Hennepin Health

Special Needs BasicCare Depression and Diabetes Performance Improvement Project 2024-2026

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Summary

This Performance Improvement Project (PIP) focuses on addressing the comorbidities of diabetes and depression for the Seniors in Minnesota Senior Health Options (MSHO) & Minnesota Senior Care Plus (MSC+) products and the Special Needs Basic Care (SNBC) populations. The PIP will be effective from 2024 through 2026 and will be used to improve member's overall diabetes care.

To amplify our efforts and facilitate improvement, this PIP will be a collaboration of Minnesota Managed Care Organizations (MCOs) ("the Collaborative"). MCOs participating in this collaboration include Blue Plus (Seniors only), HealthPartners, Hennepin Health (SNBC only), Itasca Medical Care (Seniors only) Medica, PrimeWest Health, South Country Heath Alliance and UCare. Stratis Health provides project development support and assistance to the Collaborative. The Collaborative is attuned to the various sources of data and reporting available that helps to guide ideas for intervention and training. The Collaborative uses valuable information from sources such as Minnesota Community Measurement Minnesota Health Care Disparities Reports, the Minnesota Department of Health (MDH) Center for Health Equity, and MDH Diabetes Data and Reports, among others.

Each MCO will create and establish their own goal aimed at improving the diabetes care and services for Seniors and SNBC members while working together with the Collaborative through interventions supported by the group alongside each MCO's separate interventions.

Rationale

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

Diabetes guidelines have acknowledged the importance of psychological assessment as part of diabetes care for over 25 years. The International Diabetes Federation recommends screening for depression with a validated tool in primary care diabetes clinics and referring those who screen positively to a mental healthcare professional with expertise in diabetes.[1]

According to Mental Health America[2] "One of the biggest challenges to treatment of mental health conditions for people with diabetes is low rates of detection. Up to 45% mental health conditions and cases of severe psychological distress go undetected among patients being treated for diabetes.

The American Diabetes Association standards of care recommend that treatment teams include a mental health professional with expertise with the disease, and for people to be regularly screened. However, the reality is that few clinics working with patients who have diabetes provide mental health screening or integrate behavioral health services. That's where online screening can help. Mental health screenings are a quick, easy way to discover if what an individual is feeling could be a mental health condition.

Minnesota Department of Health (MDH) has a Diabetes Dashboard[3] for monitoring the picture of diabetes in Minnesota. The state-level indicators are a set of population level measures meant to present a broad picture of diabetes in Minnesota. One indicator within the dashboard is "Depression Among Adults with Diabetes" showing that 27% of Minnesota adults with diabetes reported they have a depression diagnosis currently or at some point. MDH has a large section on their website dedicated to addressing Diabetes and Mental Health. Their data shows that in Minnesota, nearly one in four adults living with diabetes have been diagnosed with depression. The message to health care providers is they should screen for mental health conditions, such as depression and anxiety, and talk to patients about how diabetes could be causing

[1] Speight J, Hendrieckx C, Pouwer F, et al. Back to the future: 25 years of 'Guidelines for encouraging psychological well-being.
among people affected by diabetes. Diabet Med 2020;37:1225–9.

[2] Diabetes and Mental Health | Mental Health America (mhanational.org)

[3] https://www.health.state.mn.us/diseases/diabetes/diabetes-dashboard/index.html

stress. If a patient scores high on the PHQ-9[4], GAD-7[5], or diabetes distress screening, the patient should be referred to a behavior health provider.[6]

According to the Journal of Neuroscience, the comorbidity of mental and physical disorders is a major challenge for health care worldwide. Its prevalence is increasing and is likely to continue to grow due to the increase in life expectancy and a variety of other reasons. The comorbidity of depression and diabetes can be seen as a prototypical example of mental/physical comorbidity. The prevalence of both conditions is growing, and depression is twice as frequent in people with diabetes compared with those without diabetes.[7] The Centers for Disease Control and Prevention (CDC) estimates 25-50% of people with diabetes who experience depression, do not receive a depression diagnosis 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. And without treatment, depression often gets worse. [8]

According to the American Diabetes Association[9], successful diabetes care requires a systematic approach to supporting patients' behavior change efforts, including:

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

In the American Diabetes Association's (ADA) Standards of Medical Care in Diabetes, the ADA recommends that clinicians routinely screen patients with diabetes for psychosocial challenges, including mental health concerns, and refer to a mental health provider with knowledge and experience in diabetes when an issue is identified. However, as this screening becomes part of routine diabetes care, there are a limited

[4] The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression.
[5] The Generalized Anxiety Disorder 7 (GAD-7) is a self-reported questionnaire for screening and severity measuring of generalized anxiety disorder.
[6] https://www.health.state.mn.us/diseases/diabetes/about/mentalhealth.html
[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6016052/
[8] https://www.cdc.gov/diabetes/managing/mental-health.html
[9] 1. Promoting Health and Reducing Disparities in Populations | Diabetes Care | American Diabetes Association (diabetesjournals.org)

number of mental health professionals with the knowledge and experience necessary to provide high quality mental health care for people with diabetes. For the past two years, the ADA and American Psychological Association (APA) partnered to present in-person courses for licensed mental health professionals interested in providing mental health care to people with diabetes.[10]

For this PIP, the MCO's will also be looking at the disparities that exist in the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) and non- HEDIS® outcomes between members with diabetes without depression, and members with diabetes with depression. According to Healthy People 2020, "the term *disparities* is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen to a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health. It is important to recognize the impact that social determinants have on health outcomes of specific populations.[11] Hennepin Health along with our collaborative partners will focus our efforts on reducing health disparities impacting diabetes and depression.

The 2022 Minnesota Community Measurement Minnesota Health Care Disparities report, as soon in Table 1 below, presents information on disparities by race, ethnicity, language, and country of origin for quality measures for the 2021 measurement year (data collected in 2022 for care delivered in 2021) as compared to the Minnesota Statewide Average on each measure.[12]

[10] Mental Health Provider Diabetes Education Program (apa.org)

[11] https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

[12] https://mncmsecure.org/website/Reports/Community%20Reports/Disparities%20by%20RELC/2021%20MY%20Disparities%20by%20RELC%20Chartbook_FINAL.pdf

Table 1: 2022 Minnesota Community Measurement Minnesota Health Care Disparities Report
Data Source: MNCM Minnesota Health Care Disparities Report

Optimal Diabetes Care and Adult Depression outcomes are included in the disparity table and clearly illustrate racial disparities that present opportunity for the MCO's to continue working on closing the gaps.

STATEWIDE SUMMARY BY RACE AND HISPANIC/LATINX ETHNICITY

Adult Population

Rate comparison of race/ethnicity rates to statewide rate

Measure		Statewide Rate	RACE						ETHNICITY	
			Asian	Black	Indigenous/ Native	Multi Racial	Native Hawaiian/ Pacific Islander	White	Hispanic/ Latinx	Not Hispanic/ Latinx
Colorectal Cancer Screening		72.2%	64.1% ▼	57.3% ▼	53.6% ▼	62.1% ▼	59.3% ▼	73.8% ▲	56.2% ▼	72.8% ▲
Optimal Asthma Control – Adults		50.3%	53.6% ▲	41.2% ▼	31.0% ▼	47.8% ▼	45.8% ●	51.8% ▲	44.1% ▼	50.6% ●
Optimal Diabetes Care		43.6%	45.9% ▲	33.4% ▼	25.7% ▼	35.7% ▼	38.0% ▼	45.3% ▲	35.3% ▼	44.1% ▲
Optimal Vascular Care		56.5%	64.2% ▲	43.6% ▼	44.5% ▼	49.1% ▼	54.3% ●	57.1% ▲	55.1% ●	56.6% ●
ADULT DEPRESSION	Follow-up PHQ-9/9M at Six Months	45.3%	40.7% ▼	34.4% ▼	41.8% ▼	39.8% ▼	38.4% ●	46.8% ▲	38.5% ▼	45.7% ●
	Response at Six Months	18.1%	15.0% ▼	12.8% ▼	14.1% ▼	13.5% ▼	20.3% ●	19.1% ▲	14.0% ▼	18.5% ●
	Remission at Six Months	10.3%	8.2% ▼	6.8% ▼	6.8% ▼	7.0% ▼	13.8% ●	11.0% ▲	7.3% ▼	10.6% ●
	Follow-up PHQ-9/9M at 12 Months	43.9%	40.4% ▼	32.7% ▼	36.2% ▼	37.4% ▼	39.1% ●	45.9% ▲	36.6% ▼	44.7% ▲
	Response at 12 Months	18.1%	15.2% ▼	12.1% ▼	13.5% ▼	13.3% ▼	15.9% ●	19.2% ▲	14.6% ▼	18.5% ●
	Remission at 12 Months	10.6%	8.4% ▼	6.6% ▼	6.9% ▼	7.4% ▼	10.9% ●	11.3% ▲	8.3% ▼	10.8% ●

▼ Below statewide rate ● Not statistically different from statewide rate ▲ Above statewide rate

Purpose/Goal

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. In the past couple of decades primary care providers have been looking at the link between the two chronic diseases. A person with diabetes is at increased risk of depression and a person 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, which can be risk factors for diabetes. People with diabetes may have struggles with managing their disease and this can cause stress and the continued stress may lead to depression. According to an article in Psychology Today, "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.[13]

Hennepin Health will engage internal SNBC Care Guide team members, external SNBC Care Coordination agencies, provider organizations and Hennepin County Departments (Hennepin County Health and Human Services, Hennepin Healthcare, and NorthPoint Health and Wellness Center) to address the impact of depression on the individual members living with diabetes. SDoH and barriers to care will also be identified and addressed in order 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.

[13] The Relationship Between Diabetes and Depression | Psychology Today

Measures of Success

The aim of this PIP is to make year-over-year improvements in the identified measures via the PDSA cycle. In line with DHS recommendations (via email on November 3rd, 2023), we are shifting from a focus on closing racial disparities from all racial/ethnic groups to specifically focus on our members who are black in comparison to the white population. In addition, our 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.

Using the Index of Disproportionate Under-Representation (IDU) we can continue to monitor and identify disparity subpopulations in terms of their receipt of evidence-based health care relative to the general Hennepin Health population. Using these calculations for this PIP, we will see those year-over-year improvements.

Methods

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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 get to know the interventions that will resonate more with our members. Using the PDSA cycle we will test out the identified options, adopt, adjust, or abandon initiatives as needed based on their usefulness to the established target outcomes. The PDSA cycle will continue as we use lessons from previous cycle tests to reposition as needed and start a new cycle.

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 Plan-Do-Study-Act (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 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.

Community Informed Measurement

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 Seniors 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".[14] 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.

The National Academy of Medicine's *Conceptual Model for Assessing Community Engagement*[15] describes four main domains and indicators of impact: Strengthened Partnerships and Alliances, Expanded Knowledge, Improved Health and Health Care Programs and Policies, and Thriving Communities. The Collaborative will consider these domains when evaluating our engagement processes.

The Collaborative met with Minnesota (MN)-based HealthPartners Institute for Medical Education to discuss community engagement; they shared the model below from the International Association for Public Participation.[13] Within the model is a defined spectrum of public participation and goals. See a visual of the model below. The Collaborative is proceeding within the *consult* level of the spectrum which is to *obtain public feedback on analysis, alternatives, and/or decisions*. The corresponding promise to the public is to *keep you informed, listen to, and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.* The Collaborative chose this level of engagement as it seems most appropriate given the nature of the relationship between the community and health plans, as well as the extent to which health plans can feasibly influence the community's environment and social drivers of health.

[14] Presentation by Dr. Mark Foresman at the May 23rd, 2023 Quarterly Workgroup Meeting.
[15] https://nam.edu/programs/value-science-driven-health-care/achieving-health-equity-and-systems-transformation-through-community-engagement-a-conceptual-model/

Figure 1: Decide how you can engage community -Spectrum of Public Participation

Source: International Association for Public Participation

The Collaborative is committed to not overburdening our 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.[16] Finally, the MCOs must also consider the internal costs of efforts in terms of staff time and expertise in community engagement as this work is not accompanied by an increase in funding to the MCOs. As such, to the greatest extent possible the MCOs will leverage existing resources such as member meetings and population health efforts to gather information from our members. The MCOs already regularly seek feedback from our members so are fortunate that there are existing points of entry.

Hennepin Health Specific Community Engagement

Hennepin Health will work with the Collaborative on engaging our collective membership 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, we also have MCO-specific resources to employ for this new expectation.

Hennepin Health's Accountable Health Model (AHM) includes our partner, Hennepin Healthcare, which is the system which is utilized by about 50% of our current membership. Every three years, Hennepin Healthcare conducts a Community Health

[16] 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

Needs Assessment (CHNA), which is used to identify the priority health care needs of the community it serves. An implementation plan is then developed and executed to address priority health needs. The 2022 CHNA reviewed existing community data and gathered new, qualitative data through individual and facilitation group conversations with community stakeholders and public health leaders. Hennepin Healthcare deliberately sought input from the Black/African American, Native American, Hispanic, Somali/East African, and Hmong communities, as well as people of all age groups, those who identify as LGBTQ+, and parents of special needs children. Sessions were conducted in multiple languages either directly or through interpreters. Following a daylong prioritization event, the following needs rose to the top[17]:

1. Need Number One: Access to Health and Safety as a Human Right
   a. Improve access to affordable care.
   b. Demonstrate commitment to women's reproductive and comprehensive health care.
   c. Address health and wellness issues related to people feeling chronically unsafe.
2. Need Number Two: Comprehensive, Equitable Education
   a. Address impacts of trauma and systemic racism in health care.
   b. Provide more culturally tailored community health education (based locally with topics determined by community).
   c. Engage in more two-way communication between Hennepin Healthcare and the community.
3. Need Number Three: Advocacy and Cultural Sensitivity
   a. Hire more multi-lingual providers.
   b. Have community, cultural elders on staff.
   c. Improve navigation and coordination of care and access to information and resources.
   d. Hire cultural navigators to help patients navigate the system and help advocate for individual needs.

To the extent possible, Hennepin Health will apply these findings to our work, as well as participate in the Hennepin Healthcare CHNA implementation process to the benefit of our members. In the case of this 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 our SNBC members living with diabetes. Hennepin Health has begun the exploration process to identify available nutrition and cooking education for our members living with diabetes, initially in North Minneapolis area and geared toward our Black membership who reside there. The Hennepin Health diabetic assessment tool will continue to be a key source of member feedback for our

[17] Hennepin Healthcare 2023-2025 Community Health Needs Assessment, Implementation Plan-Health Services Plan; Approved by the Hennepin Healthcare System Board on 4/26/2023

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.

Currently, the MCOs, including Hennepin Health regularly seek feedback from our members and are fortunate that there are multiple existing points of contact. We will seek to use existing channels for community engagement, such as member meetings, Enrollee Advisory Council (EAC), and population health efforts to gather information from our members. We also receive this feedback through appeals and grievances from our members as well as through our member service center.

Overall, the idea of community-informed measurement is having groups of people most negatively impacted by structural inequities help identify, design, and validate a metric of quality we can then consider implementing into our overall healthcare quality improvement cycle.

Hennepin Health understands that directly consulting with various marginalized member communities will help 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. We are hoping to develop questions that can be used in many settings/methods with plans to aggregate the results as a Collaborative to identify patterns of barriers and/or successes that can be applied broadly.

While there may be some studies to inform an approach, SNBC is an extremely unique population, and it would be unwise to generalize the needs/goals of other demographics to this population. We also need to acknowledge that 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.

Hennepin Health is meeting 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 we have connected with for potential partnerships use a variety of staff who directly serve the population, including Certified Peer Specialists, CHW's, Social Workers, navigators, Care Coordinators, Care Guides, behavioral health professionals, and other professionals and paraprofessionals. These discussions include exploration of how the MCOs can capture the experiences of their front-line staff can help us better understand what is important to someone in these populations with both diabetes and depression. This information can then be used to inform measurement or interventions for this project.

As we move further along this spectrum of public collaboration, we will need to refine methods of providing feedback about how that information was used to improve care and services to those who provided input and the public. When the Collaborative engages staff from community partners, we can follow up to confirm what we heard and what we have done about it. Hennepin Health will also need to develop ways to engage and involve our members in that dialogue as we build our community engagement capacity.

Measures of Success

In addition to the stakeholder member meetings, Case Managers and Care Coordinators consistently solicit feedback from our SNBC members and, using person-centered approaches, and incorporate that feedback into management of both diabetes and depression through their individualized support plans.

Strong Action

The Collaborative has worked together to educate Care Guides and Care Coordinators on several diabetes related topics throughout the length of the 2021-2023 SNBC Comprehensive Diabetes PIP and will continue that work going forward. Alternatively, the MCO-specific initiatives are developed with an MCO's specific resources and membership as focus. Community engagement activities will be developed with a focus on direct health plan member feedback or community members with experience and understanding of communities and members the health plans serve. Hennepin Health is considering several interventions as described below and intends to be flexible as we incorporate learnings from the community engagement process.

MCO Interventions

Diabetic Nutrition and Cooking Education

One request that rose to the top in Hennepin Health's diabetic member assessments is the need for more education around nutrition and cooking. Hennepin Health is exploring how we can provide culturally relevant and diabetes specific nutrition and cooking classes in our member's communities and/or reimbursing members for registering for such classes provided elsewhere.

Eye Exam Outreach

Hennepin Health has focused on improving our EED rates for several years, yet the EED rates continue to below the Minnesota Medicaid average. Hennepin Health will continue to focus attention on this measure through increased member outreach and promotion of the member incentive for eye exams. This topic will specifically be explored during the community engagement process, as the barriers we have identified anecdotally, thus far, are varied and it is difficult to ascertain which points could most benefit from our attention.

Member Engagement Opportunities

As discussed earlier in the proposal, Hennepin Health intends to leverage the existing diabetic assessments and SNBC member meetings to engage our membership around how Hennepin Health can better support our members in addressing their mental health issues. To the extent possible, information from MnChoices will be utilized. We may also incorporate screenings and interventions into the engagement opportunities themselves, thereby both receiving member input and providing a service simultaneously. An example of this would be doing PHQ-9 screenings or handing out eye exam vouchers at SNBC member meetings.

Depression Screening Opportunities

Hennepin Health may explore interventions to support screening members living with diabetes for depression at regular intervals based on recommended practice guidelines. These interventions may include member and provider incentives for completing a PHQ-2 or PHQ-9.

Collaborative Interventions

Education and Training for Care Team

The MCO Collaborative will plan an education series for Care Coordinators that will focus on better equipping them with the knowledge and skills to best help members manage their diabetes and a co-occurring mental health diagnosis. The term “Care Coordinators” here refers to various types of case management including: MCO Care Coordinators, Community Health Workers, Health Coaches, Targeted Case Managers, ARMHS workers, etc. Care Coordinators are diverse in terms of their education, areas of expertise, ethnicity, life experience, and the skillsets that they bring to their role. Training will be designed to address a wide variety of topics related to diabetes and depression but will also attempt to level set some basic foundational knowledge about best practices in working with members who have both diagnoses. Examples of diabetes and depression training topics could include Diabetes and Depression Comorbidity, SDOH impact on Diabetes and Depression, Stigma Around Both Diseases, Race and Ethnicity Impact, Resources, MCO Supplemental Benefits, Motivational Interviewing, etc.

These are all things that are within the Care Coordinators role to educate, support, and assist the member to set health goals to improve their diabetes care. Care Coordinators routinely complete the HRA yearly in which members are screened for behavioral health. Direct service Care Coordinators often have unique abilities to engage with their clients in such a way that they are willing to accept the support and help offered. Research shows that the use of motivating and affirmative language when working with members with diabetes is critical to successful outcomes and will be incorporated into the Care Coordinator trainings throughout the project.

Process Measures for Care Coordination:

1. Number of trainings provided for Care Coordinators
2. Number of attendees at each training
3. Evaluation results from the trainings
4. Number of educational materials developed for Care Coordinators

The webinar series developed by the collaborative for this project will build upon the foundational education care coordinators gained via the 2021 Diabetes PIP webinar series. The educational opportunities developed for that project focused on a foundational understanding of diabetes as a chronic disease - the disease burden and progression including the short- and long-term impacts of the disease and how care coordinators could support members in their approach to managing diabetes.

Webinars are being planned that expand on the diabetes baseline knowledge and integrate the added element of dealing with a behavioral health condition while managing a chronic medical condition.

For example, in Q1, the Director of Behavioral Health Case Management for HealthPartners will present a webinar focused on Diabetes and Depression directly to SNBC members. The outline for this presentation includes:

- Why mental health matters
- The mind-body connection
- Diabetes Distress and Burnout
- Addressing Mental HealthPartners
- Enlisting Support and Care
- Self-care for Depression and Diabetes

This webinar will be followed in Q2 by a companion webinar by the Medical Director for Behavioral Health and the Associate Medical Director for Quality at HealthPartners aimed at case managers and care coordinators who communicate most regularly and directly with our members which will build on these themes and include case examples of members who have struggled with these conditions and what their progress has looked like. These are examples of webinars currently in the planning stages and will be supplemented by additional webinars based on needs identified through webinar evaluation and the continuous process of meeting with potential partners and identification of partnership opportunities.

In the past, Hennepin Health has been fortunate to work with community partners such as Minnesota Visiting Nursing Association (MVNA) and Touchstone Mental Health to address mental health recovery and to develop skills needed to live well in their community. These past relationships have proven effective and beneficial in connecting our efforts to target populations and soliciting meaningful feedback which continues to drive programming efforts. Building strong community partnerships only furthers our efforts to increase member involvement. For the purposes of this PIP, we will be exploring similar community partnerships to increase community engagement and member empowerment. These partnerships also serve as a direct link to community input and feedback.

Tools and Resources

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

For clinicians, care coordinators and others who support our members, it can be difficult to track the resources available to each person when they may work with people on all MCOs. This project will continue to assess the need for aligning tools across MCOs to enhance the utilization of supplemental benefits that would support the care of our members.

Collaborative Interventions

The Collaborative is focused on ensuring continual attention to opportunities to include resources that promote health care equity, and culturally tailored resources. Some resources that we anticipate including are:

- Supplemental benefits for each plan 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 plan.
- How to access resources to address SDOH as appropriate.
- Transportation services available.
- Incentives for diabetes care.
- Mental health referral resources.

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 SDOH. This includes agencies, organizations, or tools such as UniteUs, FindHelp, Hunger Solutions, and FoodRx. This project will capitalize on those relationships by integrating processes to identify and refer members with diabetes with or without depression who may also have additional social risk factors. Care Coordinators have an opportunity to work with members on problem-solving to address a diverse range of needs.

While the partnering organization(s) may vary by MCO, we will work collaboratively to promote the availability of these resources for our members. It is important to understand how SDOH overall impacts mental health which in turn may impact the chronic condition of diabetes. MCO's data may be available in the MnChoices HRAs on SDOH at a future state but currently this data is unavailable at an aggregate level to create interventions.

According to an article in the Journal of Medical Informatics Association[18] "Social determinants of health are known to influence mental health outcomes, which are independent risk factors for poor health status and physical illness. Currently, however, existing SDOH data collection methods are ad hoc and inadequate, and SDOH data are not systematically included in clinical research or used to inform patient care. Social contextual data are rarely captured prospectively in a structured and comprehensive manner, leaving large knowledge gaps. Extraction methods are now being developed to facilitate the collection, standardization, and integration of SDOH data into electronic health records. If successful, these efforts may have implications for health equity, such as reducing disparities in access and outcomes. Broader use of surveys, natural language processing, and machine learning methods to harness SDOH may help researchers and clinical teams reduce barriers to mental health care."

Process Measures for Tools and Resources:

1. Number of tools developed.

[18] Social determinants of health in mental health care and research: a case for greater inclusion - PMC (nih.gov)

2. Each MCO will determine the metrics they will use as a process measure to identify utilization of SDOH resources.

Community Outreach and **Partnerships**

2030 Minnesota Cardiovascular Health and Diabetes State Plan

In September 2018, CDC awarded funds to State and Local Health Departments to design, test, and evaluate innovative approaches to address the significant national health problems of diabetes and heart disease and stroke.[19] MDH was one of the awardees. With CDC support, these health departments will develop new approaches to increase the reach and effectiveness of evidence-based public health strategies in populations and communities with a high burden of diabetes, heart disease and stroke. Recipients will conduct rigorous evaluations so that CDC and others can learn from this work.

The creation of the 2030 Minnesota Cardiovascular Health and Diabetes Plan is a collaborative effort of state and local partners; started in 2019 and lead by MDH. The plan will be a road map 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 2019, MDH conducted a comprehensive assessment of the burden of cardiovascular disease, stroke, and diabetes in the state. They reviewed past strategic plans, gathered community input through an online survey, analyzed surveillance data, and conducted interviews of key community members.

In March 2019, MDH convened a Leadership Team of community leaders to advise and guide the planning process. The Leadership Team adopted three thematic areas for focus in this plan:

- Prevention
- Acute Treatment
- Disease Management

MDH developed a Control Your Diabetes for Life Toolkit and data identified a total of 498 downloads since 2019. MDH also has a site dedicated to Diabetes and Mental Health Diabetes and Mental Health - MN Dept. of Health (state.mn.us) and has developed “Every day tools and Tips” in a PDF Mental Well-Being (state.mn.us) These links may be shared with Care Coordinators for their work with members.

The Collaborative has worked with the workgroup at MDH, during the previous DHS Diabetes PIP, and we intend to continue these collaborative efforts.

Hue-MAN

The Hue-MAN partnership is a coalition of organizations and individuals who collaborate to address public health issues that have been identified as important by the

[19] Innovation Awards: Diabetes, Heart Disease, and Stroke | CDC

community. A core value of Hue-MAN is listening to community as it self-identifies its needs. The partnership then works with partners willing to address those concerns.

Hue-MAN is primarily metro-based, but also works with partners state-wide on health issues. For example, they have been in partnership with the Minnesota Department of Health on educating the community on diabetes issues.

Hue-MAN already works with MCOs (including some involved with the Collaborative), governmental agencies, community organizations, individuals, media, and academic institutions to uncover the access, resources, or information needed to create a healthier community.

The Collaborative approached Clarence Jones, Hue-MAN Executive Director, to explore collaboration with Hue-MAN. As a trusted community group, Hue-MAN is viewed as a catalyst to enable the Collaborative to hear authentic community input on the topic of diabetes. We met with Mr. Jones on August 24th, 2023, and look forward to further developing this relationship. Members of the collaborative will attend a Hue-MAN hosted community event in late September to hear directly from the community about their struggles and potentially meet and connect with others who are interested in working on this issue with the Collaborative. How this collaboration will play out will be determined by what the community identifies as needs, and the partners we identify to support steps to impact those needs.

National Alliance on Mental Illness

The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. What started as a small group of families gathered around a kitchen table in 1979 has blossomed into the nation's leading voice on mental health. Today, this is an alliance of more than 600 local Affiliates and 49 State Organizations who work in communities to raise awareness and provide support and education that was not previously available to those in need.

The Collaborative will explore opportunities to partner with NAMI Minnesota to identify opportunities to better support members with diabetes and depression.

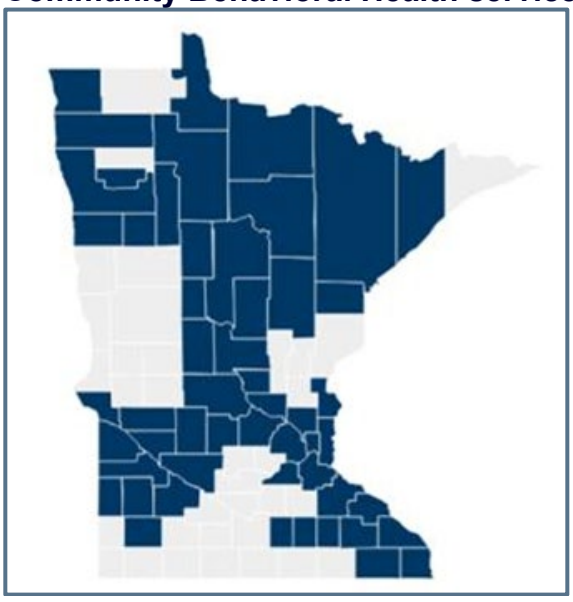
The Minnesota Association of Community Mental Health Programs

Another new partnership the MCO Collaborative is engaging in for this PIP is with The Minnesota Association of Community Mental Health Programs (MACMHP). MACMHP is a statewide network of 35 community-based mental health programs that serves over 200,000 Minnesotans each year. One of the efforts that MACMHP supports is the Certified Community Behavioral Health Clinics (CCBHCs) across Minnesota. The CCBHC model began as a federal demonstration in Minnesota in 2016, as part of a nationwide effort to implement integrated behavioral health care. CCBHCs are now able to bill services related to integrated mental health and substance use care to the Medicaid program, and do not turn away clients, regardless of ability to pay.

The goals of the CCBHCs, as determined by DHS, in conjunction with federal guidance from Substance Abuse and Mental Health Services Administration (SAMSHA), include

providing a single point of service to meet individual and family's needs around mental health and substance use. Standardized measures are monitored and reported to the state, including Quality measures, consumer level data and experience of care surveys. MAHMCP provides support and guidance for CCBHCs to implement quality improvement and monitoring for the processes and outcome measures. One example that connects CCBHC and integrated care to this PIP topic of Diabetes and Depression is that CCBHCs began collecting and monitoring physical health information such as Hemoglobin A1c, to help identify, intervene, and treat chronic conditions like diabetes, alongside behavioral health support. As of 2022, many of Minnesota's counties have a CCBHC clinic or services provided (see Figure 1). By connecting with MACMHP, we can partner with CCBHCs across Minnesota to better understand the member level needs and priorities, and how to partner to support the initiative to reduce the impact of diabetes and depression at a broader statewide level.

Figure 2: CCBHCs in Minnesota – Counties marked in blue have Certified Community Behavioral Health services. [20]



Plan for 2024

The 2024 work will set the stage to identify and build community partnerships and develop community informed measures to offer interventions more effectively to communities served.

To monitor our progression of interventions we will work towards the following timeline.

1st Quarter 2024

[20] *ShieldSquare Captcha*. (n.d.). ..Mn.Gov. Retrieved August 31, 2023, from https://mn.gov/dhs/assets/ccbhc

- Identify work already being done surrounding community informed measures/studies that could be utilized to further work.
- Meet with the community partners identified above. Learnings will drive education and training.
- Discovery/research of resources for community organizations and state-funded community support services.
- Plan schedule of webinars for the year.
- Schedule and host webinars as appropriate.
- Update and promote supplemental benefits grid under tools and resources.
- Hennepin Health will explore development and implementation of two non-HEDIS® measures for depression screening.
- Hennepin Health will review and revise diabetes assessment tool, as appropriate.
- Hennepin Health will explore/determine potential supplemental benefits, including culturally specific nutrition and cooking education classes.
- Hennepin Health will develop and implement a member communication strategy to promote eye exams.
- Hennepin Health will continue to promote the rewards specific for members living with diabetes.
- Hennepin Health will explore interventions to support screening for depression for members living with diabetes.

2nd Quarter 2024

- Develop tools and resources for the various audience members – Care Coordinators, Primary Care Providers (PCP), etc.
- Schedule and host webinars as appropriate.
- Start developing information hub to house resources and informational materials.
- Hennepin Health will Implement revised diabetes assessment tool.
- Hennepin Health will implement interventions to support screening members living with diabetes for depression, if appropriate.
- Hennepin Health will provide trainings on supplemental benefits to various audience members, if appropriate.
- Hennepin Health will identify and implement activities to engage SNBC members in identifying how Hennepin Health can support them in addressing their mental health issues.
- Hennepin Health will develop member communications addressing supplemental benefits, including diabetic nutrition and cooking education classes.

3rd Quarter 2024

- Schedule and host webinars as appropriate.

- Hennepin Health continues to implement tools/resources/communications to various audience members, as appropriate.

4th Quarter 2024

- Schedule and host webinars as appropriate.
- Discuss milestones for 2025.

Footnote:

[1] Minnesota Community Measurement 2019 Minnesota Health Care Disparities Report, June 2020.

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