Hennepin Health

Special Needs BasicCare 2022 Interim Report Comprehensive Diabetes Care Performance Improvement Project 2021-2023

May 1, 2024

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Contents

Summary

The Diabetes Performance Improvement Project (PIP) is a collaboration of Minnesota Managed Care Organizations (MCOs) ("the Collaborative"). MCOs participating in this collaboration for their Special Needs BasicCare (SNBC) and Minnesota Medicaid Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) products include: BluePlus (MSHO/MSC+ only), HealthPartners, Hennepin Health (SNBC only), Medica, South Country Heath Alliance (SCHA) and UCare. Stratis Health provides project development support and assistance to the Collaborative.

This PIP focuses on decreasing the health disparity gaps in diabetes related Healthcare Effectiveness Data and Information Set (HEDIS®) and/or process measures chosen year-over year from 2021 through 2023 by improving member's self-management of their diabetes. Each participating MCO has established a goal aimed at improving the HEDIS® Comprehensive Diabetes Care and services for MSHO/MSC+ and SNBC members with a focus on disparities. To amplify our efforts and facilitate improvement, MCOs support joint Collaborative interventions as well as individual MCO specific strategies.

Throughout the project, the Collaborative is attuned to the various sources of data and reporting available that helps to guide ideas for intervention and trainings. The Collaborative
uses valuable information from sources such as Minnesota Community Measurement (MNCM) Minnesota Health Care Disparities Reports1, the Minnesota Department of Health (MDH) Center for Health Equity, and MDH Diabetes Data and Reports to name a few.

PIP Elements

The second year of this PIP focused on continuing the Care Coordinator Training Series. Several of the 2022 training topics were requested by Care Coordinators themselves when they evaluated the 2021 Webinars. The Collaborative works to tailor training deemed most useful to Care Coordinators in their work with MSHO/MSC+ and SNBC members. An additional goal of the Collaborative was that the webinars provide knowledge and insight into the health care disparities experienced within the MSHO/MSC+ and SNBC populations and the impact of these inequities. Care Coordinators are a cornerstone of the members' interdisciplinary care team and come to their work with a variety of educational backgrounds that vary in their knowledge of diabetes and optimal diabetes management. Enhancing their knowledge about diabetes care and management have both an immediate and long-term impacts in how Care Coordinators support and educate members. The 2022 Care Coordinator Webinar Series is detailed later in this report.

Another significant goal achieved in the Diabetes PIP Collaborative Work plan has been to engage with the Minnesota Department of Health Diabetes and Health Behavior Unit.

The collaboration between the MCO PIP Collaborative and the MDH team came to fruition in 2022, when we co-sponsored two webinars attended by over 1000 people from various disciplines across the state of Minnesota. The collaborative webinars are detailed later in this report. This successful collaboration between the MCOs and MDH is a natural fit given the alignment of our goals to improve diabetes care and health in Minnesota. It was a pleasure working closely with the MDH Diabetes team throughout 2022. We continue to be in contact with the MDH Diabetes and Health Behavior Unit and each group benefits from the support and promotion of each other's initiatives, webinars, and toolkits.

Hennepin Health Goal Statement

Hennepin Health seeks to improve the health and wellness of SNBC members, ages 18 – 65, diagnosed with diabetes mellitus. The goal is to reduce disparities in healthcare, access to care, and to address social determinants of health (SDoH). Hennepin Health engages with the internal SNBC Care Guide team members, external SNBC care coordination agencies, provider organizations, and the Hennepin Health Accountable Health Model partners (Hennepin County Health and Human Services, Hennepin Healthcare, and NorthPoint Health and Wellness Center) to address the individual members' SDoH and barriers to care to facilitate comprehensive management for members with diabetes. 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 diabetes 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.

Methods and Data Analysis

This project will measure 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 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, we will be *comparing HEDIS® data collected in 2019 to HEDIS® data collected in 2021 and 2022. 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.

Table 1 below presents the measurement periods for the HEDIS® EED, HBD, and BPD.

Table 1. HEDIS® EED, HBD, and BPD Measurement Periods

Reporting Year	Measurement Period	PIP Intervention Year
2020	January 2019 – December 2019	Baseline
2021	January 2020 – December 2020	Pre-implementation
2022	January 2021 – December 2021	Year 1
2023	January 2022 – December 2022	Year 2
2024	January 2023 – December 2023	Year 3

Data Analysis

This project will attempt to measure closing disparity gaps by leveraging the SNBC HEDIS® measure set listed below.

- Hemoglobin A1c Control for Patients with Diabetes (HBD)
- Hemoglobin A1c Testing for Patients with Diabetes (retired, no longer using 2022)
- Blood Pressure Control for Patients with Diabetes (BPD)
- Eye Exam for Patients with Diabetes (EED)

Error! Reference source not found. below details the change in selected HEDIS® measures from 2019-2022, including sample sizes. The goals to improve three metrics of the HEDIS® CDC measures for eligible SNBC members were not yet reached as detailed in following tables and figures below. The measure that has seen an improvement is HbA1c Poor Control, which has decreased slightly from the 2019 rate of 32.2% to 28.3% in 2022 (lower is better for this metric). At Hennepin Health, we leverage our position in the Hennepin County systems that Medicaid members often rely upon as well as our Accountable Health Model partners - Hennepin Healthcare and NorthPoint. Both the Collaborative and Hennepin Health have accomplished much in the beginning of the PIP with much more planned for the future. Hennepin Health has provided baseline rates below for the entire measure population and drill down analysis on healthcare disparity in the healthcare disparity analysis section.

Table 2. HEDIS® Diabetes Rates, 2019, 2021, 2022

Year	Numerator	Denominator	Rate	Percent Change
Blood Pressure Control				
2019	149	199	74.5%	**-7.2%**
2021	143	203	70.4%	
2022	148	226	67.3%	
HbA1c Testing				
2019	185	199	93.0%	**-5.4%**
2021	186	203	91.6%	
2022	198	226	87.6%	
HbA1c Poor Control >9% (Lower is Better)				
2019	64	199	32.2%	**3.9%**
2021	54	203	26.9%	
2022	64	226	28.3%	
Eye Exams				
2019	128	199	64.3%	**-12.5%**
2021	109	203	53.6%	
2022	117	226	51.8%	

Data Source: Hennepin Health HEDIS® CY 2019, CY 2021, CY2022

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Healthcare Disparity Analysis

Hennepin Health is committed to reducing health inequities for all members. In analyzing the data in 2022 compared to 2019, inequities for the chosen HEDIS® measures exist. However, it is difficult to draw conclusions because of the small denominators and whether the differences are significant. The COVID-19 pandemic had a significant impact on members accessing health care on a timely basis. The pandemic not only exposed but worsened many long-standing barriers for some members to access care. Hennepin Health has 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. Hennepin Health continues to engage care

coordinators to develop processes to better identify if and what social determinants are impacting members' ability receive timely health care services. In addition, racial disparity gaps between Non-Hispanic White and members of color will continue to be monitored for impact. Hennepin Health will focus on decreasing other disparities and addressing social determinants of health as a way to improve the population measures.

To review health care race/ethnic disparities, we are leveraging race and ethnicity data available through the member's enrollment application. The Minnesota Department of Human Services (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 has chosen 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 of health. 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 diabetic measures. The number of SNBC members living with diabetes is below the HEDIS® required sample of 411; therefore, the data reflects all 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®.

Interventions and Measures of Success

Collaborative Interventions

Education and Training

Care Coordination

The MCO Collaborative created an education series for Care Coordinators to provide them with the knowledge and skills to best assist members with managing their diabetes. Care Coordinators/Case Managers have an essential role in educating, supporting, and assisting members in setting and achieving health goals to improve their diabetes care and play a key role in closing the gaps in health care disparities within our populations. While some Care Coordinators/Case Managers are nurses, many are social workers who benefit from additional information on the role they can play to support their members with diabetes. With that in mind, the trainings included information for those with a range of experience and skillsets to supplement their current knowledge base. For example, a social worker is not typically knowledgeable about medical issues, so a diabetes basics course was beneficial in enhancing their knowledge of working with their members who are living with diabetes. Many Care Coordination Delegates serve members of multiple health plans, increasing the impact of conducting training as a collaborative. The high attendance and positive evaluations of these webinars reinforced the value of providing this type of information for our care coordinators and case managers.

All of these webinars are recorded and posted on the PIP Project page of the Stratis Health website for viewing anytime. The Diabetes PIP website also includes resources and information about upcoming webinars.

Webinar Series

The Collaborative offered a series of webinars in 2022 to improve the comprehensive diabetes care and services for MSHO/MSC+ and SNBC members. The series is being continued in 2023 and will continue throughout the project. The webinars offered in 2022 were:

Meeting the Challenges of Diabetes: Consequences of Disease Progression – 5/11/2022 Presented by Janet Ungs, Nurse Practitioner, Endocrinology, Park Nicollet Clinic

This webinar was the first in a series addressing knowledge gaps of care coordinators and others in diabetes progression. The goal of the presentation series was to provide Care Coordinators, Case Managers, and other professionals working with MSHO/MSC+ and SNBC members information to understand the impact of diabetes on a member's

health better and enhance their skillsets when working with members with diabetes. The webinar was attended by 401 people.

Approximately 97% of respondents indicated that this webinar increased their ability to understand the role of the Care Coordinator in helping members manage their diabetes with the context of their life.

Food is Medicine – Integrating Effective Nutrition Interventions into the Healthcare System: A Concept Whose Time Has Come – 6/28/2022 Presented by Dr. Dariush Mozaffarian, Dean at the Tufts Friedman School of Nutrition Science/Policy

Presented in collaboration with the Minnesota Department of Health Diabetes section, this webinar focused on food insecurity as a social determinant of health and contributor to chronic disease prevention and management. Participants learned how health care clinicians and systems are finding new clinical and community interventions to improve patients' access to quality nutrition and education. This webinar was attended by 607 individuals.

Of those who completed the evaluation, 92.3% agreed that the webinar enhanced their knowledge and ability to apply new strategies and tools in their work setting.

Implicit Bias & the Pursuit of Health Equity 8/10/2022 Presented by Dr. Talee Vang, licensed health psychologist and Director of Health Equity Education & Welcome Services at Hennepin Healthcare

Implicit bias occurs on an unconscious level. Research suggests that implicit biases affect behaviors more than explicit biases. Research also points to the correlation between implicit bias and health disparities. Rooted in psychological theory, research, and practice, this webinar focused on developing a deeper understanding of implicit bias, how it is formed, and its impact on health disparities. In addition to increasing awareness of the relationship between implicit bias and health disparities, evidence-based approaches to decreasing implicit bias were presented. This webinar was attended by 471 people.

Of those who completed the evaluation, 95.4% agreed that the webinar enhanced their knowledge and ability to apply new strategies and tools in their work setting.

Transforming Food Shelves to Meet Clients Needs with SuperShelf 9/20/2022 Presented by a panel of collaborators with the MN SuperShelf partnership.

Minnesota's SuperShelf partnership is helping to increase access to healthy, appealing, and culturally connected foods across the state. Presented in collaboration with the Minnesota Department of Health Diabetes section, this webinar shared how food shelves are transforming to meet the food needs and improve the experience of people who are food insecure in Minnesota. This presentation included an overview of the

results of the SuperShelf Evaluation Study (NIH) including the Statewide Food Shelf survey, a unique data set with direct insight from people served by food shelves throughout the state. This webinar was attended by 479 individuals.

Of those who completed the evaluation, 90.5% agreed that the webinar enhanced their knowledge and ability to apply new strategies and tools in their work setting.

Meeting the Challenges of Diabetes: Working with Non-English Speakers with Diabetes
12/6/2022 Presented by Hilda Hererra, CHW with CHW Solutions and Marie Sherwood, Health Coach Disease Management, UCare Diabetes Health Journey program and Migraine Management Program

A diagnosis of diabetes can be overwhelming. When a person does not speak the primary language of the health care system, it can be especially daunting to learn about your condition and understand all the recommended steps patients should take to stay healthy. This webinar reviewed the basics of working with interpreters; how language and cultural differences impact care, create misunderstandings, and jeopardize appropriate follow-through and common points where misunderstandings can happen. Community Health Workers and Care Coordinators can play a valuable role in reducing these barriers. The presenters shared tips from their years of experience working directly with people with diverse languages and cultures. This webinar was attended by 496 individuals.

Of those who completed the evaluation, 92.6% agreed that the webinar enhanced their knowledge and ability to apply new strategies and tools in their work setting.

As described earlier in this report, the primary intended audience for this webinar series was MSHO/MSC+ and SNBC Care Coordinators. However, other disciplines that heavily attended the events included Public Health Nurses, Community Health Workers, RNs and LPNs, Dieticians, Social Workers, and students, along with many other adjacent disciplines. At least 2,025 unique individuals attended a diabetes project webinar in the first two years of the project.

Overall, response to the webinar series has been extremely positive as shown in figures 1 – 3 below in combined evaluation summaries from the 2022 webinars. Enhanced knowledge and increased ability to understand the role of the Care Coordinator are universal questions asked in every webinar evaluation.

Figure 1. Knowledge and Ability

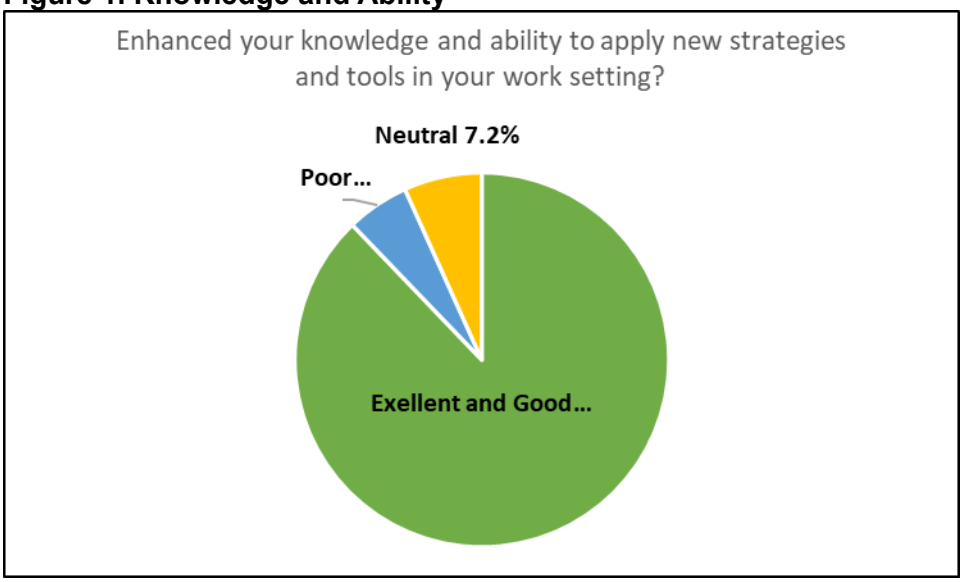


Figure 2. Understanding of Role

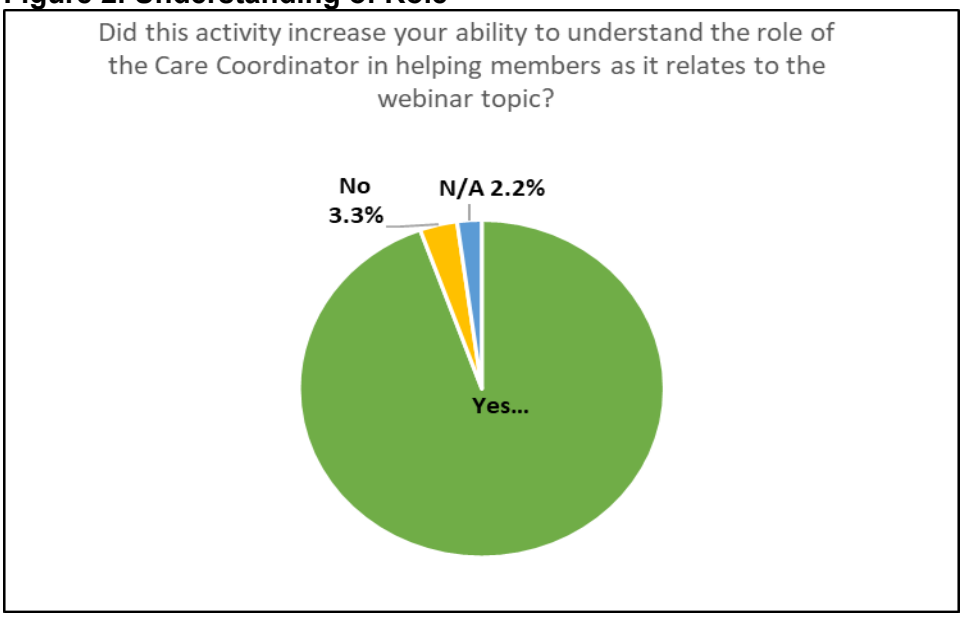
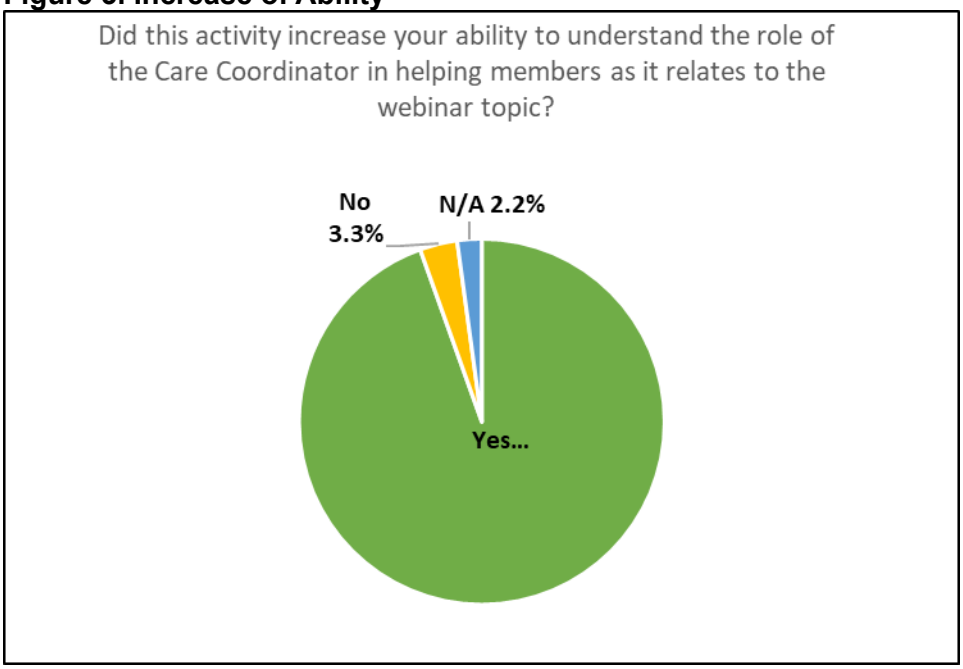


Figure 3. Increase of Ability



Tools and Resources

Minnesota's MCOs have a history of providing supportive services for our members to improve both overall health as well as specific health conditions. This support may come in the form of incentives to encourage members to seek recommended care, enhanced care coordination for specific conditions, or educational resources. Increasingly, these supports include resources to address social determinants of health.

For clinicians, care coordinators, and other staff that support our members, it can be difficult to track the resources available to each individual member that they care for, especially when they may work with people across multiple MCOs. In Q4 2021, the MCOs launched a standardized supplemental benefits grid identifying 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.

This tool has received positive feedback from care coordinators, as it creates symmetry when working with multiple plans. The Collaborative is focused on ensuring continual attention to opportunities to include resources that promote health care equity and that are culturally tailored. The resource tool also follows the conceptual order of the new MnCHOICES health risk assessment questionnaire to make it easier to incorporate into the care coordinators standard workflow. Some of the resources that are included on the benefits grid include:

- Supplemental benefits for each plan relevant to diabetes care such as fitness/wellness classes, technology supports, healthy diet or cooking classes and weight management.
- Access to care coordination or disease management resources for each MCO.
- How to access resources to address social determinants of health.
- Transportation services.
- Incentives for diabetes care.

The benefits grid tool is posted on each individual MCO's care coordination resource hub which is the main location where care coordinators access tools and resources while working with members. The resource was publicized across each organization through training and newsletters. The tool will be updated annually to reflect any new or updated benefits.

In addition to these MCO specific resources, each MCO has or is developing a connection to a community program to help address food insecurity and other social determinants of health. This includes agencies, organizations, or tools such as NowPow, Aunt Bertha, Hunger Solutions, and FoodRx. This project has capitalized on those relationships by integrating processes to identify and refer members with diabetes who may also have food insecurity to these resources.

A healthy diet is vital to controlling diabetes and other comorbidities such as high blood pressure and obesity. Often people with a limited income need to rely on food shelves or other resources for supplemental food. Food shelves are often stocked with staples that have a long shelf life and contain high levels of refined carbohydrates, sodium, and preservatives. By maximizing other resources, we hope to provide our members with options to supplement their diet with healthier alternatives.

These resources are included in the hub of resources and were included in health plan training for care coordinators and other support staff. While the partnering organization may vary by MCO, we have worked collaboratively to promote the availability of these resources for our members.

Community Outreach and Partnerships

Minnesota Department of Health

The 2030 Minnesota Cardiovascular Health and Diabetes State Plan was created as a collaborative effort of state and local partners. It was started in 2019 and is led by MDH. The plan was to develop a focused roadmap and call to action for individuals, communities, and organizations to collaborate and prevent, treat and manage diabetes, heart disease, and stroke for the next ten years.

In the fall of 2020, the Collaborative initiated communication with the workgroup at MDH, making them aware of the DHS Diabetes PIP and the MCO Collaborative's desire to learn about the priorities of the State Strategic Plan and to identify how the Diabetes PIP interventions can align with and support the State Plan and vice versa. It was mutually decided that this collaboration is a natural fit. The Collaborative and the MDH Diabetes and Health Behavior Team started meeting in November 2020 and have continued throughout 2021 and 2022. MDH Diabetes Team members, Teresa Ambroz and Esther Maki, were the point people for the PIP Collaborative. The MDH Diabetes Team was diverted to work on COVID-19 pandemic initiatives in 2020 and 2021 so were grateful and appreciative to see the MCO Diabetes PIP work and interventions moving forward despite the field's focus on COVID at that time.

During 2021, MDH primarily took the role of supporting the work of the Collaborative by promoting the Collaborative's webinars. Later in 2021, more robust planning started for 2022 initiatives and identifying specific webinar topics that MDH would co-sponsor with the MCO Collaborative. The planned focus of the 2022 webinars was on food and nutritional disparities and the corresponding impact on diabetes and overall health of MSHO/MSC+ and SNBC members. The MDH/MCO Collaborative cosponsored webinars in 2022 were:

- Food is Medicine – *Integrating Effective Nutrition Interventions into the Healthcare System: A Concept Whose Time Has Come*
- Super Shelf Panel- Webinar on healthy food initiatives in Minnesota.

To continue to support the work of the MDH diabetes health initiatives, the Collaborative agreed to assist in promotion of a Diabetes Toolkit available on the MDH website:

Control Your Diabetes for Life Toolkit - MN Dept. of Health (state.mn.us)

The toolkit is posted on the Diabetes PIP page on the Stratis Website, and the link is included in Collaborative webinars throughout the year.

Hennepin Health Specific Interventions and Partnerships

Hennepin Healthcare

Hennepin Healthcare has been a long-time partner with Hennepin Health, committed and engaged in various activities and projects that address social determinants of health, improving quality care gaps, and is an active accountable health model partner. Last year, both entities worked in partnership to develop a dual role representing both agencies and serving as a change agent for the accountable health model by managing performance improvement initiatives that focus on increasing the quality of care and services. The main responsibility of the person in this role has been to work directly with

department leaders at Hennepin Healthcare and Hennepin Health to identify quality issues, create solutions to issues, and assist with implementation of corrective actions.

University of Minnesota Extension Expanded Food and Nutrition Education Program

The Expanded Food and Nutrition Education Program (EFNEP) is a United States Department of Agriculture funded program that successfully addresses critical societal concerns by employing peer educators. EFNEP positively influences nutrition and physical activity behaviors of low-income caregivers of children, and of youth attending schools with the highest free and reduced lunch rates. The EFNEP educators, called Community Nutrition Educators (CNEs), deliver a series of hands-on, interactive lessons to low-income families. Lessons are evidence-based and tailored to the needs of the audience. This education helps families develop skills, attitudes, and behaviors necessary to maintain a healthy diet and stay physically active. Hennepin Health has established a relationship with this organization and will continue to partner with this organization in 2023.

Diabetes Assessment and Member Experience

In 2021, an assessment tool addressing social determinants of health and health care delivery for SNBC members living with diabetes was developed and implemented. The purpose of the assessment tool is to gather member input to better understand how well members are managing their diabetes to better assist members, to understand each member's unique situation, and identify additional resources that may help them improve their diabetes health care outcomes. The assessment tool was shared with the SNBC member stakeholder group in October 2021 prior to the implementation of the tool. Positive feedback from the SNBC member stakeholder group was received about the tool. Members were excited about the assessment tool and felt that it would assist in providing valuable feedback to assist members living with diabetes to meet their health care goals.

Both the internal and external SNBC care coordinators conducted telephonic outreach to complete the assessment tool with members living with diabetes, starting at the end of 2021 and continuing throughout 2022. The initial assessment results were shared with the Chief Medical Officer, Director of Clinical Services, Behavioral Health and SNBC Care Coordination Manager, and the Manager of the Quality Management department in June 2022. Of the 140 members who are actively engaged in care coordination services, 55 members completed the assessment for a completion rate of 39%. One-third of the members (33%) expressed an interest in receiving information and resources to improve their understanding of their condition and to better self-manage it. Forty-nine percent (49%) indicated that they would be interested to learn more about the best foods to eat in order to better manage their diabetes. A total of 9 patients (16%) indicated that food and clothing were items they were unable to get

when it was really needed. Very few members indicated they were having difficulties with equipment such as a blood pressure monitoring equipment. The majority of members (80%) stated that they take their diabetic medications every day. Current members will be reassessed in 2023 to evaluate the effectiveness of the interventions provided to address their unique needs. New members or newly diagnosed members living with diabetes will be assessed in 2023 using this assessment tool, until the MnChoices assessment is implemented in 2023. The MnChoices assessment includes many questions contained within the Hennepin Health assessment.

Care coordinators informed members of the wellness reward incentive programs for completing an annual HbA1c test and an eye exam. Members were excited about the gift card incentive programs and were appreciative of receiving this information. Care coordinators provided information on how to obtain the rewards and worked with the members to obtain eye exam appointments and/or appointments with their health care providers to discuss diabetes management. An increase of gift card incentive reward requests for eye exams and HbA1c testing were processed in late 2021 and early 2022. Additionally, members submitted gift card vouchers for completion of HbA1c testing and eye exams throughout 2022. The rewards programs for completing an annual HbA1c test and eye exam will continue in 2023.

Hennepin Health specific interventions include member education through Healthwise Knowledgebase®, an online health resource available on the Hennepin Health website. With Healthwise® Knowledgebase, the member can research tests, medicine, 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 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.

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