Hennepin Health

SNBC Comprehensive Diabetes Care Performance Improvement Project 2021-2023

May 1, 2023

Hennepin Health
300 South Sixth Street, MC 604
Minneapolis, Minnesota 55487-0604

Contents

Project Implementation Date: January 1, 2021
Interim Report Submission Date: September 1, 2022

MCO: Hennepin 09/01/2022

Summary

This Performance Improvement Project (PIP) is a collaboration of Minnesota Managed Care Organizations (MCOs) ("the Collaborative"). MCOs participating in this collaboration for their SNBC, MSHO & MSC+ products include: BCBS (MSHO and MSC+ only), HealthPartners, Hennepin Health (SNBC only), Medica, South Country Heath Alliance (SCHA) and UCare. Stratis Health provides project development support and assistance to the Collaborative.

This PIP focuses on decreasing the health disparity gap in HEDIS® and/or process measures chosen year-over-year from 2021 through 2023 by improving member's self-management of their diabetes. Each participating MCO has established a goal aimed at improving the comprehensive diabetes care and services for Seniors and Special Needs Basic Care (SNBC) members with the focus on disparities varying by MCO. To support improvement, MCOs support joint Collaborative interventions as well as individual MCO specific strategies.

Throughout the project, the Collaborative is attuned to the various sources of data and reporting available that helps to guide ideas for intervention and trainings. Valuable information is obtained from Minnesota Community Measurement Minnesota Health Care Disparities Reports[1], Minnesota Department of Health (MDH) Center for Health Equity, MDH Diabetes Data and Reports, to name a few.

I. PIP Elements

Year 1 Focus

The first year of the Diabetes PIP has focused on the training needs of the Care Coordinators who serve Minnesota Senior Health Options (MSHO) and SNBC members who are diagnosed with diabetes, as well as those members who are at high risk for becoming diabetic. Care Coordinators are a cornerstone of the members interdisciplinary care team and come to their work with a variety of educational backgrounds that vary in their knowledge of diabetes and optimal management. Enhancing their knowledge that focuses on helping members to more effectively improve their diabetes care and management can have an impact in real time, as well as long term for that Care Coordinator in their role. The 2021 Care Coordinator Webinar Series is detailed later in this report. Another significant goal achieved in the 2021 Diabetes PIP Collaborative Work plan has been to engage with the Minnesota Department of Health Diabetes team. MDH expressed appreciation for the invitation to collaborate with the MCO's on activities

[1] Minnesota Community Measurement 2019 Minnesota Health Care Disparities Report, June 2020: https://mncmsecure.org/website/Reports/Community%20Reports/Disparities%20by%20RELC/2019%20Disparities%20by%20RELC%20Chartbook%20-%20FINAL.pdf

to support our common initiatives. This successful collaboration with MDH is a natural fit given the alignment of our goals to improve diabetes care and health in Minnesota. More detail about this collaboration is found later in this report.

Hennepin Health Goal Statement

Hennepin Health seeks to improve the health and wellness of SNBC members, ages 18 – 65, diagnosed with diabetes mellitus. The goal is to reduce disparities in healthcare, access to care, and to address social determinants of health (SDoH). Hennepin Health will engage internal SNBC Care Guide team members, external SNBC care coordination agencies, provider organizations, and the Hennepin Health Accountable Health Model partners (Hennepin County Health and Human Services, Hennepin Healthcare, and NorthPoint Health and Wellness Center) to address the individual members' SDoH and barriers to care in order to facilitate comprehensive management for members with diabetes. When the need has been identified, members will be offered diabetic education to encourage self-awareness, self-care, and promote person -centered decision making around their diabetic management that may lead to improved health outcomes. It has been shown that people who have received diabetes education are more likely to use primary care and preventive services, take medication as prescribed, and control their blood glucose and blood pressure.

Year 1 Evaluation Report – Methods and Data Limitations

The project was initiated in calendar year 2021. This report focuses on interventions and activities completed during 2021, the first year of the interim report, and data available to reflect that timeframe. The project will attempt to measure closing disparity gaps by leveraging the HEDIS® Comprehensive Diabetes Care (CDC) metrics detailed more specifically in the Interventions and Measures of Success section.

A data limitation in each measure is the hybrid collection methodology that we all employ. Hybrid allows the health plan to use a sample size of 411 to review compliance via medical record abstraction. To maintain protected health information (PHI), the nurses that abstract data from medical records are only given the pieces to prove measure compliance, thus they would not have access to the patient's race/ethnicity. To address this limitation, our method will be to produce two rates - Hybrid and Admin. The hybrid rate provides this research with a project goal that is statistically valid. The admin rate provides the opportunity to analyze race and ethnicity as it's reported through the enrollment file (834).

Lastly, all the MCOs acknowledge collecting data on patient race, ethnicity, and language (REL) is an important step in reducing health care disparities, as clinical performance measures can then be stratified by REL to guide quality improvement efforts. To see success in this project, we encourage our Department of Human Services (DHS) partners to devise a strategy to strategically increase the availability and quality of data on race and ethnicity. This information is collected through the enrollment application and shared with health plans via the 834 monthly feeds. It is imperative for Medicaid beneficiaries to see the importance in the optional enrollment

question and DHS is the trusted partner to deliver that educational message. We would welcome additional conversation via our quarterly MCO-DHS Quality Workgroup meeting to discuss the critical gaps in data on race, ethnicity, and socioeconomic status in existing systems, and methods for filling those gaps.

II. Interventions and Measures of Success

The project will attempt to measure closing disparity gaps by leveraging the HEDIS® Comprehensive Diabetes Care (CDC) measure set listed below. The following HEDIS® CDC metrics will be used to monitor the success of the project:

- **Hemoglobin A1c Control** – the percentage of members ages 18-75 with diabetes (Type 1 and Type 2) whose most recent HbA1c test performed during the measurement year result is >9 (poor control).
- **Hemoglobin A1c Testing** – the percentage of members ages 18-75 with diabetes (Type 1 and Type 2) who had an HbA1c test performed during the measurement year.
- **Blood Pressure Control** <140/90 mm HG – the percentage of members ages 18-75 with diabetes (Type 1 and Type 2) whose blood pressure was adequately controlled.
- **Diabetic Eye Exam** – the percentage of members ages 18-75 with diabetes (Type 1 and Type 2) who had a retinal or dilated eye exam performed during the measurement year or a negative retinal or dilated eye exam (negative for retinopathy in the year prior to the measurement year.

To review healthcare race/ethnic disparities, we are leveraging data available through the enrollment application. Hennepin Health is using HEDIS hybrid data as the entire SNBC members with diabetes are in the sample. Hennepin Health has access to the Hennepin Healthcare electronic medical record, Epic®. To minimize the impact of the lack of REL data, Hennepin Health will utilize Epic® to obtain REL data for members seen at Hennepin Healthcare and NorthPoint Health and Wellness Center. Therefore, our "unknown" race/ethnic rate may be lower than the other MCOs. The matching process is labor intensive and a burden in the analysis process, however. The tables below show the numerators, denominators, and rates for the total population and by racial groups as defined by NCQA HEDIS®.

In the first year, the goals to improve all four metrics of the HEDIS® CDC measures for eligible SNBC members were not reached as detailed in following tables and figures below. At Hennepin Health, we work to leverage our position in the Hennepin County systems that Medicaid members often rely upon as well as our Accountable Health Model partners - Hennepin Healthcare and NorthPoint Health and Wellness. Both the Collaborative and Hennepin Health have accomplished much in the beginning of the PIP with much more planned for the future.

Table 1: HEDIS® CDC Rates, 2019, 2021

Year	Numerator	Denominator	Rate	Percent Change
Blood Pressure Control				
2019	149	199	74.5%	**-4.1%**
2021	143	203	70.4%	
HbA1c Testing				
2019	185	199	93.0%	**-1.4%**
2021	186	203	91.6%	
HbA1c Poor Control > 9%				
2019	64	199	32.2%	**-5.3%**
2021	54	203	26.9%	
Eye Exams				
2019	128	199	64.3%	**-10.7%**
2021	109	203	53.6%	

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

Healthcare Disparity Analysis

Hennepin Health is committed to reducing health inequity for all members. In analyzing the data in 2021 compared to 2019, inequities for the HEDIS® CDC measures exist. However, we find it difficult to draw conclusions because of the small denominators and whether the differences are significant. The COVID-19 pandemic has had a significant impact on members accessing health care on a timely basis. The pandemic not only exposed but worsened many long-standing barriers to get care for some members. 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 will continue to engage care coordinators to develop processes to better identify if and what social determinants are impacting members ability receive timely health care services. In addition, racial disparity gaps between Non-Hispanic White and members of color will continue to be monitored for impact. Hennepin Health will focus on decreasing other disparities and addressing social determinants of health to lift the population measures.

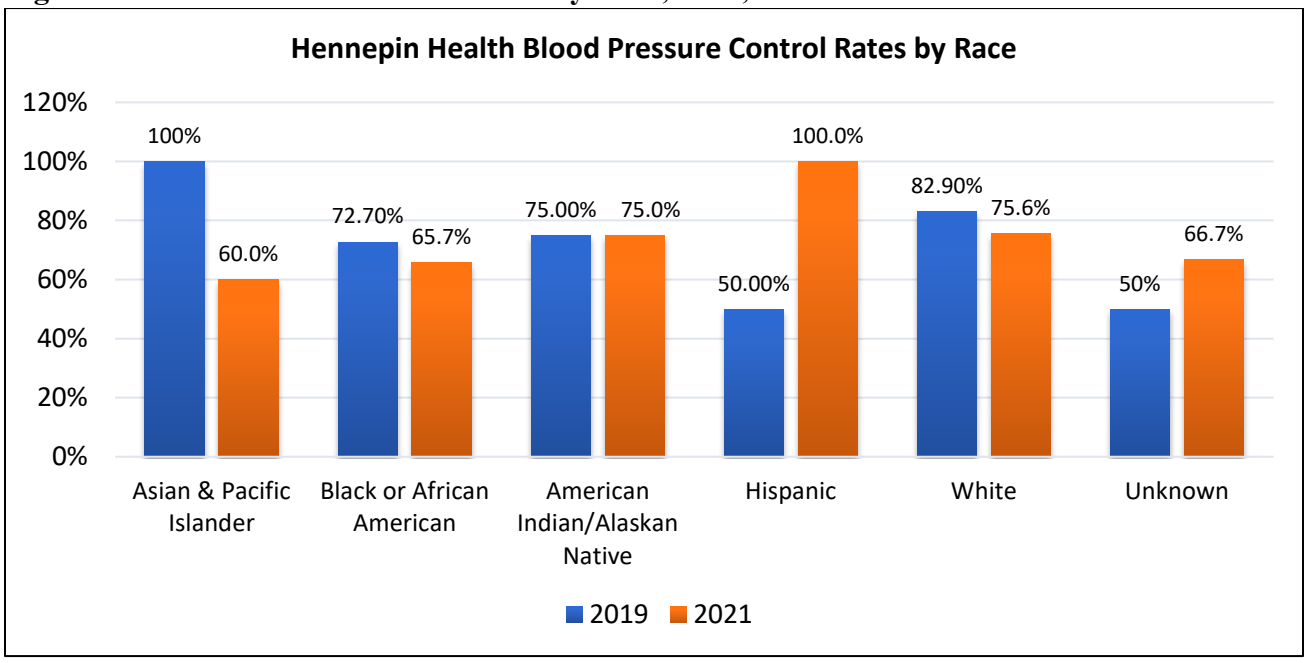
As show in Table 2, blood pressure control rates slightly improved for the Hispanic and Native American populations while all other rates decreased for the Black, Asian, and Unknown races. The data reflected in Figure 1 shows increased blood pressure control rates for the Hispanic and Unknown races while rates for all other races decreased in 2021.

Table 2: CDC Blood Pressure Control, 2019, 2021

Race	Numerator	Denominator	Rate	Difference Relative to Non-Hispanic Whites (percentage points)
Black	88	134	65.7%	-9.90%
Asian/Pacific Islander	6	10	60.0%	-15.6%
Hispanic	1	1	100.0%	24.4%
Native American	6	8	75.0%	-0.60%
Non-Hispanic White	34	46	75.6%	0.00%
Unknown	2	4	66.7%	-8.90%
Total	137	203	67.5%	-8.10%

Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS CY 2021

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



Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS CY 2021

For the HEDIS® CDC HbA1c testing in 2021, every racial group except the group for which race is unknown had higher HbA1c testing rates compared to Non-Hispanic White population as displayed in Table 3. Additionally, testing rates improved for every racial group except the Black and unknown race populations in 2021 compared to 2019 (Figure 2). However, the sample size is small, so it is possible the differences are due to random variation.

Table 3: CDC HbA1c Testing Rates by Race, 2021

Race	Numerator	Denominator	Rate	Difference Relative to Non-Hispanic Whites (percentage points)
Black	121	134	90.3%	1.20%
Asian/Pacific Islander	10	10	100.0%	10.90%
Hispanic	1	1	100.0%	10.90%
Native American	8	8	100.0%	10.90%
Non-Hispanic White	41	46	89.1%	0.00%
Unknown	3	4	75.0%	-14.10%
Total	186	203	90.7%	1.60%

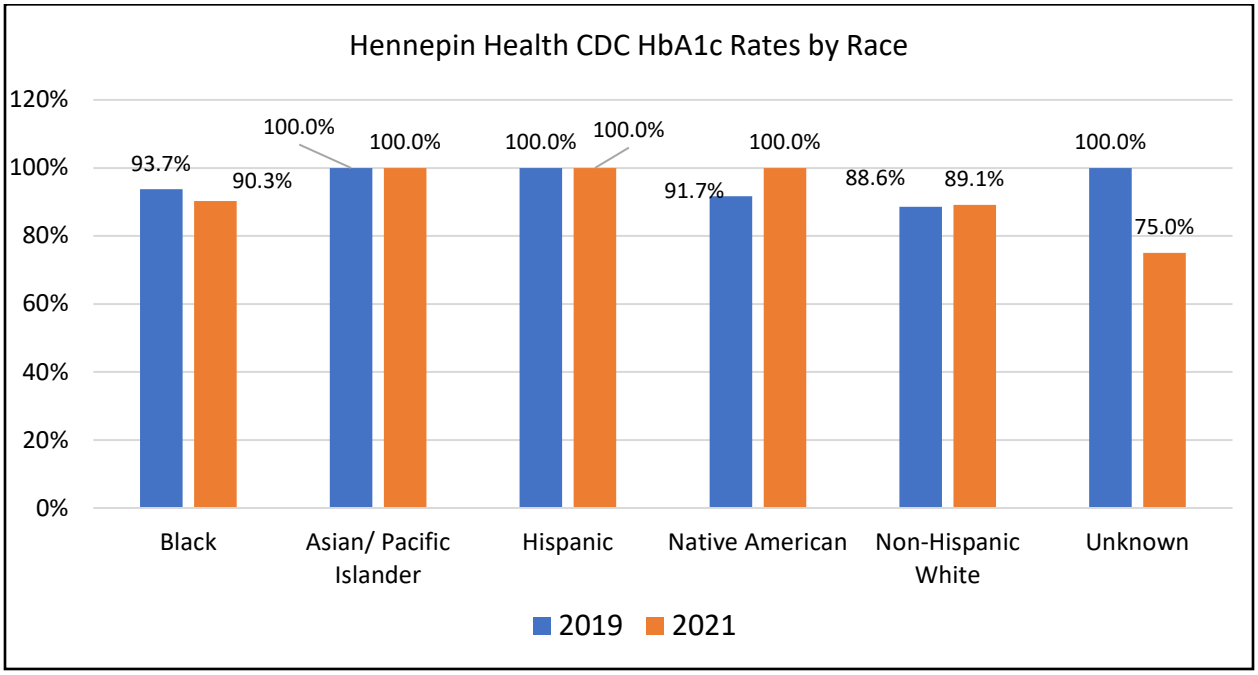
Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS CY 2021

Table 4: CDC HbA1c Poor Control >9%, 2021

Race	Numerator	Denominator	Rate	Difference Relative to Non-Hispanic Whites (percentage points)
Black	23	134	17.3%	-2.30%
Asian/Pacific Islander	1	10	9.1%	-10.50%
Hispanic	0	1	0.00%	-19.60%
Native American	2	8	22.2%	2.60%
Non-Hispanic White	9	46	19.6%	0.00%
Unknown	2	4	50.0%	30.4%
Total	37	203	18.2%	-1.40%

Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS CY 2021

Figure 2: HbA1c Rates by Race, 2019, 2021



Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS CY 2021

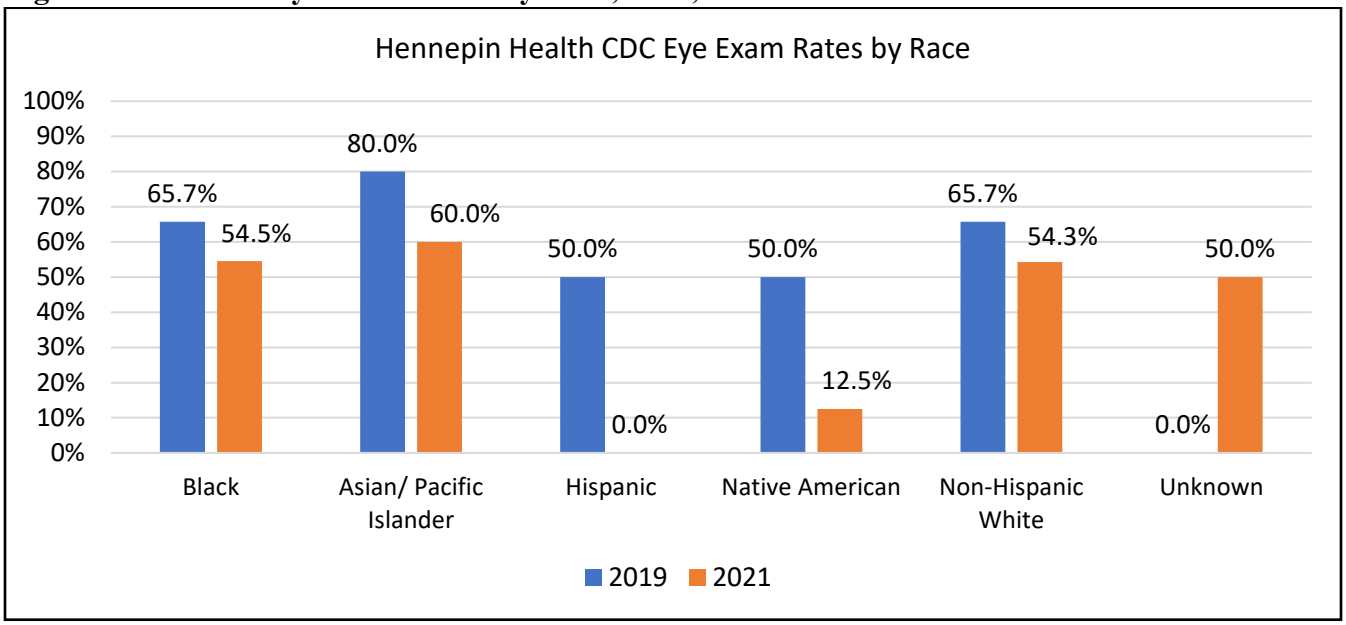
As displayed in table 5, the Black and Asian/Pacific Islander populations had slightly higher CDC eye exam rates compared to Non-Hispanic Whites in 2021. Racial disparities were seen in the Hispanic, Native American, and the unknown races when compared to the Non-Hispanic White population. The eye exam rates decreased for all race/ethnic groups in 2021 compared to 2019, except for the unknown racial group as seen in Figure 3 below. However, the sample size for all race/ethnic groups in 2019 and 2021 is relatively small, with limited interpretation.

Table 5: HEDIS® Eye Exam Rates by Race, 2021

Race	Numerator	Denominator	Rate	Difference Relative to Non-Hispanic White (percentage points)
Black	73	134	54.5%	0.20%
Asian/Pacific Islander	6	10	60.0%	5.70%
Hispanic	0	1	0.0%	-54.30%
Native American	1	8	12.5%	-41.80%
Non-Hispanic White	25	46	54.3%	0.00%
Unknown	2	4	50.0%	-4.30%
Total	109	203	53%	-1.30%

Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS CY 2021

Figure 3: HEDIS® Eye Exam Rates by Race, 2019, 2021



Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS CY 2021

Collaborative Interventions

Care Coordination

The MCO Collaborative created an education series for Care Coordinators designed to better equip them with the knowledge and skills to best help members with managing their diabetes. Care Coordinators/Case Managers have an essential role in educating, supporting and assisting members in setting and achieving health goals to improve their diabetes care and play a key role in closing the gaps in health care disparities within our populations. While some Care Coordinators/Case Managers are nurses, many are social workers who benefit from additional information on the role they can play to support their members with diabetes. With that in mind, the trainings developed included information for those with a range of experience and skillsets to supplement their current expected knowledge base. For example, a social worker is not typically knowledgeable about medical issues, so a diabetes basics course was found to be beneficial in enhancing their knowledge of working with their members with diabetes. The high enrollment, attendance and positive evaluations of these webinars reinforced the value of this type of information for our care coordinators.

All these webinars are recorded and posted on the project page of the Stratis Health website for viewing anytime.

Webinar Series

The Collaborative offered a series of webinars in 2021 to improve the comprehensive diabetes care and services for Seniors and SNBC members. The series is being continued in 2022 and will continue throughout the project. The webinars offered in 2021 were as follows.

Meeting the Challenges of Diabetes: Core Basics – 3/2/21 Presented by Dr. Jody Nelson, Medica

This training is the first of a series of trainings that will be offered over the course of this project focused on helping Care Coordinators/Case Managers gain a better understanding of diabetes, it's impact on persons living with diabetes, and how to best support members to best manage their condition. The training aims to ensure that Care Coordinators, Case Managers, and other professionals working with MSHO and SNBC members have a good understanding of diabetes, its impact, and to begin to enhance your skillset used when working with members with diabetes. Over 300 people participated in this webinar live and three additional people watched the recorded webinar.

Over 92% of respondents indicated that they learned new information and strategies they could apply in their work. And over 96% said they learned at least three new strategies to support members in managing their diabetes.

Meeting the Challenges of Diabetes: Updates with the Pharmacists – 8/17/21 Presented by Grant Scaft, PharmD and Kaylin Maddy, PharmD from UCare

This training aims to ensure that Care Coordinators, Case Managers, and other professionals working with MSHO and SNBC members have a good understanding of the work of pharmacists in relation to diabetes care, its impact, and to begin to enhance their skill set for working with members with diabetes. Almost 300 people participated in this webinar live and three more watched the recorded webinar at a later date.

Of those who completed the evaluation, 94.5% agreed that the webinar improved their knowledge and ability to apply new strategies to their work with members with diabetes. And 92.5% said it improved their knowledge of the role MTM plays in diabetes care.

The Challenges of Achieving Optimal Diabetes Results: Barriers, Disparities and Strategies for Care Coordination Success – 10/26/21 Presented by Thomas von Sternberg, MD Julie Hughes, RN, and Beth Simpson, MSN, EdM, RN, NE-BC from HealthPartners

The goal of the presentation series is to provide Care Coordinators, Case Managers, and other professionals working with MSHO and SNBC members information to understand the impact of diabetes better and enhance their skillsets when working with members with diabetes.

As part of the webinar, we shared a tool *Care Coordination Resources for Working with Individuals with Diabetes*, that is a collection of resources and information about diabetes management for care coordinators, links to resources and training opportunities, financial assistance tools and other SDoH tools and resources available to people with diabetes.

Approximately 415 people participated in this webinar live and ten more watched the recorded webinar later. Over half of those attending completed the evaluation and of those, 88% indicated the information addressed gaps in their knowledge and included strategies they can apply in their work. Ninety-five percent said the webinar increased their ability to identify social and

behavioral barriers to optimal diabetes care and their ability to understand the impact of racial disparities on diabetes outcomes and 91% indicated an improved ability to address barriers to diabetes care with their clients.

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 recommended care, enhanced care coordination for specific conditions or educational resources. Increasingly, these supports include resources to address social determinants of health.

For clinicians, care coordinators, and other staff that support our members, it can be difficult to track the resources available to each individual they care for, especially when they may work with people across multiple MCOs. In Q4 of 2021, the Collaborative launched a standardized supplemental benefits resource. This resource serves as an information hub to find relevant resources and supplemental benefits that enhance and support the care of our members.

This tool has received positive feedback from care coordinators, as it creates symmetry when working with multiple plans. The Collaborative is focused on ensuring continual attention to opportunities to include resources that promote health care equity, and culturally tailored resources. The standardized template also follows the order of the new MnChoices questionnaire to incorporate smoothly in the care coordinators standard workflow. Some of the resources included on the benefits grid 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
- Access to care coordination or disease management resources for each plan
- How to access resources to address social determinants of health
- Transportation services available
- Incentives for diabetes care

Hennepin Health is exploring the possibility of developing an effective resource guide that will benefit SNBC members to be able to fully utilize and access the supplemental guide.

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

It is clear that a healthy diet is vital to controlling diabetes and other comorbidities such as high blood pressure and obesity. Often people with a limited income need to rely on food shelves or other resources for supplemental food. Food shelves are often stocked with staples that have a long shelf life and contain high levels of refined carbohydrates, sodium and preservatives. By

maximizing other resources, we hope to provide our members with options to supplement their diet with healthier alternatives.

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

Community Outreach and Partnerships

Minnesota Department of Health

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

In the fall of 2020, the Collaborative initiated communication with the workgroup at MDH, making them aware of the DHS Diabetes PIP and the MCO Collaborative's desire to learn about the priorities of the State Strategic Plan and to identify how the Diabetes PIP interventions can align with and support the State Plan and vice versa. It was mutually decided that this collaboration is a natural fit. The MDH Diabetes Team was very receptive to our outreach, and meetings with them commenced in November 2020 and have continued throughout 2021 and 2022. MDH Diabetes Team members Teresa Ambroz and Esther Maki were identified as the point people to work with the PIP Collaborative. The MDH Diabetes Team was enlisted to work on COVID-19 Epidemic initiatives in 2020 and 2021 so they were grateful and appreciative to see the MCO Diabetes PIP work in motion and working on diabetes health interventions.

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

- Food is Medicine – Integrating Effective Nutrition Interventions into the Healthcare System: A Concept Whose Time Has Come
- Super Shelf Panel - Webinar on Healthy Food Initiatives in Minnesota

Hennepin Healthcare

Hennepin Healthcare has been a long-time partner with Hennepin Health, committed and engaged in various activities and projects that address social determinants of health, improving quality care gaps, and is an active accountable health model partner. Last year, both entities worked in partnership to develop a dual role representing both agencies and serving as a change

agent for the accountable health model by managing performance improvement initiatives that focus on increasing the quality of care and services. The main responsibility of the person in this role has been to work directly with department leaders at Hennepin Healthcare and Hennepin Health to identify quality issues, create solutions to issues, and assist with implementation of corrective action.

University of Minnesota Extension Expanded Food and Nutrition Education Program

The Expanded Food and Nutrition Education Program (EFNEP) is a United States Department of Agriculture funded program that successfully addresses critical societal concerns by employing peer educators. EFNEP positively influences nutrition and physical activity behaviors of low-income caregivers of children, and of youth attending schools with the highest free and reduced lunch rates. The EFNEP educators, called Community Nutrition Educators (CNEs), deliver a series of hands-on, interactive lessons to low-income families. Lessons are evidence-based and tailored to the needs of the audience. This education helps families develop skills, attitudes, and behaviors necessary to maintain a healthy diet and stay physically active. Hennepin Health has established a relationship with this organization and will continue to partner with this organization in 2022.

Hennepin Health Interventions

Diabetes Assessment and Member Experience

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

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

total of 9 patients (16%) indicated that food and clothing were items they were unable to get when it was really needed. Very few members indicated they were having difficulties with equipment such as a blood pressure monitoring equipment. The majority of members (80%) state that they take their diabetic medications every day. Members will be reassessed in 2022 to evaluate the effectiveness of the interventions provided to address their unique needs.

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

Next Steps

The COVID-19 pandemic has had a significant impact on members accessing health care on a timely basis. The pandemic not only exposed but worsened many long-standing barriers to get care for some members. Increasing eye exam rates for individuals living with diabetes while focusing on eliminating racial disparities is an area of opportunity for Hennepin Health in 2022. To be able to reduce the disparities in diabetes, evidence-based programs already available will be used to address the many factors that influence health, such as access to nutritious foods, options for physical activity through a collaborative approach between both health care and non-health care to improve diabetes and addresses the social and environmental factors that affect vulnerable populations

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. They encourage members to schedule visits with the health care provider and receive necessary tests such as HbA1c test and eye exams.

Hennepin Health will continue to engage care coordinators to develop processes to better identify if and what social determinants are impacting members ability receive timely health care services. In addition, racial disparity gaps between Non-Hispanic White and members of color will continue to be monitored for impact. Hennepin Health will focus on decreasing other disparities and addressing social determinants of health to lift the population measures. In addition, Hennepin Health will continue to meet with the Collaborative twice a month to carry out goals and ensure interventions will be implemented accordingly.

III. Barrier Analysis

Multiple barriers, both predicted and unforeseen while drafting the proposal for this project, have become evident throughout planning and implementation of interventions. Several, but not all, barriers are related to the COVID-19 pandemic.

- **COVID-19 Pandemic** - People may still be hesitant to see their provider due to the COVID-19 pandemic. Education to inform communities of how to get care within the COVID-19 guidelines and safety may not reach all people who need to get care.
- **Access to healthy and culturally connected foods** - Access to quality food options become challenging for people living in rural areas and any food deserts across the state. Although members may have access to resources such as food shelves, there may be limited options.
- **Linguistic barriers and culturally specific diabetes education** - There are patient education supporting material and tools for diabetes management available. Many of these materials can be found translated in a variety of languages but there could be differences in levels of health literacy, cultural practices, and beliefs to fully optimize management of diabetes among diverse groups of populations.
- **Access to quality care and support** – Access and referrals to diabetes specialists such as endocrinologists may be limited. To manage diabetes effectively, it often takes having a specialist and comprehensive referral for the patient to successfully maintain their treatment plan. For MSHO and SNBC members, a care coordinator plays a key role in this process by helping the member implement the necessary actions to support their treatment. Unfortunately, not all members accept care coordination.
- **Addressing Social Determinants of Health (SDOH)** - For effective diabetes management, it is important to have a trusted relationship with your health care team. Unfortunately, it may be challenging for some health care systems because there could be mistrust among diverse communities and their provider or misinformation from sources like the internet, social media, etc. Comprehensive treatment planning includes looking at the member from a whole person view, which includes all SDoH. It is critical for providers to address implicit bias and align providing care with their patients for culturally sensitive care.
- **Medication challenges –** Medications may be complex and require ongoing education for both the patient and their support system. For Medicaid members, prescribers do not have liberty to choose drugs that are outside of the preset formulary. There may be various reasons why a member may be better managed by a non-formulary drug option, such as side effects and lack of access to specific medications.

- **Limited access to technology** - Telemedicine is increasingly being used to meet gaps with delivering care but there is still a lack of access and support with self-monitoring in-home devices such as blood pressure cuffs and insulin pumps.

IV. Sustainability of Interventions

All webinars, education series, training materials and any collaborative efforts with other organizations will be posted on the Stratis Health website for continued use and updated annually, provided they remain accurate and clinically relevant. Investment in training for Care Coordinators and the diabetes knowledge and skills gained, is carried into their work with MSHO and SNBC members now and into the future. Outreach efforts to members that are determined to be effective will be continued indefinitely. Community partnerships will be maintained.

Assessment of Short-term and Long-term Effects

The initiatives implemented within the scope of this project are intended to improve health outcomes for MSHO and SNBC members with diabetes. The MCO will evaluate the Collaborative interventions 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.

V. Plan for 2022

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

- 1st Quarter 2022
    - Determine topics for Care Coordinator Training Series in 2022
    - Solidify plans work plan with MDH Diabetes team to cohost 2022 two statewide webinars
- 2nd Quarter 2022
    - Consequences of Disease Progression webinar.
    - Food is Medicine webinar in collaboration with MDH
    - Determine topics for webinar series for diabetes management and disparities.
    - Schedule webinar presenters for 3rd and 4th quarter.
- 3rd Quarter 2022
    - Diabetes and Implicit Bias webinar
    - Super Shelf Panel webinar in collaboration with MDH
    - Addressing Diabetes with Non-English Speakers webinar
    - Work on enhancing resources section of PIP page on Stratis Website.
- 4th Quarter 2022
    - MCO's will update Supplemental Benefits Grid and make available to Care Coordinators
    - Discuss milestones for 2022

300 South Sixth Street, MC 604
Minneapolis, Minnesota 55487-0604

hennepinhealth.org