Hennepin Health
your community health plan

2024-2026 SNBC Diabetes and Depression Performance Improvement Project

First Year Report

September 1, 2025

Table of Contents

Summary **2**
Rationale 2

Purpose **2**

Measures of Success **2**
Methods 2
Community Informed Measurement 3
Hennepin Health-Specific Community Engagement 7
Data Limitations 8
MCO Specific Goal 9
Measures 9

Data Analysis **10**
Statistical Analysis 10
Healthcare Disparity Analysis 11

Strong Action **14**

Intervention Tracking Measures (ITMs) **14**
MCO Interventions 15

Collaborative Interventions **16**
Education and Training for Care Team 16
Tools and Resources 20
Community Outreach and Partnerships 22

Barriers and Challenges **24**

Sustainability **27**
Changes Made 27
Assessment of Short-term and Long-term Effects 27

Plan for 2025 / Next Steps **27**

Summary

This Performance Improvement Project (PIP) focuses on addressing the comorbidities of diabetes and depression for the Seniors in Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) products and the Special Needs Basic Care (SNBC) product. The PIP is effective from 2024 through 2026 and aims to enhance overall diabetes care for members.

To amplify the efforts and facilitate improvement, this PIP is 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.

Each MCO creates and establishes their own goal(s) 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 comorbidities of diabetes and depression is strongly supported by extensive research highlighting the bidirectional relationship between the two – how depression can negatively affect diabetes management, and how living with diabetes can exacerbate symptoms of depression.

Purpose

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. The hope is 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.

Measures of Success

The aim of this collaborative PIP is to progress year-over-year improvement in the years 2024 through 2026 for members with diabetes and depression by engaging the community to address health disparity gaps and improve effectiveness of care for diabetes HEDIS® measures.

Methods

This project measures gaps in care by leveraging the HEDIS® comprehensive diabetes care measures with a focus on members who have comorbidities with diabetes and depression. Each MCO has identified which measure(s) to focus targeted efforts. Hennepin Health continues to explore the feasibility of developing two non- HEDIS® metrics to identify the following:

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

Community Informed Measurement

As directed by the Minnesota Department of Human Services (DHS) in May 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".[1] 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.

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 that can be considered for implementing into the overall health care quality improvement cycle.

The Collaborative understands consulting with various marginalized member communities directly will help the MCOs understand what matters the most about their diabetes and/or depression care, however, the population in this PIP has small numbers for some racial groups. Questions were developed 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 and MSHO are both extremely unique populations, and it would be unwise to generalize the needs/goals of other demographics to those populations. It needs to be acknowledged that the response rate on surveys to these populations is extremely low, and the limited number of members with diabetes and depression has further decreased the eligible population to survey.

In the first half of the year, the Collaborative established two common questions that would be used across MCOs to gather community input relevant to defining value for members' health outcomes. The purpose of producing these questions was to overcome the limitation of the small numbers within individual plans and the difficulty of engaging members and gathering meaningful data from small pools of participants. Compiling responses from the various plans into a single data set offers a broader perspective on what members consider most important for their health. The following questions were used to obtain community feedback through informal discussions with:

(i) "What or who has been the most helpful in managing your <diabetes or depression>, <physical or mental health>, and how?"
(ii) "What could your health plan offer that would help you achieve your best health?"

Over the course of the year, the Collaborative used the questions in different settings including stakeholder meetings such as the Enrollment Advisory Committees, MSHO and SNBC member meetings/ outreach, and at public events including the Minnesota State Fair, flu clinics, and MCO Member Day events. Below is a summary of the feedback received for the two questions:

Feedback from members highlighted the vital support from family members and pets in managing their daily activities and medical needs. Likewise, members found care coordinators

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

and care navigators invaluable for clarifying health benefits, providing regular preventive care reminders, problem solving and offering advice. Other providers like doctors, home care nurses, therapists, mental health workers, and Personal Care Aids (PCAs) were also found to be supportive. Members used health management tools like pill boxes, medication reminder applications, and electronic glucometers to manage their conditions, and emphasized the benefits of health and wellness activities including exercise, gym membership and telehealth visits.

To achieve their best health, members had the following recommendations for health plans:

- Regular well-being check-ins to ensure individuals are doing well.
- Providing more detailed information and coverage options for dental procedures.
- Offering coverage for continuous glucose monitors earlier to prevent worsening health conditions.
- Offering and / or increasing access to gym memberships to promote physical fitness.
- Offering incentives to make healthy food options, like fruits and vegetables, more affordable.
- Offering nutrition education to help individuals make better dietary choices.

To supplement the discussion questions, the Collaborative also developed a set of survey questions to gather more insights from members about their expectations to meet their health needs. The survey was administered to the MSHO, MSC+ and SNBC populations. A QR code was developed for each MCO to enable use of the questionnaire at different community events. While the cumulative results of the survey could be gathered for the collaborative efforts, MCOs could also access their MCO specific data. Apart from the demographic and insurance questions, the survey covered the three key questions below:

(i) Imagine your health plan helping you achieve your best health. What does that look like?
(ii) What has been going well in managing your chronic condition?
(iii) What has been the most challenging part of managing chronic condition(s)?

In total, 48 members completed the survey, including 4 incomplete responses which were not counted in the data. Out of the 44 complete survey responses, 94% had Medical Assistance (MA), 37% had Medicare (dual eligibility with MA) and 6% of the members chose not to disclose their health insurance type. The highest responders to the survey were White (41%), followed by Black/African American (27%), Asian/ Pacific Islander (10%), and American Indian (5%). The race of 17% of respondents was unidentifiable. The primary language for 83% of respondents was English. Other identified languages were Somali (4%) and Vietnamese (4%). The primary languages of 9% of respondents were not identifiable. See Figure 1 and Figure 2 below for race and language representation of respondents.

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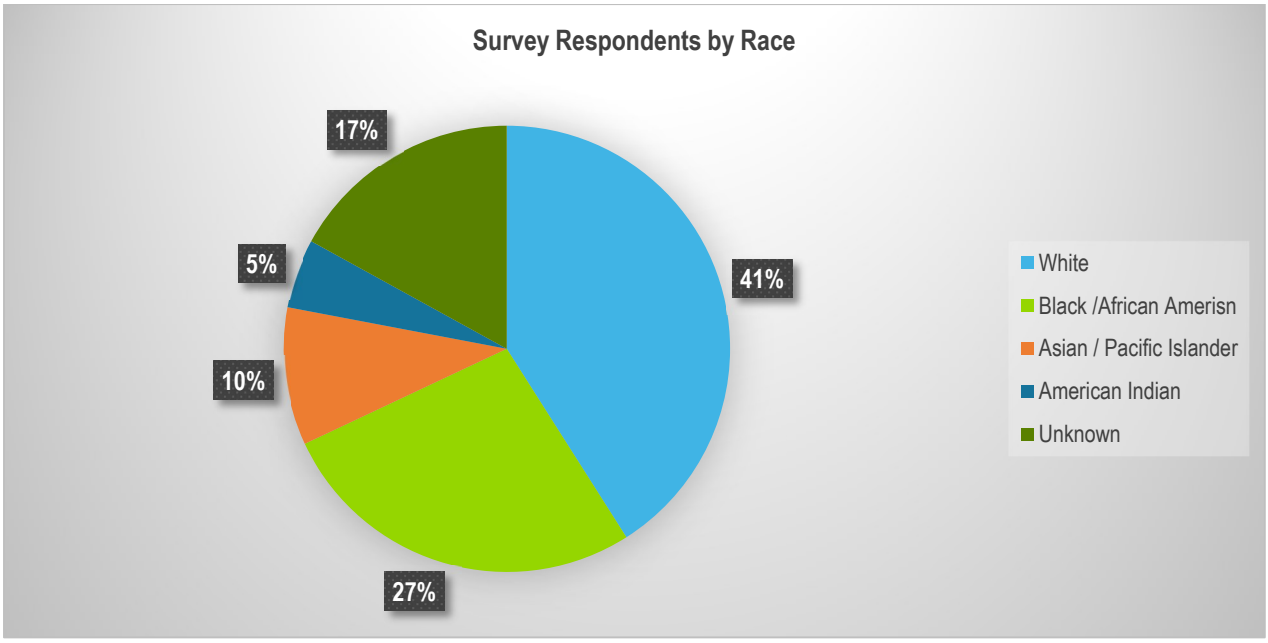
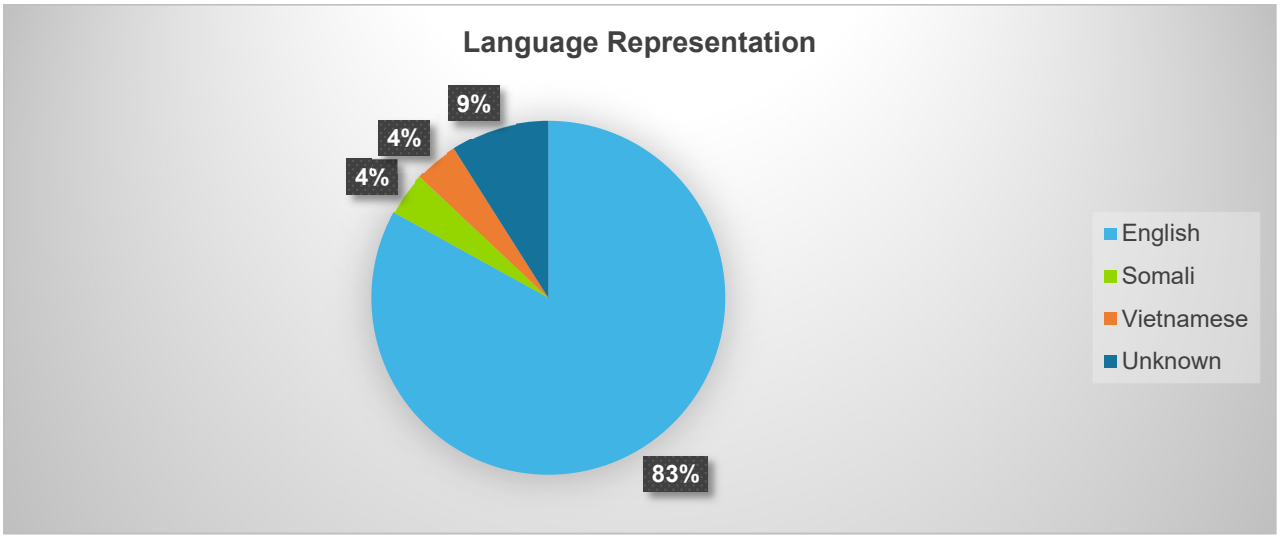
Figure 1: Survey Respondents by Race



Data Source: Stratis Health Data

Figure 2: Language Representation of Respondents



Data Source: Stratis Health Data

From the perspective of members, best health is achieved when there is:

- Constant communication with providers and helping meet physical activity needs.
- Support for achieving best health through various services and resources.
- Knowledgeable providers and personalized care coordination.
- Support in home with smoke-free environments, weight loss, exercise, and healthy meals.
- Support for aging, health, and financial needs through annual classes and quarterly checkups.
- Increased availability of doctors and more providers with shorter waitlists.
- Support for mental health with online services for convenience and privacy.
- Transportation assistance and home visits for those in need.
- Educational outreach, classes on stress management, and health events.

- Early health education for youth and support for maintaining a happy and healthy lifestyle.
- Comprehensive coverage for services and medications.

Some key successes that members have experienced in managing their chronic conditions included:

- Support from materials, services, and programs.
- Family assistance in managing chronic conditions.
- Effective communication with primary doctors and care coordinators.
- Healthy diet adjustments.
- Listening to one's body and regular checkups.
- Access to medical transportation and services.
- Medications and quality care from primary care physicians and specialists.
- Help with diabetic conditions.
- Participation in hobbies and social activities reduces anxiety.

The most challenging part of managing chronic conditions for members included:

- Challenges with member services and getting proper attention.
- Issues with sleep studies and coordination.
- Difficulty managing diabetes.
- Balancing body movements.
- Managing chronic conditions like low back pain.
- Problems with mobility and stress.
- Finding support groups and assistance for quitting smoking.
- Living alone and aging concerns.
- Dietary restrictions and new habits.
- Scheduling suitable medical appointments.
- Switching doctors and obtaining proper medical care.
- High medical or pharmacy costs.
- Issues with health insurance.

The Collaborative also pursued community engagement by soliciting input and feedback from webinar participants, primarily providers serving MCO members. Direct feedback from providers such as care coordinators gave insights into what matters to the members from the providers' perspective. This input is crucial for enhancing health outcomes and guides future collaborative activities. Polls were utilized during webinars to ask about topics providers wanted covered in educational sessions. Feedback indicated a desire for a stronger connection between webinar contents and measurable health improvements.

While achieving significant attendance at community engagement meetings is challenging, the Collaborative will continue to explore ways to enhance community participation by strengthening partnerships and utilizing existing feedback loops. Considering surveys are currently in English, the Collaborative may translate surveys and discussion questions into languages like Somali, Hmong and Spanish. To accommodate those less familiar with technology, (MSHO, SNBC, MSC Plus populations), we will explore discussing the survey questions during members sessions.

Hennepin Health-Specific Community Engagement

Hennepin Health has worked and will continue to work with the Collaborative on engaging our collective membership for guidance on defining success and refining the direction of these PIPs.

Hennepin Health's Accountable Health Model (AHM) includes our partner, Hennepin Healthcare, which is the system utilized by about 50% of our current membership. Every three years, Hennepin Healthcare conducts a Community Health Needs Assessment (CHNA), which is used to identify the priority health care needs of the community it serves (submitted with original proposal). 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[2]:

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

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

be a key source of member feedback for our 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 is utilized as an opportunity for direct member consultation on this PIP. These meetings were held in both May and October of 2024. The focus of the meeting held in May 2024 was on eye health, mental health, and dental health—with a step-by-step appointment walk through by a dental provider. October's meeting reiterated dental services, available rewards and highlighted waiver services and care coordination efforts.

Data Limitations

A data limitation in each measure is the hybrid collection methodology that we all employ. The hybrid methodology allows the health plan to use a sample size of 411 to review compliance via medical record abstraction rather than reviewing the data for the full population. Hennepin Health's SNBC member sample size for the NCQA HEDIS® Effectiveness of Care Diabetes measure set is under 411; therefore, Hennepin Health's entire population is reviewed using the hybrid collection methodology. The hybrid rate provides this project with a project goal that is statistically valid but cannot demonstrate race/ethnicity analysis. To account for this, Hennepin Health's Data Analytics department uses the DHS enrollment data, including the twice-a-year enhanced race/ethnicity data to extrapolate race and ethnicity for the SNBC HEDIS® Effectiveness of Care Diabetes measure samples.

If Hennepin Health's sample size exceeds the 411 requirement at some point during this project, Hennepin Health will produce two rates – Hybrid and Administrative. The administrative rate includes race and ethnicity data that is supplied through the DHS enrollment files and DHS enhanced race/ethnicity data, and therefore, provides the opportunity to analyze the data by race and ethnicity.

Lastly, all the MCOs acknowledge collecting data on patient race, ethnicity, and language (REL) is an important step in reducing health care disparities, as REL data allows for the stratification of clinical performance measures that guide quality improvement efforts. To see success in this project, we encourage our DHS partners to continue their efforts to increase the availability and quality of data on race and ethnicity. This optional information is collected through the enrollment application and shared with health plans via the 834 monthly feeds. We welcome additional and ongoing conversations via our quarterly MCO-DHS Quality Workgroup or other venues meeting to discuss solutions to the critical gaps in data on race, ethnicity, and socioeconomic status in existing systems.

On July 1, 2024, the platform DHS "MnCHOICES" was launched with all MSHO/MSC+ and SNBC care coordinators in Minnesota using it to document their work with members in the system. The documentation within this platform presents the potential for member data that will be invaluable to quality improvement work. In particular, the MnCHOICES Annual Health Risk Assessment (HRA) completed with each member contains firsthand member health information that, when extracted, could provide member data that is not accessible on an aggregate level. However, the capability for this data to be used by the MCOs is limited due to the quantity of the data, and it will take some time to mine the data for what is needed.

Efforts to use HEDIS® depression measures that include items like the PHQ-9 to monitor how interventions affect a change are currently limited because of the available measures and by the Electronic Clinical Data Systems (ECDS) nature of the measure.

Most HEDIS® depression measures track depression diagnosis billed during the calendar year. Providers sometimes do not code for it, making it appear as though the person no longer has depression when it simply was not coded. Overall, the depression measures HEDIS® is starting to use are intended to be helpful but will only represent part of the story for members living with chronic depression.

Monitoring PHQ-9 screening data has its limitations as well. PHQ-9 data is only available from providers that send MCOs clinical data and is limited due to the lack of claims information on depression screening. Members who work with a care coordinator already have a tool that is not PHQ-2 or PHQ-9 within their normal workflow. Both systems' issues lead to unreliable data collection and reporting.

The MCOs will continue to monitor one or more HEDIS® depression measures to determine if the data that is available is useful to understand whether members living with diabetes who have depression are being screened so that they can receive appropriate care. It is also difficult to tie any PHQ-9 result back to a specific intervention unless it is in a research setting. PHQ-9 data will need to be monitored using process measures until it can be determined how existing HEDIS® measures can better support this work.

Through claims data and chart review, the number of members who have been screened for depression will be calculated. The most common screening tool used for this is the PHQ-2 screening. Hennepin Health will continue to explore other options to collect and understand this screening data.

MCO Specific Goal

Hennepin Health seeks to improve the health and wellness of SNBC members, ages 18 – 65, diagnosed with diabetes mellitus and depression. The goal is to reduce disparities in healthcare, access to care, and to address social drivers of health (SDoH). Hennepin Health engages with the internal SNBC care coordination team members, external SNBC care coordination agencies, provider organizations, and the Hennepin Health Accountable Health Model partners (Hennepin County Public Health and Human Services, Hennepin Healthcare, and NorthPoint Health and Wellness Center) to address the individual member's SDoH and barriers to care, thereby, facilitating comprehensive management for members with co-occurring diabetes and depression. 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 both their diabetes and depression management that may lead to improved health outcomes.

Measures

This project will attempt to measure closing disparity gaps by leveraging the NCQA HEDIS® SNBC measure set listed below. The baseline rates for the PIP are the HEDIS® rates for 2019 dates of service for the diabetes related measures. 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 cycle. Hennepin Health will continue to report the following measures to focus targeted efforts.

- Hemoglobin A1c Control for Patients with Diabetes (HBD)
- Blood Pressure Control for Patients with Diabetes (BPD)
- Eye Exam for Patients with Diabetes (EED)

Hennepin Health will also explore developing and reporting the two non-HEDIS® metrics listed below and will conduct 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.

Data Analysis

Statistical Analysis

Throughout this PIP, Hennepin Health will continue to consider how best to analyze available mental health and diabetes data. During the planning process, Hennepin Health examined how the depression diagnosis rates differ within the selected diabetes measures and found that for BPD and EED, the rates were nearly identical for BPD with 66.1% of SNBC members living with diabetes and were not diagnosed with depression having control of their blood pressure, compared to 67.0% of members living with diabetes and having a depression diagnosis. For EED, the rate of those who had received their eye exam was slightly higher for members with a depression diagnosis than those without (52.3% vs 50.1%). Within the HBD measure (where a lower rate is better), SNBC members living with diabetes and being diagnosed with depression had a notably better rate of 14.7% relative to those without diagnosed depression at 22.9%. In measures such as these, the absence of a depression diagnosis does not necessarily equate to the absence of depression. Potentially, members with diabetes could be receiving more regular medical care and be screened for depression more often than those without diabetes, so it is not clear as to whether to consider any change in rates to be a success. For these reasons, Hennepin Health will continue to monitor these data and seek clarity from member feedback as to how these rates reflect member experiences.

As illustrated in Tabe 1, rates for Blood Pressure Control for members living with diabetes have slightly decreased from 2019 to 2024. The largest decrease in rates are found in Glycemic Status Testing. From 2019 to 2024, the rate dropped 32.9%. However, the number of members who have poorly controlled diabetes (indicated by an A1c of 9% or greater) has decreased by 2.1% from 2019 to 2024. Finally, the rate of diabetic members undergoing an eye examination focused on determining eye health and the presence of retinopathy decreased 9.6% from 2019 to 2024.

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Table 1: HEDIS® CDC Rates, 2019 (baseline), 2022, 2023, and 2024				
Year	**Numerator**	**Denominator**	**Rate**	**Percent Change (from baseline 2019)**
Blood Pressure Control				
2019	149	199	75.5%	
2022	148	226	67.3%	
2023	138	232	59.5%	
2024	152	213	71.4%	**-4.1%**
Glycemic Status Testing (Formerly HbA1c Testing)				
2019	185	199	93.0%	
2022	198	226	87.6%	
2023	202	232	87.1%	
2024	128	213	60.1%	**-32.9%**
HbA1c Poor Control >9% (Lower is Better)				
2019	64	199	32.2%	
2022	64	226	28.3%	
2023	65	232	28%	
2024	66	213	30.1%	**2.1%**
Eye Exams				
2019	128	199	64.3%	
2022	117	226	51.8%	
2023	132	232	56.9%	
2024	117	213	54.7%	**-9.6%**

Data Source: Hennepin Health HEDIS® CY 2019, CY2022, CY2023, CY 2024

Healthcare Disparity Analysis

The sample sizes are very small for Hennepin Health's selected HEDIS® measures which make statistical tests of analysis challenging to conduct. Based on this, Hennepin Health sought technical assistance from DHS's External Quality Review Organization, IPRO, to determine how to implement any tests for the most recent interim report and are applying the results of that technical assistance to this report. Upon discussion, running a chi-squared test for the Diabetes related HEDIS® data is not applicable because the samples are not independent. Additionally, small denominators for each group make confidence intervals unhelpful, as the group sizes are so disparate, and confidence intervals are so large that nothing meaningful or actionable can be extrapolated. The conclusion was to calculate the Index of Disproportionate Underrepresentation (IDU) in the race analysis, and that future PIPs may include benchmark goals to strive towards in lieu of tests of statistical significance. The Index of Disproportionate Under-Representation (IDU) is used 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. Since Hennepin Health is continuing to use the same measures in this PIP as in the 2021-2023 PIP, and because the population sizes are unlikely to increase drastically, the Index of Disproportionate Underrepresentation will continue to be

reported as a deeper level of analysis. The following HEDIS® metrics will be used to track progress for the duration of this PIP cycle.

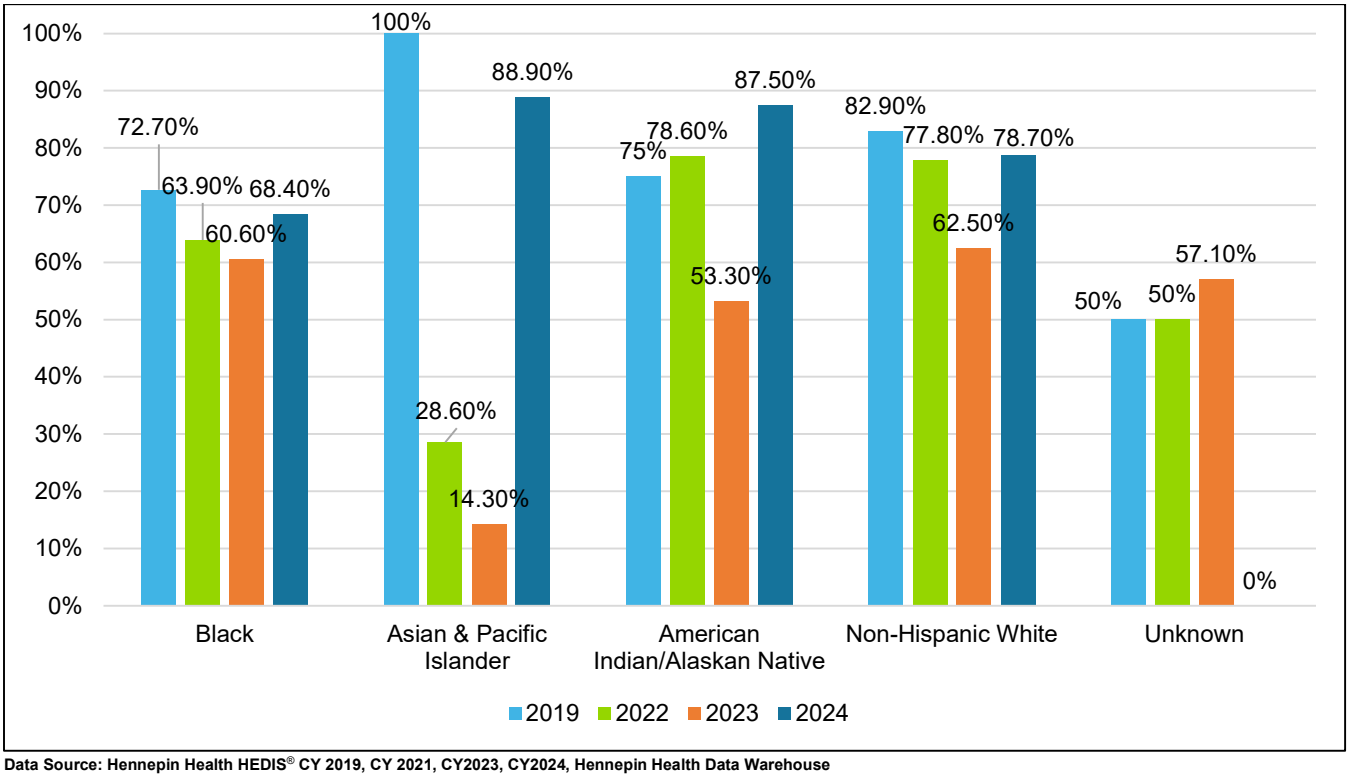
- GSD: Black and White members
- BPD: Black and White members
- EED: Black and White members

Hennepin Health is committed to reducing health inequities for all members. In analyzing the data in 2024 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. 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 drivers of health are impacting members' ability to receive timely health care services. In addition, racial disparity gaps between White and members of color will continue to be monitored for impact. Hennepin Health will focus on decreasing other disparities and addressing social drivers of health to improve the population measures.

BPD

As evidenced in Figure 3, the groups for whom the BPD rate improved from 2019 to 2024 are American Indian/ Alaskan Native, Hispanic (non-white), and Non-White Hispanics members. Rates dropped for both the Black and Asian and Pacific Islander populations. Hennepin Health's Black members were disproportionately underrepresented in this measure (IDU: 104%). The American Indian/Alaskan Native population is also underrepresented (IDU: 123%).

Figure 3. Blood Pressure Control (BPD) by Race, 2019, 2022, 2023, and 2024

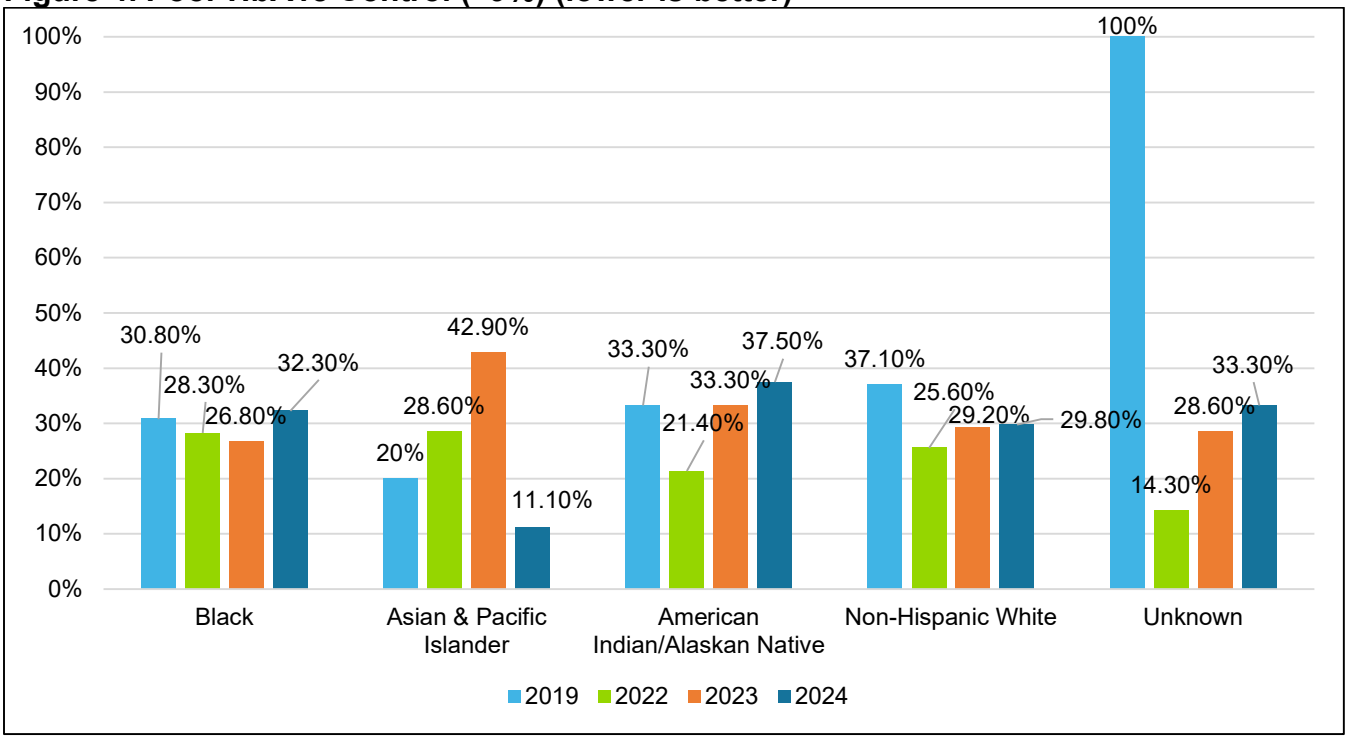


Data Source: Hennepin Health HEDIS® CY 2019, CY 2021, CY2023, CY2024, Hennepin Health Data Warehouse

GSD

As demonstrated in Figure 4, the rates of Poor HbA1c Control have increased across the populations except for the Non-Hispanic White since 2019. As lower rates for this measure are considered successful, this shows an increase in members having poorly controlled diabetes. Hennepin Health's Black members were disproportionately underrepresented in this measure (IDU: 219%). The American Indian/Alaskan Native population (IDU:123%) and the Hispanic population (IDU: 106%) are also underrepresented. Uniquely, the Non-Hispanic White population (IDU: 238%) is vastly underrepresented for this measure. Since lower rates are better in this case, being underrepresented is a positive; therefore, the Asian/Pacific Islander members are faring worse in this case.

Figure 4. Poor HbA1c Control (>9%) (lower is better)



Data Source: Hennepin Health HEDIS® CY 2019, CY 2021, CY2023, CY2024, Hennepin Health Data Warehouse

EED

The eye exam rates have decreased across all race and ethnic groups except for the Hispanic population (**Error! Reference source not found.**5). This measure is particularly challenging to improve, as Hennepin Health has heard anecdotally SNBC members do not often prioritize vision care compared to their other health care needs and may not understand the importance of having an annual retinal eye exam. IDUs for this measure show that Black (IDU 101%) and Native American (IDU 123%), populations are underrepresented.

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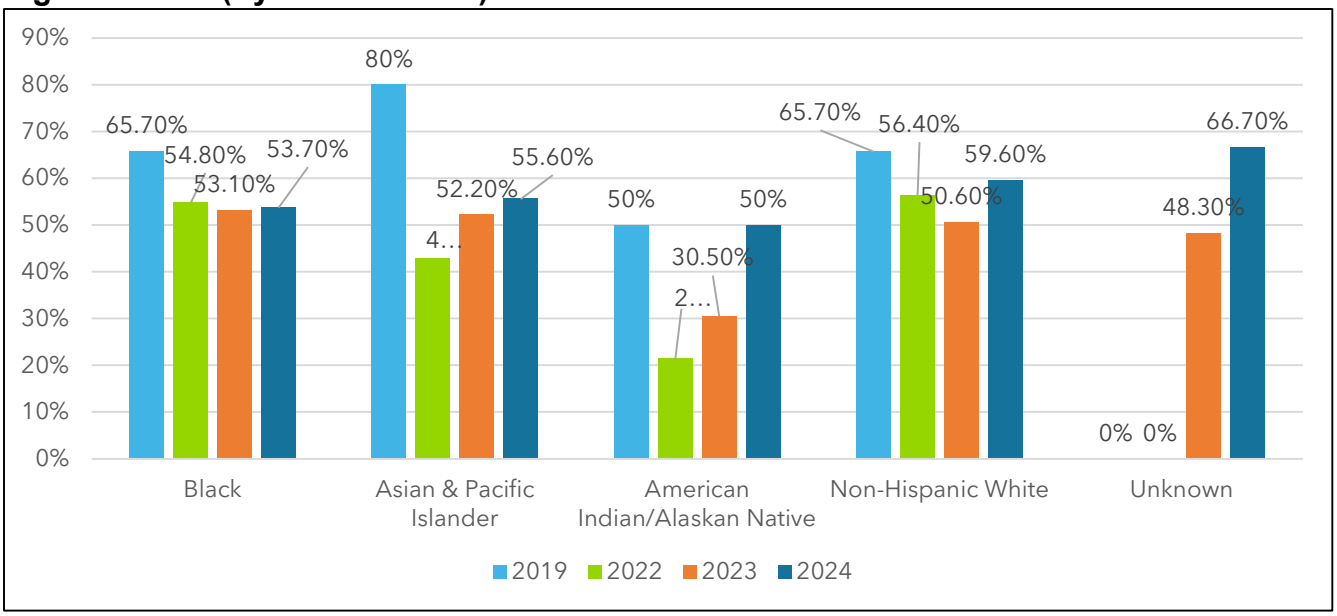
Figure 5. EED (Eye Exam Rates)



Data Source: Hennepin Health HEDIS® CY 2019, CY 2021, CY2023, CY2024, Hennepin Health Data Warehouse

Strong Action

Intervention Tracking Measures (ITMs)

DHS has tasked MCOs to develop and use intervention tracking measures as a way to assess progress throughout this PIP cycle. Hennepin Health is monitoring the number of eye exams completed by SNBC members living with diabetes on a quarterly basis in order to increase the number of SNBC members who have been diagnosed with diabetes and have completed an eye exam in the measurement year in hopes of seeing a 2% improvement year over year.

Table 2. Eye Exams Completed

Quarter	Number of Eye Exams Completed (across all products)	Number of Eye Exams completed by SNBC Members
Q1 2024	129	48
Q2 2024	158	48
Q3 2024	179	27
Q4 2024	137	27

Data Source: Hennepin Health Data Warehouse

Hennepin Health is also monitoring the number of PHQ-2 screening assessments completed for members living with diabetes. Early efforts involved counting claims for SNBC members with diabetes and manually exploring those claims by visit type within Epic®, an electronic medical record, to determine if a depression screening had occurred during that visit. This proved unfruitful and did not garner accurate results. PHQ-2 results were not always available, and follow-up was often not addressed within the members' records. There was also not a way to see past scores and notice trends that might indicate the presence of depression. Individual chart reviews proved tedious and trend results between those with chronic conditions such as diabetes and without is difficult to see within the SNBC population. Efforts are now focused on the PHQ-2 data within the diabetic assessments completed with members living with diabetes and the results will be reflected in the next interim report. PHQ-2 results were not always available, and follow-up was often not addressed within the members' records. There was also not a way to see past scores and notice trends that might indicate the presence of depression.

Individual chart reviews proved tedious and trend results between those with chronic conditions such as diabetes and without is difficult to see within the SNBC population.

MCO Interventions

In 2021, an assessment tool addressing social drivers 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. In 2024, this assessment was updated to include the PHQ-2 questionnaire that assesses the severity of depression symptoms over the past two weeks. The results of this screening can then be shared with the members primary care and/or behavioral healthcare providers.

Over the last two weeks, how often have you been bothered by the following problems?

- **Little interest or pleasure in doing things**

  *Not at all
  * Several days
  *More than half the days
  *Nearly every day

- **Feeling down, depressed or hopeless**

  *Not at all
  * Several days
  *More than half the days
  *Nearly every day

In 2024, thirty (30) diabetic assessments were completed by SNBC care coordinators. Fourteen of the 30 responses indicated a willingness to learn about the connection between eye exams, foot exams, A1c values, and blood pressure values with diabetes; 17 of the 30 members felt they ate a healthy diet while nine of the 30 members responded that they ate less than they felt they should because they didn't have enough money for food. Half of the members assessed (15/30) responded yes to the question "Would you like to learn more about the best foods to eat for managing diabetes based on your food preferences or culture." When asked, "Over the last two weeks, how often have you been bothered by the following problems? Little interest or pleasure in doing things?", nine of 30 members had responses other than "not at all." One-third (10/30) had responses other than "not at all" when asked if they had felt down, depressed, or hopeless over the last two weeks. However, there is a notable limitation to this intervention in that only members who have accepted care coordination are participating in these assessments.

Hennepin Health continued to promote the use of incentives to reward members for seeking care for their diabetes as well as developing communication strategies surrounding eye exams. Work began in 2024 on the creation of an information hub for members where they can access information related to comprehensive diabetes and depression care on Hennepin Health's member website.

Collaborative Interventions

Education and Training for Care Team

Care coordinators play an essential part in supporting members with co-occurring diabetes and depression as their role involves providing education, connecting members to resources, and working closely with them to establish and reach their health goals. Care coordinators are diverse in terms of their education, areas of expertise, ethnicity, life experiences, and skillsets. More importantly, they also conduct MnCHOICES Health Risk Assessments (HRA) yearly in which members are assessed for diabetes and mental health management. Direct service care coordinators have trusting relationships with members which allows them to engage in disease and mental health management by providing support services and resources to manage their health conditions.

In 2024, 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” here refers to several types of case management staff including: MCO care coordinators, Community Health Workers, Health Coaches, Targeted Case Managers, ARMHS Workers, etc. Trainings were 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.

Webinar Promotion Process

The Collaborative has developed a process to share the Performance Improvement Project webinars and resources with the appropriate audiences to align messages and increase impact throughout Minnesota. There are approximately two thousand participants on the distribution.

- A master distribution participant list was created which is utilized for upcoming webinars.
    - As participants attend, they are added to an email distribution list.
    - Emails are sent via mail merge from Stratis Health (neutral convenor for the health plans).
    - There is an option to opt out.
- The distribution list is housed on the PIP SharePoint page that is managed by Stratis Health.
    - Select plan member removes duplicates.
    - With support from Stratis Health, the team is working on a process to remove bounce back emails.
- Health plans who lead the webinars also have a process to share webinars.
    - Each health plan shares with care coordinators and appropriate individuals and teams.
- Some health plans distribute to the MDH mail bag.

Webinar Series

The Collaborative offered a series of webinars to improve the HEDIS® Effectiveness of Care diabetes measures for MSHO/MSC+ and SNBC members. Educational webinars addressing diabetes and depression that took place in 2024 are listed below

Supporting People with Co-Occurring Diabetes and Depression – 2/29/24

Presented by Mary Holland, Director of Behavioral Health Case Management, HealthPartners

This webinar is the first in a series of webinars focusing on improving the health of people with diabetes and depression. Care coordinators received an overview of issues commonly seen when these conditions co-occur and strategies for supporting clients with both conditions.

A total of 538 people participated in this webinar live and completed the evaluation. Of those who completed the evaluation, 85.9% rated an enhanced knowledge and ability to apply new strategies and tools in the work setting, and 92.9% rated their ability to identify strategies to support and care for people with both diabetes and depression. Another 89.2% rated their ability to identify why mental health matters in relation to people with diabetes.

Diabetes and Depression: Case Reviews – 6/20/24

Presented by Dr. Sarah Spilseth, Associate Medical Director, HealthPartners and Dr Brian Palmer, Associate Medical Director, Health Plan Behavioral Health, HealthPartners

This webinar reviewed three different cases and identified different scenarios in working with people who have both diabetes and depression. It also defined the vital role care coordinators have in supporting the care teams in managing the complexity of co-occurring diabetes and depression.

A total of 359 people participated in this webinar live and completed the evaluation. Of those who completed the evaluation, 94.1% rated an enhanced knowledge and ability to apply new strategies and tools in the work setting and 97.2% rated their ability to identify two medical consequences of diabetes and linkage to depression. Another 98.3% rated their ability to describe how addressing depression is essential in supporting members with diabetes.

Understanding and Overcoming the Unique Barriers to Care for People with Depression and Diabetes – 7/16/24

Presented by Molly Peterson, National Alliance on Mental Health Illness (NAMI)

This webinar highlighted the realities of living with both a mental illness and a chronic health issue, how confounding symptoms can complicate care, and how care coordinators, social workers, counselors, and other caregivers can support the health of the person with the illnesses. Care coordinators engaged in dialogue, solved sample client scenarios, and learned to find resources to assist clients and their families.

A total of 290 people participated in this webinar live and completed the evaluation. Of those who completed the evaluation, 95.1% rated an enhanced knowledge and ability to apply new strategies and tools in the work setting while 96.5% rated their ability to define the challenges of co-occurring mental illness and diabetes. Another 95.2% articulated the ability to identify strategies to engage patients and families in care.

Changing the Narrative on Suicide and Mental Health – 10/22/24

Presented by Jenilee Telander, Suicide Prevention Coordinator, Minnesota Department of Health and Wil Sampson-Bernstrom, Suicide Prevention Coordinator, Minnesota Department of Health

Talking about mental health and suicide can be an uncomfortable and uncertain topic that can bring up different feelings, beliefs, and attitudes for everyone. This webinar empowered conversations to start in hopes of changing perceptions of mental health toward hope and resilience.

A total of 326 people participated in this webinar live and completed the evaluation. Of those who completed the evaluation, 95.8% rated an enhanced knowledge and ability to apply new strategies and tools in the work setting, and 95.7% rated their ability to understand language when talking about mental health and suicide. Another 97.8% rated this activity with increased ability to understand and have conversations about mental health and suicide.

Process Measures for Care Coordination Education and Training

1. Number of trainings provided for care coordinators and care navigators
2. Number of attendees at each training
3. Evaluation results from the trainings

Table 3. Webinars Demographics

Title of Webinars 2024	Date of Webinar	# of Registrants	# of Attendees	# Evaluations completed
Supporting People with Co-occurring Diabetes and Depression	2/29/24	954	636	538
Diabetes and Depression: Case Reviews	6/20/24	795	447	359
Understanding and Overcoming Unique Barriers to Care for People with Diabetes and Depression	7/16/24	604	385	290
Changing the Narrative on Mental Health and Suicide	10/22/24	755	482	326
Total # of Webinars: 4		Total # registered: 3,108 with potential to attend or watch on demand through Stratis site	Total # of attendees: 1,950	Total # of evals: 1,513

Data Source: Stratis Health Data Warehouse

Figures 6 and 7 demonstrate the combined evaluation summaries of two post webinar questions.

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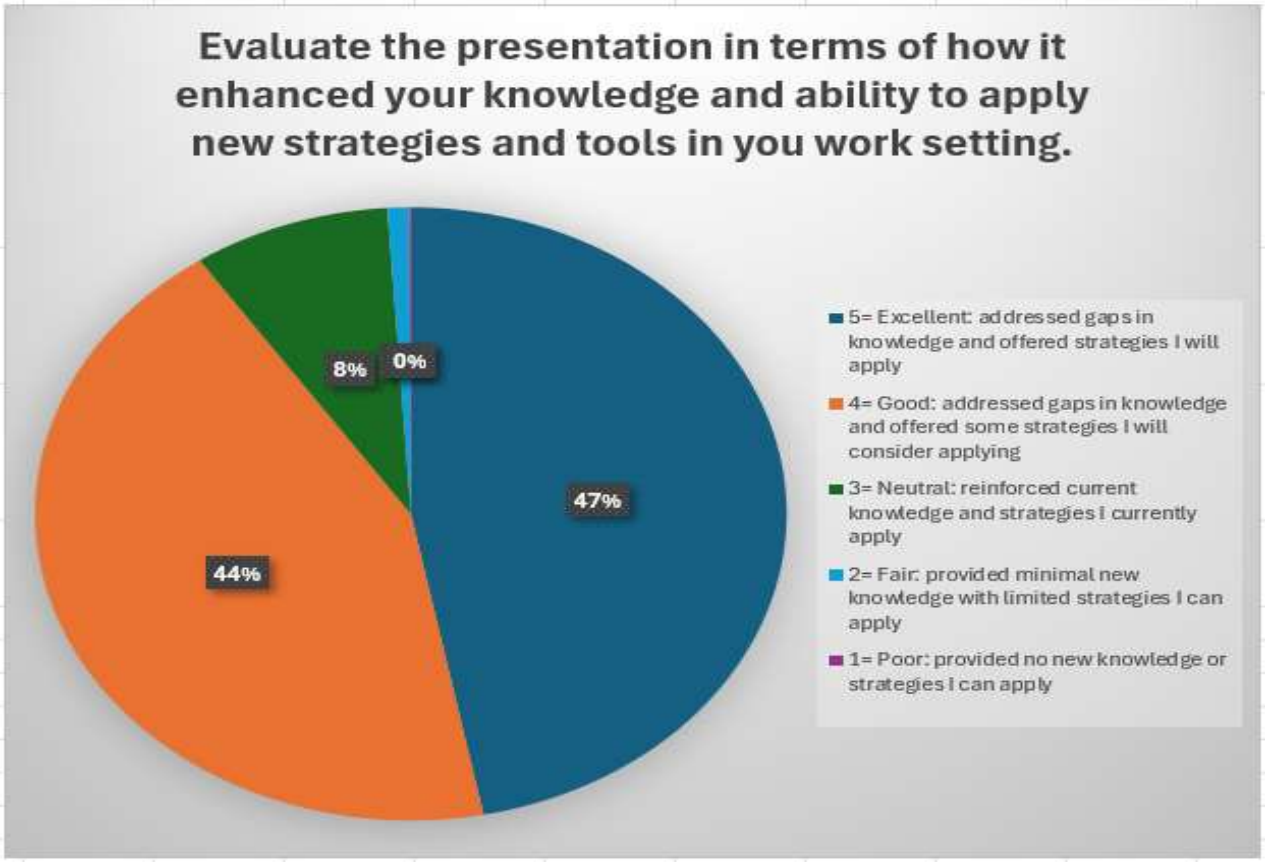
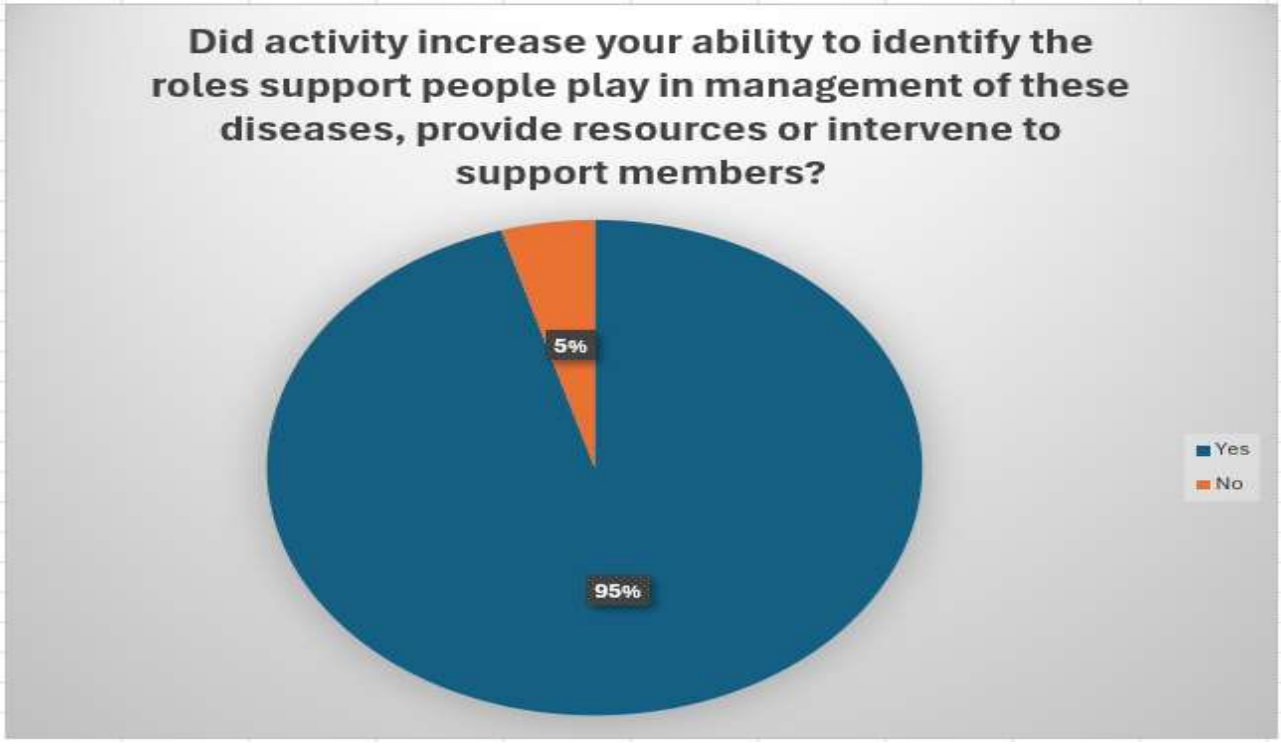
Figure 6. Evaluation of Enhanced Knowledge and Ability to Apply to Work Setting



Data Source: Stratis Health Data Warehouse

Figure 7. Roles Support People Play in Disease Management, Provide Resources or Intervene to Support Members



Data Source: Stratis Health Data Warehouse

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 specific health conditions. This support may come in the form of incentives to encourage members to seek the care that is recommended and /or in providing enhanced care coordination for specific conditions or educational resources. Increasingly, these supports also include resources to address social drivers of health (SDOH).

As the Collaborative assessed the need for aligning tools across MCOs to enhance the utilization of supplemental benefits to support the care of our members, it was concluded that the Collaborative will discontinue the supplemental benefit grid as there was not a high demand for it. Each MCO has their own resource webpage for care coordinators where benefits, programs/services, and incentives information can be accessed; therefore, to update an external supplemental grid would be duplicative of efforts.

Stratis Health Website

All webinars mentioned above in the "Education and Training for Care Team" section of the report are located on the Stratis Health website which is the Collaborative's resource hub. Performance Improvement Project (PIP): Improving Care for People with Co-Occurring Diabetes and Depression - Stratis Health is made accessible to everyone and houses all previously recorded webinars, presentation slides, and resources provided by the presenter if applicable.

Performance Improvement Project (PIP): Improving Care for People with Co-Occurring Diabetes and Depression

Eight Minnesota Managed Care Organizations (MCOs), including Blue Plus, HealthPartners, Hennepin Health, Itasca Medical Care, Medica, PrimeWest Health, South Country Health Alliance, and UCare are collaborating on this Performance Improvement Project (PIP).

Interventions will focus on addressing the co-occurring conditions 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 focus on improving care for people with co-occurring diabetes and depression. This PIP will also be centered around improving diabetes care and control, focusing on reducing health disparities.

The Collaborative will incorporate community-informed measures into the PIP processes for MSHO, MSC+, and SNBC members. The overall goal of community-informed measurement is to have groups of people most negatively impacted by structural inequities engaged by collecting enrollee input on their interactions with the healthcare system and developing community-informed measures for the project.

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Improving Care for People with Co-Occurring Diabetes and Depression Webpage Views

Total Visits	Total Unique Visits	Webinar Recording Views
859	446	320

*Data only reflects views and visits from January-July 2024 as there was a glitch in system which prevented tracking from July-December 2024. Data Source: Stratis Health

Webinar	Views
Supporting People with Co-Occurring Diabetes and Depression	99
Diabetes and Depression: Case Reviews	120
Understanding and Overcoming the Unique Barriers to Care for People with Diabetes and Depression	105
Improving Care for People with Co-Occurring Diabetes and Depression	TBD

Data Source: Stratis Health

Minnesota Department of Health – Diabetes and Mental Health Website

MDH has a site dedicated to Diabetes and Mental Health Diabetes and Mental Health - MN Dept. of Health (state.mn.us) and has developed "Everyday tools and Tips" in a PDF Mental Wellbeing (state.mn.us), Diabetes and Mental Health - MN Dept. of Health. 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. Two webinars were co-hosted that focused on the importance of nutrition when managing diabetes, food insecurities, and local resources. The group's efforts align with key components of the PIP work making them a natural partner. These collaborative efforts will continue as MDH has expressed similar interest.

National Alliance of Mental Health (NAMI) Website

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 NAMI website, NAMI | National Alliance on Mental Illness, provides its viewers with a great range of information from common knowledge on the various mental health conditions, treatments, guidance for family members and caregivers, NAMI connections to support groups and their Help Line, self-help video resources, and links to podcasts and other webinars, just to name a few.

MCO Specific Community Resource Tools

In addition to the Collaborative 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 living with diabetes with or without depression who may also have additional social risk factors.

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.

Process Measures for Tools and Resources:

1. Stratis Health Webpage and Webinar Views
2. Each MCO will determine the metrics they will use as a process measure to identify utilization of SDoH resources.

Community Outreach and Partnerships

Juniper/Trellis

Juniper, a program of Trellis, is a network of community-based organizations and health systems that makes evidence-based health promotion programs available for free or at low cost to people throughout Minnesota. Juniper was created by Minnesota's Area Agencies on Aging in partnership with our provider community leveraging the Older Americans Act Title III-D network of providers across Minnesota. This structure creates opportunities to provide wrap-around support for patients' health and social needs. Their live classes offer individuals education about their chronic conditions while providing a space to talk to other peers who have similar health concerns. More specifically to this PIP, Juniper offers a diabetes management program where it addresses how mental health can impact one's ability to manage their diabetes. Since Juniper requires a contract with health plans (in which a couple of health plans do have a contract with Juniper for the MSHO members), it was determined that each plan will reach out to Juniper individually if they are interested in contracting or working together.

Minnesota Department of Health (MDH)

MDH met with the Collaborative to share data collected from a public health population survey called Behavioral Risk Factor Surveillance Survey (BRFSS). The BRFSS is a telephone-based survey aimed at insured and uninsured adults who are institutionalized except for some college students. Analyses included age, crude vs age adjusted, race, and gender. Data instruments used consisted of PHQ-2 and GAD-2 to identify presence of depression and anxiety, and PHQ-4 which assesses depression and anxiety in individuals with diabetes.

MDH-obtained data implicated notable key findings. It was found that people living with diabetes had higher stress levels and those who were younger ranging from ages 18-44 experienced more stress. Moreover, the younger population was more likely to report more mental health concerns than the senior population. Lastly, the report stated that those living with diabetes have higher mental health concerns than those who do not have diabetes. Meaningful discussion took place after the data was reviewed and, although the next steps were not determined, MDH and the Collaborative recognized that more data analyses should be conducted to identify and to discern how this information can be used in the real world.

National Alliance on Mental Illness (NAMI)

Given NAMI's dedication to building better lives for the millions of Americans affected by mental illness and their strong reputation within the community, the Collaborative met with NAMI to discuss partnership opportunities on how to better support members living with diabetes and depression. It was identified that NAMI provides a free curriculum that serves as a hybrid support group where individuals receive education on various topics such as chronic diseases, pain management, medical self-advocacy, and nutrition, just to name a few. What sets this program apart from others is its focus on incorporating the mental health aspect into each of the topics mentioned above. To carry out their mission in spreading mental health awareness, NAMI agreed to partner with the Collaborative and presented a webinar in July 2024 to care coordinators. Their tools and resources were also shared during the webinar.

American Diabetes Association (ADA)

The American Diabetes Association hosted a State of Diabetes Event in Twin Cities, MN to convene with influential figures across various sectors to discuss the current landscape of diabetes and tangible outcomes to improve diabetes care, workplace wellness, and advocacy efforts. The target audience was geared towards employers to foster discussion on how to support employees who have diabetes and the importance of creating an environment that is conducive to diabetes management. Other stakeholders present included health plans for informational purposes and vendors of diabetes programs. Attendance at this event led to networking for collaborative opportunities and discussions on how the Collaborative can explore continuous glucose monitoring programs to better understand not only how it may positively impact diabetes management, but also its accessibility to our Medicaid recipients.

Minnesota Association of Community Mental Health Programs (MACMHP)

MACHMHP is a statewide network of thirty-six community-based mental health programs serving over 200,00 Minnesotans every year. They serve those regardless of their insurance status or ability to pay. They serve culturally diverse, low-income, uninsured and public healthcare program Minnesotans who cannot access services elsewhere. 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 CCHBCs to implement quality improvement and monitoring for the processes and outcome measures.

Previous discussions centering around Certified Peer Specialists and Certified Community Behavioral Health Clinics (CCBHC's) piqued the Collaborative's interest to learn more from MACMHP; therefore, a meeting occurred. During the meeting, they shared that they have limited funding and capacity issues and that the Certified Peer Specialists are currently out of scope as an option given that the Collaborative wanted to leverage them to obtain feedback for the community informed measures component. Furthermore, as more details were provided on the CCBHC model and having learned that the care provided is holistic and integrated, the Collaborative took the initiative to invite the actual servicing providers to better understand how we can support this population from a health plan perspective and seek if there are potential efforts for partnership. The Collaborative is still determining possible next steps with MACMHP and hopes to reconnect with them again once future opportunities arise.

Canvas Health – CCBHC

Canvas Health is a mental health provider who offers CCBHC services to those living in Isanti, Chisago, Anoka, Washington, Hennepin, and Scott counties. They ensure access to integrated evidence -based care which includes a 24/4 crisis response, day treatment, outpatient therapy, medication assisted treatment for addiction, care coordination with social services, criminal justice, and educational systems.

Touchstone Mental Health – Behavioral Health Homes (BHH)

Touchstone Mental Health's Behavioral Health Homes model provides a wide array of person-centered behavioral health and primary care support. Services that they render that includes Adult Rehabilitative Mental Health Services (ARMHS), Intensive Residential Treatment Services (IRTS), Targeted Case Management, care coordination, transitional care, patient and family support, referral to community and social support services.

Concluding the meet and greets, the Collaborative and community partners discovered many gaps where opportunities for collaboration can emerge, especially related to care coordinator education. The community partners shared interest in educational webinars that the Collaborative periodically hosts as their care coordinators can always gain more knowledge. As a follow up, Collaborative resources were shared with the partners, and their contact information was added to the extensive list of entities who receive our promotional webinar materials.

Barriers and Challenges

There can be several challenges related to this population including:

Mental Health Stigma Barriers

- Recent studies show that mental health concerns still carry a stigma. Many people feel hesitant to address any topics related to mental health, including depression. Some people may still be fearful of judgment or embarrassment in mentioning the topics.[3]

Access to Information Barriers

- Health plan resource challenges to gather relevant data for the measures selected.
- Contact information for members.
  - Outreach to members may not always be successful. This can be due to the incorrect phone numbers, no voicemail option, or members not returning calls. Seeking additional ways to engage members will be an important focus of this project.

Communication Barriers

- The barrier in communicating in a member's preferred language in provider visits, resources regarding depression and diabetes that are culturally relevant, discharge summaries, electronic medical record documentation, and health plan outreach for preventive screenings.
  - Feedback received from members during year one of the PIP noted the challenges in receiving information in their preferred language. There was also discussion on the cultural barriers related to communication. Members felt there were times that there was a lack of understanding with their provider regarding the different cultures.

Health Literacy Between Provider and Member Barriers

- In analyzing the focus of this PIP, it is important to understand the member perspective of health literacy. When members have multiple diagnoses between a physical health condition and a behavioral health condition, managing the terms given by each provider can be difficult. This could include understanding the actual diagnosis, test results, follow up instructions, and medications. According to the Center for Health Care Strategies, it is found that 36% of adults have low health literacy, with most of these adults being lower-income and eligible for Medicaid.[4]

Coordination of Care Barriers

- Members who utilize behavioral health services from facilities that are not integrated with their primary care providers can be challenging. This is due to the providers not always communicating with each other in terms of medication management, treatment

[3] The Impact of Stigma on Mental Health | McLean Hospital
[4] Health Literacy Fact Sheets - Center for Health Care Strategies (chcs.org)

planning, side effects, etc. Increasing communication across settings is an important aspect of this project.

Providers Not Addressing or Diagnosing Depression Barriers:

- According to an article in the Journal of General Internal Medicine[5], studies conducted in primary care settings suggest that only about 50% of patients with depression are recognized. Even when primary care physicians are alerted to the diagnosis of depression, it does not appear to change treatment patterns, and most primary care physicians do not escalate antidepressant medication doses as needed to achieve complete remission. Data shows that a large portion of patients discontinue prescribed medications within the first 3 months, and even with treatment, less than 50% of subjects with major depression go into remission over a 9- to 12-month period. Therefore, recognition and treatment of depression in primary care is less than ideal because of physician and patient factors."

Social Determinates of Health (SDOH) Impact Barriers

- According to an article in the Journal of Population Health Management, SDoH contributes to health outcomes. Members may not always have stable housing, access to healthy foods, or a safe environment. This can affect members seeking health care needs, in the aspect of them prioritizing these non-health care needs first.[6]

Transportation to Appointments Barriers

- Transportation for members can become challenging and create obstacles to health care needs, especially when managing multiple appointments. This can be a barrier in members not attending or delaying their appointment for their depression or their appointment for diabetes.

Access to both Behavioral Health and Primary Care Providers Barriers

- Many areas around the nation have a behavioral health care provider shortage. In March 2023, it was found 160 million Americans live in residential areas with behavioral health care provider shortages. It was found that there would need to be 8,000 more professionals needed to supply this demand.[7] This shortage makes it difficult for members to be seen by professionals who specialize in behavioral health care.
  - Member feedback noted the long delays in accessing mental health services, with one member stating there was even up to a 4-month wait to be seen by a therapist.
- Statistics from Mental Health America[8] identifies "The Access Ranking indicates how much access to mental health care exists within a state. The access measures include access to insurance, access to treatment, quality and cost of insurance, access to special education, and workforce availability. A high Access Ranking (1-13) indicates that a state provides relatively more access to insurance and mental health treatment". Minnesota ranks 14th. "In the U.S., there are 350 individuals for every one mental health provider. The term "mental health provider" includes psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health care." Minnesota ranks 23rd. As of June 2022, over 152 million people lived in a mental health workforce shortage area,

[5] Failure to Recognize Depression in Primary Care: Issues and Challenges - PMC (nih.gov)
[6] Addressing the Social Needs of Medicaid Enrollees Through Managed Care: Lessons and Promising Practices from the Field - PMC (nih.gov)
[7] Understanding the U.S. Behavioral Health Workforce Shortage | Commonwealth Fund
[8] Access to Care Data 2023 | Mental Health America (mhanational.org)

and only 28% of the mental health need in shortage areas was being met by mental health providers."

- According to an article from Wolters Kluwer[9], the five key barriers to access to health care are listed below and some already discussed above.
    - Insufficient Insurance Coverage
    - Healthcare Staffing Shortages- "By 2034, The Association of American Medical Colleges estimates that the American health care system could be up to 124,000 doctors short, with roughly a third of those deficits in primary medicine.[10] But it's not just physicians that will be lacking — nurses, technologists, and other roles have predicted shortfalls as well."[11]
    - Stigma and Bias Among the Medical Community
    - Transportation and Work-Related Barriers
    - Patient Language Barriers
- Rural populations are especially impacted. According to statistics from the National Rural Health Association[12], patients must not only contend with clinician shortages, but also the patient-to-primary care physician ratio in rural areas is 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas.
    - During year one of the PIP, feedback was received from members regarding the lack of resources in rural areas. As noted in the research above, it is known that rural populations have limited access to both primary care providers and behavioral health providers. It is important to note the members' perspective of feeling there is a lack of resources.

Member Engagement Barriers:

- During year one of the PIP, the Collaborative reached out to community agencies for collaboration and feedback on the topic of this project. Although we did have some groups come to share feedback, we did see a barrier in groups that work with populations with disparities. There were times outreach was attempted; however, no response was received. This could be due to cultural differences in communication, lack of trust due to prior discrimination, or lack of resources to support collaboration.
- Member engagement with the project is a goal for the Collaborative. The Collaborative created a survey to intake member feedback that can be applied to the project. Although some responses were received, we would like to increase member feedback. The lack of member engagement may be due to not having correct phone numbers, members not knowing where this information is found, or the feeling of survey fatigue.

Data Limitations:

- The data for this project shows that members with a dual diagnosis of diabetes and depression have better outcomes for our measurements than members with the single diagnosis of diabetes. It is speculated that these members see a provider more often.
- Research for this project also showed that there may be times when members do have depression but do not have the diagnosis tied to their profile. This could be a gap in the data used for this project. It may depend on whether depression is

[9] Five Key Barriers to Healthcare Access in the United States | Wolters Kluwer
[10] The Complexities of Physician Supply and Demand: Projections From 2019 to 2034 (aamc.org)
[11] The Nursing Shortage Demands Boldness and Creativity. Now. | Wolters Kluwer
[12] Top Challenges Impacting Patient Access to Healthcare (patientengagementhit.com)

identified by a diagnosis code alone or along with medications, which are sometimes prescribed for other conditions.

- Another data challenge is capturing depression screenings performed on members. Providers do not always submit claims separately for these screenings, and if they do, the resulting PHQ-9 values are typically not captured. This data would be helpful for our outreach and project analysis.
- The diagnosis of diabetes captured by HEDIS® has had gaps in recent years. Members were falling incorrectly into the denominator due to weight-loss drugs or other medications that may have been used for conditions outside of diabetes. There were updates made to the HEDIS® MY2024 technical specifications this year to update the diagnosis criteria and medication tables, so this should improve moving forward.

Sustainability

Changes Made

All webinars, education series, training materials, and any collaborative resources with other organizations are posted on the Stratis Health website for continued use. Resources are updated annually, provided they remain accurate and clinically relevant. Investment in training for care coordinators provides many dividends now and, in the future, for the Seniors (MSHO, MSC+) and SNBC members served. The knowledge about co-occurring conditions of diabetes and depression and the skills gained with a focus on utilizing appropriate resources to reduce disparities will benefit members and the community. Outreach efforts to members determined to be effective will be continued indefinitely. Community partnerships will be maintained and expanded in future.

Assessment of Short-term and Long-term Effects

The initiatives implemented within the scope of this PIP are intended to improve health outcomes for Seniors and SNBC members with diabetes and depression comorbidities. The Collaborative will evaluate both group and MCO-specific interventions to determine how to sustain these in the years to come. The MCOs will use the Plan, Do, Study, Act (PDSA) quality cycle to evaluate the effectiveness of these programs on making internal changes and to sustain these initiatives. Further additions of interventions related to community engagement, community informed measures, addressing disparities, structural inequities, and diabetes and depression comorbidities will be implemented in 2025.

Plan for 2025 / Next Steps

Collaborative Activities planned for 2025 are listed below.

- Continue to Identify and build community partnerships in the diabetes and depression space
- Utilize learning from previous care coordinator training webinars and feedback to offer webinars that are relevant to the work of care coordinators who work directly with MSHO/MSC+ and SNBC members who have diabetes and depression.
- Implement the member survey that was developed by the Collaborative to obtain information from members and the community.
- Utilize member feedback to determine opportunities for improvement and a potential community informed measure. The responses/data will be analyzed by each MCO, as

well as a Collaborative in looking at the consolidated data as MCO's implement the same survey.

Throughout 2025, Hennepin Health will:

- Continue use of the diabetic assessment coupled with PHQ-2 questions. SNBC care coordinators and care navigators will continue to review these assessments and notify appropriate resources and providers.
- Investigate the use of In Lieu of Services funding and programming to address needs outlined by members.
- Create a member-focused, easy to navigate webpage on the Hennepin Health member website that can be used to address the needs of members who are living with co-occurring diabetes and depression.
- Continue to create partnerships to foster collaboration within the community and with Hennepin Health's community partners.
- Provide SNBC care coordinators and care navigators with tools and resources to better inform our members, identify additional need for resources, and ultimately help members improve health outcomes for both diabetes and depression.

Hennepin Health
your community health plan

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