Hennepin Health
your community health plan

2024-2026 SNBC – Impact of Depression on Diabetes Care Performance Improvement Project

June 1, 2025

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Rationale and Purpose

This PIP is designed to promote health equity and decrease the racial disparities for SNBC members living with both diabetes and depression by providing information for members to self-manage their diabetes and depression. The "Collaborative" participants include Blue Plus (Seniors only), HealthPartners, Hennepin Health (SNBC only), Itasca Medical Care (Seniors only) Medica, PrimeWest Health, South Country Heath Alliance and UCare.

Diabetes and depression are among the top conditions within the Senior and SNBC populations for the Minnesota MCOs participating in this PIP. Addressing the impacts of the comorbidities of diabetes and depression are supported by research on the prevalence and impacts depression can have on diabetes management, as well as impacts diabetes can have on a person with depression.

According to the American Diabetes Association (ADA), successful diabetes care requires a systematic approach to supporting patients' behavior change efforts, including:

- Healthy lifestyle choices (physical activity, healthy eating, tobacco cessation, weight management, and effective coping).
- Disease self-management (taking and managing medications and, when clinically appropriate, self-monitoring of glucose and blood pressure).
- Prevention of diabetes complications (self-monitoring of foot health; active participation in screening for eye, foot, and renal complications; and immunizations).
- ADA recommends clinicians routinely screen patients with diabetes for psychosocial challenges, including mental health concerns, referring patients to a mental health provider with knowledge and experience in diabetes, when appropriate.

The purpose of this PIP is to address the impact of depression on diabetes management and to incorporate community informed measures through work within the conceptual community engagement model. In essence, the hope would be to impact both the mental and physical health conditions simultaneously to improve overall health outcomes and learn from the community what actions they feel would create the most opportunity for that improvement. There appears to be a bidirectional relationship between diabetes and depression. Primary care providers have been looking at the link between the two chronic diseases in the past couple of decades. A person living with diabetes is at an increased risk of depression and a person living with depression is at increased risk of getting Type 2 diabetes. Depression may lead to challenges with managing lifestyle and completing daily activities, from eating well to exercising; both are risk factors for diabetes. People living with diabetes may struggle with managing their disease and this can cause stress, with the continued stress leading to depression. According to Psychology Today article, "Although diabetes and depression can co-occur together, both can also be treated together, and effective management of one can help have a positive outcome on the other".

Analysis

Acknowledging the complexities that can arise from attempts to directly correlate behavioral modification outcomes with specific interventions, Hennepin Health, and the Collaborative, embarked on several interventions with the expectation that we will get to know the interventions that resonate more with our members. Using the PDSA cycle, identified options were tested, adopted, adjusted, or abandoned as needed based on their usefulness to the established target outcomes. The PDSA cycle continued as lessons learned from previous cycle tests were used to reposition as needed and start a new cycle.

The measures identified below were used to monitor the success of the PIP along with non- HEDIS® measures that may be developed. The baseline rates for the PIP are the HEDIS® rates for 2019 dates of service for the diabetes related measures. For the Diagnosed Mental Health Disorders (DMH) measure, the baseline year will be 2022, which is the first year this measure was calculated. HEDIS® data from measurement year (MY) 2024 was not available at the time of writing this

document. The goal is to see year-over-year closure in the disparity gaps with a statistically significant improvement by the end of the three-year project.

- Hemoglobin A1c Control for Patients with Diabetes (HBD).
- Hemoglobin A1c Testing for Patients with Diabetes (retired, no longer using since MY2022 but will continue to report for PIP purposes).
- Blood Pressure Control for Patients with Diabetes (BPD).
- Eye Exam for Patients with Diabetes (EED).
- Diagnosed Mental Health Disorders (DMH).

Hennepin Health continues to explore the development and reporting of two non- HEDIS® metrics and conducting statistical and healthcare disparity analyses, if reported.

- 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.

The Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) Measure HEDIS® has limitations which would make data collected from this measure unreliable. This measure excludes members with depression diagnosed during the year prior to the measurement period; therefore, it may not capture the existing cohort. Automatic mental health referrals based on initial diagnoses are not current community health practices. Most primary care providers initially treat and monitor depression patients. Medications alone are not always a default choice for treatment. Only measuring medication use would exclude members not on medications. Finally, the HEDIS® electronic clinical data system (ECDS) data structure does not exist to provide a valid result.

Hennepin Health continued to monitor one or more applicable HEDIS® depression measures to determine if the data available would be useful to understand whether members living with diabetes and depression are being screened so they can receive appropriate care. The development of non- HEDIS® depression measures will continue to be pursued. It is also very difficult to tie any PHQ-9 result back to a specific intervention unless it is in a research setting. PHQ-9 data will most likely need to be monitored using process measures until it is evaluated if existing HEDIS® measures can better support the work. PHQ-9 scores are not always available and are a screening tool and not a diagnostic one. Its use does not necessarily equate to a diagnosis of depression. In review, Hennepin Health did not see any measures pertinent to the population focused on in this PIP for depression screening. Therefore, Hennepin Health is proposing the development of non- HEDIS® measures that would better evaluate and be more specific and effective to that population.

The aim of this PIP is to make year-over-year improvements in the identified HEDIS® measures for members living with diabetes and depression via the PDSA cycle. This will be incrementally achieved by engaging the community to address mental health comorbidities and health disparity gaps. In line with DHS recommendations, Hennepin Health's focus is shifting from closing racial disparities for all racial/ethnic groups to specifically focus on the members who are Black/ African American in comparison to the Non-Hispanic White population.

Additionally, planning started on implementing the recommended ITMs to closely monitor performance trends for the measures identified and offer the opportunity to promptly adopt strategies in alignment with the measurement goals using the Plan-Do-Study-Act (PDSA) technique. More information will be shared about the Collaborative's interventions in the interim report for implementation year 2024.

Collaborative and Hennepin Health specific interventions focused on reducing racial disparities and improving the rates for the measures. Collaborative interventions included the development of an education series and resources for members, care coordinators, community health workers, health coaches, and others. Hennepin Health continued to utilize existing resources such as:

- Availability of transportation resources
- Utilizing care coordination services
- Promotion of supplemental benefits including fitness memberships
- Incentives for diabetes care.

Hennepin Health continued to engage internal SNBC care navigator team members, external SNBC care coordination agencies, provider organizations and our AHM partners to address the impact of depression on the individual members living with diabetes. When the need is identified, members are 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 diabetic assessment tool, designed by Hennepin Health for the 2021-2024 Comprehensive Diabetes Care PIP, continued to be utilized with all SNBC members. The assessment was updated to include depression screening measures and has been used to determine what resources are most needed within this population as well as the intersectionality of the cooccurring conditions of depression and diabetes.

The MCOs, including Hennepin Health, continued to seek feedback from the members made possible due to multiple existing points of contact. The existing channels for community engagement continued to be used, such as SNBC member meetings, Enrollee Advisory Council (EAC), and population health efforts to gather information from members. Feedback is also received through appeals and grievances from the members and the Member Service Center. Case managers and care coordinators consistently solicited feedback from the SNBC members and, using person-centered approaches, and incorporate that feedback into management of both diabetes and depression through their individualized support plans. In addition, the collaborative and individual MCOs solicited feedback through created common questions that gathered input relevant to defining value for members' health outcomes. The feedback will be incorporated in future planning.

The Collaborative planned and executed various educational series for care coordinators to better equip them with the knowledge and skills needed to support members in managing their diabetes and co-occurring mental health diagnosis. The term "care coordinators" refers to several types of case management staff including: MCO care coordinators, community health workers (CHWs), health coaches, targeted case managers, ARMHS Workers, etc. Training was designed to address a wide variety of topics related to diabetes and depression while also providing basic foundational knowledge about best practices in working with members who have both diagnoses.

The Collaborative initiated plans to implement community-informed measurements which is important so people most negatively impacted by structural inequities can help identify, design, and validate a metric of quality that could be implemented into the overall health care quality improvement cycle. The Collaborative is committed to not overburdening the members with requests for feedback and ideas. The MCOs are conscious of this for multiple reasons, one being that communities are increasingly reporting that they are tired of being asked for their feedback without seeing meaningful change. Another reason is that when people are over surveyed, they grow weary of the process and stop participating, which in turn increases the risk of skewing data towards more engaged participants[1][2].

Hennepin Health understands that directly consulting with various marginalized member communities helps us understand what matters the most about their diabetes and/or depression care, however, the population in this PIP has very small numbers for some racial groups. Questions were developed that could be used in many settings/methods with the results aggregated so, as a Collaborative, patterns of barriers and/or successes could be identified and applied broadly. However, as the SNBC is an extremely unique population, it would be unwise to generalize the needs/goals of other demographics to this population. The response rate on surveys to this population is extremely low, and the limited number of members with diabetes and depression have further decreased the eligible population to survey.

[1] Evaluation Matters—He Take Tō Te Aromatawai 6: 2020 © New Zealand Council for Educational Research 2020 https://doi.org/10.18296/em.0054 http://www.nzcer.org.nz/nzcerpress/evaluation-matters

Hennepin Health continued to meet with community organizations that serve this population to obtain input from focus groups or member events on what is important to members about their condition(s). The organizations identified for potential partnerships use a variety of staff who directly serve the population, including certified peer specialists, CHW's, social workers, navigators, care coordinators, behavioral health professionals, and other professionals and paraprofessionals. These discussions included exploration of how the MCOs can capture the experiences of their front-line staff, which can lead to a better understanding of what is important to individuals with both diabetes and depression. This information can then be used to inform measurements or interventions for the PIP.

Recommendations and Next Steps

Hennepin Health will meet with the Collaborative twice a month throughout the PIP. Both Hennepin Health and Collaborative interventions will be implemented according to the timeline submitted in the PIP work plan. Efforts will continue to focus on developing member communications and educational trainings for care coordinators. Hennepin Health will file the Year One report with DHS by September 1, 2025.

Hennepin Health will explore with the AHM partners potential process improvements to their current diabetic and depression education programs to reduce barriers to receiving this education. Another Hennepin Health specific intervention includes engaging the SNBC care coordinators to develop a process to better identify if and what social drivers are impacting the members to receive timely health care services and/or engage in healthy activities such as exercise, weight management and blood glucose and blood pressure monitoring. Hennepin Health will investigate the potential of providing nutrition education to include coaching on how to shop for and cook foods that meet the member's dietary needs. In addition, member communications that include a direct link to appropriate community services will be created and promoted.

As progression continues on the spectrum of public collaboration, methods will continue to be refined that provide feedback about how information can be used to improve care and services to those who provide input and the public. When the Collaborative engages community partners' staff, there is a strong commitment to engage in active listening and follow-through, ensuring that the community partners' voices are acknowledged and that potential actions considered, leading to meaningful collaboration.

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