the work.

Hennepin Health will work with the Collaborative on engaging our collective members for guidance on defining success and refining the direction of both PIPs. Much of this work will be developed during the first year of the PIP as MCO-specific resources will be needed to implement this new expectation.

To the extent possible, Hennepin Health will apply the identified needs of Access to Health and Safety as a Human Right, Comprehensive, Equitable Education, and Advocacy and Cultural Sensitivity to the work of the PIP, as well as participate in the Hennepin Healthcare Community Health Needs Assessment (CHNA) implementation process to the benefit of our members. For the new SNBC PIP, the primary focus will be on Need Number Two: Comprehensive, Equitable Education, specifically culturally tailored community health education based locally with topics determined by community. Nutritional and cooking education is the top need and member request based on the Hennepin Health diabetes assessment conducted with the SNBC members living with diabetes. Hennepin Health has begun the exploration process to identify available nutrition and cooking education for the members living with diabetes, initially in North Minneapolis area and geared toward our Black/ African American members who reside there. The Hennepin Health diabetic assessment tool will continue to be a key source of member feedback for the community engagement elements, as well. As the DHS MnCHOICES tool continues to roll out, the Hennepin Health diabetic assessment tool will be reviewed and revised to eliminate obtaining duplicative information from our members. Additionally, Hennepin Health conducts SNBC stakeholder member meetings twice a year which will be utilized as an opportunity for direct member consultation on this PIP.

References:

[1] https://www.health.state.mn.us/communities/equity/ehdi/priority.html
[2] Minnesota Community Measurement 2022 Minnesota Health Care Disparities Report, October 2023: https://mncmsecure.org/website/Reports/Community%20Reports/Disparities%20by%20RELC/2022MY%20Disparities%20by%20RELC_FINAL.pdf
[3] https://www.health.state.mn.us/diseases/diabetes/data/diabetesfacts.html
[4] https://www.health.state.mn.us/communities/equity/ehdi/priority.html
https://www.cdc.gov/diabetes/managing/mental-health.html

[3] Presentation by Dr. Mark Foresman at the May 23rd, 2023, Quarterly Workgroup Meeting.

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