# Performance Improvement Project Project:
# The Reduction of Racial Disparities in the Management of Depression

***Description***

The goal of this Performance Improvement Project (PIP) is to increase the use of antidepressant medication treatment for individuals with depression within the Hennepin Health populations and to reduce the existing disparity gaps within the critical racial groups within antidepressant medication adherence.

Hennepin Health is collaborating with the other Minnesota Health Plans on championing these efforts and on achieving consistency for enrollees and across health care systems for intervention methods. As a collaborative group, there was a prime opportunity to leverage many pivotal intervention strategies that would have proved challenging to do as a single health plan. Through new interventions, Hennepin Health would be able to support enrollees in improving their treatment of depression through increased medication adherence.

Mental illness may be stigmatizing and understood differently by racial and ethnic minority groups, including African Americans, American Indians and Hispanics. Increasing awareness of depression and the benefits of treatment could help reduce the stigma and improve the treatment engagement in these communities.

***Process and Documentation***

<u>Intervention Strategies</u>
In collaboration with the other health plans, Hennepin Health developed common messaging for enrollees and provider resources on depression and medication adherence to support development of intervention materials. Using such messaging in the proposed enrollee and provider interventions helps increase consistency and reduce confusion by communicating key factors and information using the same terminology. Thus, providers and/or enrollees are receiving the same messaging across various communication channels from all the plans.

Interventions focus on primary care provider resources and education regarding the treatment of depression within a culturally and racially diverse population. A primary intervention was a collaborative and interactive provider toolkit that went live in April 2015. Much of the content development and research for the depression toolkit occurred in

late 2014 and into 2015. Updates to the provider toolkit in 2016 included new links and resource tools for serving seniors and patients in rural areas. The provider toolkit was promoted during educational webinars offered throughout the year and promoted via posting on the Stratis Health website and individual plan websites. Stratis Health also tweeted the availability of the updated toolkit to their followers.

Webinars were offered quarterly in 2016 to providers working with culturally diverse patients experiencing depression. Newsletter articles were used to share information with providers.

Community outreach and partnerships occurred with two Catholic churches to promote a Latino Family Health Fair that would raise awareness, reduce stigma, and provide education on mental illness to their congregations.

The collaborative also participated in and presented at conferences during 2016.

Provider Interventions:
Hennepin Health in collaboration with other health plans (the "Collaborative"), developed common messaging for enrollees and provider resources on depression and medication adherence.

**Provider Process Measures**:
Toolkits

- Number of tool kits distributed, downloads or web hits
- Promotional log of activities for distribution/promotion of the toolkit.
- Partnership log for community outreach activities.

Training for Care Providers

- Number of attendees at trainings
- Number of trainings provided
- Results of training evaluations

Enrollee Interventions:
Enrollee intervention consist of telephonic outreach by care coordinator staff to enrollees newly diagnosed with depression. The outreach calls aim to address specific treatment barriers, such as concerns about addiction, as well as to teach strategies for managing side effects. Enrollees may receive educational materials as a component to the telephonic call process. Due to a change in the claims system during 2015, Hennepin Health continued to experience problems with receiving accurate data reports so calls were delayed until June, 2016. Since the initial proposal was submitted, staffing resources at Hennepin Health changed, so additional training was provided for new staff assisting with these calls.
A letter with an educational flyer is sent to enrollees after being newly identified as meeting the Antidepressant Medication Management (AMM) continuation phase criteria per claims data. Internal Hennepin Health Quality staff and external Hennepin Health care guides conduct telephonic outreach calls after receiving biweekly data reports and the

letters have been sent to enrollees. Subsequent calls are also made to enrollees if they reach 40 or more days of non-compliance for refilling their medications. On occasion, for the SNBC population, the external care guides review information in person in lieu of conducting a phone call with the enrollee per the enrollee's request to discuss these issues in person. Therefore, contact may have occurred outside the normal timeframe for initiating calls. Call outcomes for this report cover the period from June through October, 2016. Calls are considered complete if an enrollee was reached or three attempts were made to reach the enrollee. For each call, staff tracked the assistance provided and barriers experienced by the enrollee. Initial outreach calls began June, 2016 and follow-up calls to enrollees not refilling their medications began in September, 2016.

Based upon feedback from staff conducting the calls, enrollees identified various concerns not accurately reflected on the call-tracking sheet to capture enrollee process measures. The call-tracking sheet was revised to more accurately reflect barriers, issues, and other concerns raised by the enrollees. Staffing changes within some of the external care agencies caused questions to arise on how to capture the information. Uncertainty related to the tracking process impacted data collection, specifically whether to categorize calls as an initial outreach or as a follow-up/no refill outreach call. Staff received training on the correct process to use.

**Enrollee Process Measures**

Telephone follow-up

- Number of attempts to contact enrollees for follow-up
- Number and rate of completed follow-up calls
- Number of mailings or materials given to enrollees during call process
- Partnership log kept for community outreach activities

### *Analysis*

Due to the timing of HEDIS measurement (see Table 1 below), the impact of the PIP's interventions were not reflected in the primary outcome measures until HEDIS 2016, which was reported in June 2016. It is important to note that HEDIS rates will not reflect a full year of this PIP's interventions until 2017. Thus, a complete picture of the impact of the PIP's interventions will not be available until at least 2019. HEDIS rates for 2019 will reflect dates of service in 2017 and 2018. Therefore, it is too early in the project to identify if Hennepin Health is on target to meet its improvement goal of reducing the disparity in antidepressant medication adherence between Blacks and Whites by 20%, and between Native American and Whites by 20% by the end of the three-year project.

| Table 1. HEDIS AMM Continuation Phase Measurement Periods | | |
|---|---|---|
| **HEDIS Reporting Year** | **HEDIS Measurement Period** | **PIP Intervention Year** |
| 2014 | May 2012 – April 2013 | Baseline |
| 2015 | May 2013 – April 2014 | Pre-implementation |
| 2016 | May 2014 – April 2015 | Year 1 (first four months of implementation) |
| 2017 | May 2015 – April 2016 | Year 1-2 |
| 2018 | May 2016 – April 2017 | Year 2-3 |
| 2019 | May 2017 – April 2018 | Year 3 |

**Process Measures**

**Provider Interventions**

### *Collaborative Provider Interventions*

During 2016 the Collaborative updated resources developed in the first year of the project, and continued to offer webinars for providers who work with culturally diverse patients experiencing depression. Hennepin Health worked with a collaborative of Minnesota Health Plans (the "Collaborative") to develop these resources as described below. The resources address best practices for depression care, with an emphasis on the importance of delivering such care in a culturally appropriate way.

### *Provider Toolkit*

The Collaborative developed *Antidepressant Medication Management: A Provider Toolkit* in the first year of this project. The toolkit (The Provider Toolkit is available on the Stratis Health website for this project) provides relevant resources and tools for providers working with culturally diverse Medicaid patients who have depression. The toolkit focuses on issues related to medication adherence with an emphasis on racial and cultural perspectives. In 2016, the collaborative reviewed toolkit materials, updated links and added new resources such as tools for seniors and patients in rural areas.

The toolkit includes the following topics:

- Best Practices in Depression Care, including screening, medication adherence, and follow-up after hospitalization.
- Emerging Best Practice: Integration of Behavioral Health into the Primary Care Setting
- Cultural Awareness and Treating Depression
- Shared Decision Making for Depression Treatment
- Mental Health Resources for providers, patients and caregivers.
- Health Plan Resources and contacts

The Collaborative continued to promote the toolkit through multiple channels, as outlined in Table 2.

To assist with promotion, the Collaborative utilizes a postcard with a Quick Response Code. One hundred eighty-nine (189) unique visitors viewed the toolkit 221 times from November 20, 2015 – October 31, 2016. Feedback on the toolkit has been positive and analysis of the web hits suggests that promotion of the toolkit through provider communications, newsletter articles, social media, webinars and conferences have driven interest in the toolkit.

In addition to clinics in Minnesota, the Collaborative received a request from Anthem Health Plan in Maine, to utilize the provider toolkit. The Collaborative gave permission for its use as long as credit is given to the group. After modifying the toolkit to include Maine relevant content, Anthem has shared it with their provider network as part of an effort to improve HEDIS measures.

**Table 2. Promotion of the Provider Toolkit – Activity Log**

| Date | Activity | Outcome |
|---|---|---|
| Quarter 1 2016 | Provider Toolkit | Toolkit updated and posted to Stratis Health website and internal health plan sites. |
| Quarter 3 2016 | Tweet | Stratis Health tweeted to their followers the availability of the updated Provider Toolkit. |
| Quarters 1-4 2016 | Webinar training sessions | Promoted link to toolkit and presented toolkit as part of presentation. |

### *Webinars*

The Collaborative continues to offer highly successful webinars addressing various areas associated with culturally sensitive depression care. Those attending the webinars represented a variety of disciplines including care coordination, behavioral health, nursing, public health, social work, social services and others.

As noted in the 2015 interim report, a webinar was offered in November titled *Shared Decision-Making & Depression Treatment in Primary Care*. The webinar was attended by 33 individuals and 19 people completed the evaluation for CME Credits. The assessment was overwhelmingly positive with participants noting increases in knowledge of the issues reported. Of note, 100% of respondents replied that they are better able to discuss shared decision making, including new strategies to use with patients. Additionally, all respondents were able to identify barriers to implementation in practice, demonstrating the ongoing difficulty of integration of this strategy into routine practice.

## 2016 Webinars

Webinar 1: *Behavioral Health Care for Refugees: Barriers, Best Practice and Cultural Humility*. [February 2016.] Dr. Georgi Kroupin, a therapist from HealthPartners Center for International Health and an expert in the area of refugee behavioral health shared information on the relationship of culture to help seeking, mental health adherence practices, and ways to improve the patient/provider relationship. Demand for this webinar was extremely high and maximum capacity was achieved for the webinar attendance. Ninety-eight respondents completed the evaluation. Of those, 88% indicated that the webinar was good or excellent and 99% indicated an increased understanding of how culture affects help seeking behavior and adherence to behavioral health interventions.

This webinar was so successful that Dr. Kroupin offered to supplement the overview with more in-depth information related to the mental health of refugees. The collaborative worked with Dr. Kroupin to offer a series of webinars on this topic as detailed below.

Webinar 2: *Behavioral Health Care for Refugees series: Immigration; Surviving Trauma, Loss and Finding Hope.* [May 2016.] This webinar focused on understanding the levels of loss and trauma experienced by refugees and their families, and the changes that occur in relationships and between generations. At least 100 people attended the presentation, and 74 completed the on-line evaluation. Many participants viewed the webinar in groups to increase availability. Feedback from the evaluation showed that 89% of those who attended this webinar rated the presentation good or excellent, and more than 97% indicated they had an increased understanding of how culture affects help seeking and adherence. Dr. Kroupin integrated comments and requests for specific information into future webinars.

Webinar 3: *Depression Care for Somali Americans: Barriers, best practice and cultural humility*. [July 2016.] Ahmed Hassan, a Therapist and Program Director at Summit Guidance and Donna Smith, a marriage and family therapist at Summit Guidance discussed the Somali-American community's perception of mental health issues and how provider awareness of these beliefs can improve interactions with patients. At least 100 people attended and 77 completed the on-line evaluation for CEU credits. Approximately 75% rated the presentation good or excellent and reported an increase in their knowledge of this cultural community. More than 90% indicated this webinar increased their understanding of best practice to engage the Somali community. The expansive comments provided will shape future webinar offerings.

Webinar 4: *Behavioral Health Care for Refugees Series: Mental Health Issues of the Refugee Population: Screening, Diagnosis and Treatment.* [July 2016.] This webinar looked at mental health issues in the refugee population. Dr. Kroupin discussed screening, diagnosis and treatment. One hundred twenty-four (124) people attended the second webinar in the series by Dr. Kroupin and 74 people completed the evaluation for CEU credits. Seventy-five

percent (75%) of respondents indicated that their knowledge and their ability to apply new strategies to their work increased and 89% agreed that their ability to identify sources of mental health issues increased due to attending this webinar.

Webinar 5: *Behavioral Health Care for Refugees Webinar Series: Mental Health Issues of the Refugee Population – Compliance and Adherence to Treatment.* [October 2016.] Dr. Kroupin discussed potential cultural reasons for non-adherence and resistance to treatment and how providers can move past these barriers when treating refugees. Eighty-eight (88) people attended Dr. Kroupin's third webinar and 67 completed the evaluation. Ninety-eight percent (98%) of respondents indicated they had an increased ability to work with multiple dimensions of people's lives to improve compliance and outcomes as a result of attending this webinar and over 90% had an increased understanding of national or cultural differences related to health care.

Webinar 6: *Behavioral Health Care for Refugees Webinar Series: Mental Health Issues of the Refugee Population – Working with Interpreters in Mental Health Settings.* [December 2016]. Dr. Kroupin discussed working with interpreters as part of the clinical team and the therapeutic process of treating behavioral health issues in refugees. Eighty-eight (88) people attended and 51 completed the evaluation. Eighty-eight (88%) of respondents indicated they had enhanced knowledge and ability to apply new strategies and tools in their work setting as a result of this webinar and 94% reported they had a good or excellent understanding of the role of the interpreter in behavioral health encounters.

### *Newsletters*

The Collaborative also used newsletter articles to share information with providers.

- Each health plan shared an article in their provider newsletter discussing the availability of translated prescription medication information at certain pharmacies. This resource is not heavily utilized and the Collaborative believes enhancing provider knowledge of this resource may support compliance among patients whose preferred language is not English. Hennepin Health's article was posted on its website in November 2016.
- Each health plan involved in the Collaborative published an article in its provider newsletter informing their network about the availability of the updated toolkit. Hennepin Health's article was posted on its website in November 2016.

### *Community Outreach & Partnerships*

Integrating mental health education and supporting the community health fairs are effective in reaching people who may not otherwise seek out mental health services due to cultural beliefs, stigma and general lack of information. On December 4, 2016, the MCO Collaborative partnered with St. Alphonsus and Ascension Churches to sponsor a Latino

Family Health Fair. The fair integrated mental health education and resources, alongside vendors doing health screenings, flu shots, mammograms, dental education, etc. The "Make it Ok" organization provided mental health education and resources in Spanish and English, NW Family Services conducted a depression screening survey and Hennepin Crisis Services (COPE) provided mental health resource information. Approximately 120 -175 people attended with 49 receiving flu shots, 38 had health screenings and 14 women had mammograms.

Most health plans sponsored the NAMI Walk in 2016. The event is a 5K walk to increase public awareness of mental illnesses, fight stigma, and raise funds for NAMI Minnesota.

***Conference Presentations & Participation***

The Collaborative participated in several conferences in 2016:

- Minnesota Rural Health Conference. In June, several of the health plans had a booth at this conference and disseminated postcards promoting the toolkit.

- Community Health Advisor Meeting. Two health plans attended this meeting to discuss the resources that communities need to support mental health of their entire population. The outcome of the meeting will be the development of an on-line tool containing research, best practices and tools for implementation of community wide health efforts.

- Accountable Communities for Health – Brooklyn Park. Two health plans also attend ongoing workgroup meetings and report relevant information back to the Collaborative. Workgroups focus on improving clinic-community care coordination delivery model for people with depression, implementing strategies promoting a community of health through opportunities for healthy nutrition, physical activity, social connectedness, and creating sustainable community relationships to improve the opportunities for all people to realize their health potential and improve the quality and cost of health care.

## Enrollee Interventions

Hennepin Health experienced problems with receiving accurate data reports so enrollee outreach calls were delayed until June, 2016. Internal Hennepin Health Quality staff and external care guides conducted telephonic outreach calls to enrollees newly diagnosed with depression, with an added emphasis on enrollees identified as being non-adherent to medication therapy. On occasion, for the SNBC population, the external care guides review information in person in lieu of conducting a phone call with the enrollee. For each call, staff track assistance provided and barriers experienced by the enrollee.

A letter with an educational flyer is sent to enrollees when they are newly identified with a depression diagnosis per claims data. After sending the initial letter and flyer, outreach

calls are made to the enrollee. In addition, if enrollees are non-compliant with refilling their medications, a subsequent follow-up/no-refill call is made to the enrollee. Call outcomes for this report cover the period from June through October, 2016. Calls are considered complete if an enrollee was reached within three attempts.

For the Hennepin Health-SNBC population, there were 226 unique enrollees. Of those, 129 had a telephone. The overall call completion rate was 78.29%, with 48.06% completed with one attempt, 15.50% completed with two attempts, and 14.73% completed with three attempts. Table 3 shows the number of initial outreach attempted calls, completed calls, outreach calls not fully completed, and number of letters/fliers resent after the initial letter. Only eight enrollees (6.20%) requested that the flier be resent and the rest indicated they did not want additional material sent.

**Table 3. Hennepin Health-SNBC Initial outreach call summary, June–October 2016**

| Call information | # SNBC Population | # White | # Black | # Native American / Alaskan / Hawaiian | # Asian | # Hispanic |
|---|---|---|---|---|---|---|
| # Initial outreach calls completed (includes those with no phone but who had a face-to-face contact) | 105 | 27 | 67 | 5 | 4 | 0 |
| # completed on 1 attempt | 62 | 16 | 38 | 3 | 3 | 0 |
| # completed on 2 attempts | 20 | 4 | 15 | 1 | 0 | 0 |
| # completed on 3 attempts | 19 | 5 | 12 | 2 | 0 | 0 |
| **Total** | **101** | **25** | **65** | **6** | **3** | **3** |
| No call done as enrollee termed off health plan prior to call period | 4 | 1 | 2 | 0 | 1 | 0 |
| # outreach calls not fully completed | 31 | 5 | 23 | 3 | 0 | 0 |
| # letters/fliers resent after call | 8 | 2 | 6 | 0 | 0 | 0 |

For the follow-up/no refill calls, the overall call completion rate was 20.93%, with 11.63% completed with one attempt, 3.10% completed with two attempts, and 6.20% completed with three attempts. The lower call completion rate was impacted due to the following reasons: enrollee phones were disconnected during follow-up call process, enrollees were no longer at the current phone number provided, enrollees were in a treatment facility or in jail and could not be reached and 19.38% of enrollees preferred no further calls after

receiving the initial outreach call. Table 4 summarizes the number of follow-up/no refill calls attempted, the call completion rate, and calls not fully completed.

| **Table 4. Hennepin Health-SNBC Follow-up/no refill outreach call summary, June–October 2016** | | | | | | |
|---|---|---|---|---|---|---|
| **Call information** | **# SNBC Population** | **# White** | **# Black** | **# Native American / Alaskan / Hawaiian** | **# Asian** | **# Hispanic** |
| # Follow-up/no refill outreach calls completed (includes those with no phone but who had a face-to-face contact) | 27 | 6 | 18 | 1 | 1 | 0 |
| # completed on 1 attempt | 15 | 3 | 9 | 1 | 1 | 0 |
| # completed on 2 attempts | 4 | 1 | 3 | 0 | 0 | 0 |
| # completed on 3 attempts | 8 | 2 | 6 | 0 | 0 | 0 |
| **Total** | **54** | **12** | **36** | **2** | **2** | **0** |
| # follow-up/no refill outreach calls not fully completed | 23 | 5 | 15 | 3 | 0 | 0 |

For the Hennepin Health-PMAP population there were 622 unique enrollees. Of those, 340 had a telephone. The overall call completion rate was 53.82%, with 29.41% completed with one attempt, 13.82% completed with two attempts, and 10.59% completed with three attempts. Only three enrollees (0.88%) requested that the flier be resent and the rest indicated they did not want additional material sent. Table 5 shows the number of initial outreach attempted calls, completed calls, outreach calls not fully completed, and number of letters/fliers resent after initial letter.

| Table 5. Hennepin Health-PMAP Initial outreach call summary, June–October 2016 | | | | | | |
|---|---|---|---|---|---|---|
| **Call information** | **# PMAP Population** | **# White** | **# Black** | **# Native American / Alaskan / Hawaiian** | **# Asian** | **# Hispanic** |
| # Initial outreach calls completed (includes those with no phone but who had a face-to-face contact) | 183 | 72 | 67 | 8 | 2 | 0 |
| # completed on 1 attempt | 100 | 30 | 44 | 5 | 1 | 0 |
| # completed on 2 attempts | 47 | 24 | 17 | 1 | 1 | 0 |
| # completed on 3 attempts | 36 | 18 | 6 | 2 | 0 | 0 |
| **Total** | **183** | **72** | **67** | **8** | **2** | **0** |
| No call done as enrollee termed off health plan prior to call period | 0 | 0 | 0 | 0 | 0 | 0 |
| # outreach calls not fully completed | 157 | 59 | 66 | 9 | 3 | 0 |
| # letters/fliers resent after call | 3 | 1 | 1 | 0 | 0 | 0 |

For the follow-up/no refill calls, the overall call completion rate was 2.94%, with 1.47% completed with one attempt, 1.47% completed with two attempts, and 0% completed with three attempts. Follow-up calls did not begin until September 2016, as there had been many questions from staff conducting the calls when initial outreach calls were made. Time was spent fine-tuning the process and educating the staff on how to conduct the follow-up calls. In addition, some staff inadvertently listed some calls as an initial outreach call rather than as a follow-up/no refill outreach call. Staff were retrained on the correct procedure for logging call outcomes. Table 6 summarizes the number of follow-up/no refill attempted calls, call completion rate, and calls not fully completed.

| Table 6. Hennepin Health-PMAP Follow-up/no refill outreach call summary, June–October 2016 | | | | | | |
|---|---|---|---|---|---|---|
| **Call information** | **# PMAP Population** | **# White** | **# Black** | **# Native American / Alaskan / Hawaiian** | **# Asian** | **# Hispanic** |
| # Follow-up/no refill outreach calls completed (includes those with no phone but who had a face-to-face contact) | 10 | 4 | 4 | 1 | 1 | 0 |
| # completed on 1 attempt | 5 | 1 | 3 | 1 | 0 | 0 |
| # completed on 2 attempts | 5 | 3 | 1 | 0 | 1 | 0 |
| # completed on 3 attempts | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **20** | **8** | **8** | **2** | **2** | **0** |
| # follow-up/no refill outreach calls not fully completed | 157 | 59 | 66 | 8 | 3 | 0 |

The lower call completion rate for the Hennepin Health – PMAP population was also impacted with the same reasons which impacted the SNBC population: enrollee phones were disconnected during follow-up call process, enrollees were no longer at the current phone number provided, voice message was left and no enrollee response, and enrollees preferred no further calls after receiving the initial outreach call. In addition, some enrollees were in a treatment facility or in jail and could not be reached or were out of the area with an unknown return date. Table 7 summarizes additional reasons affecting the call completion rates for Hennepin Health-PMAP and Hennepin Health-SNBC enrollees.

| Table 7. Hennepin Health-PMAP and Hennepin Health-SNBC call outcomes, June-October 2016. | | |
|---|---|---|
| **Outcome** | **Hennepin Health-PMAP** | **Hennepin Health-SNBC** |
| Enrollees with a phone | 54.66% | 57.08% |
| Enrollees without a phone | 45.34% | 42.92% |
| Enrollees with phone disconnected/not in service | 15.59% | 15.50% |
| Enrollee no longer at this phone number | 2.06% | 3.10% |
| Enrollees - no answer; no ability to leave voice mail message | 7.94% | 4.65% |

| Table 7. Hennepin Health-PMAP and Hennepin Health-SNBC call outcomes, June-October 2016. | | |
|---|---|---|
| **Outcome** | **Hennepin Health-PMAP** | **Hennepin Health-SNBC** |
| Enrollee phone does not accept incoming calls | 0.59% | NA |
| Enrollee where voice mail message was left but no enrollee response | 21.76% | 11.63% |
| Enrollees temporarily away with unknown return date | 0.88% | 1.55% |
| Enrollee prefers no calls | 4.41% | 19.38% |
| Enrollees who had letters returned | 8.04% | 3.54% |

**Baseline Measurement**

HEDIS 2014 and 2015 AMM Continuation Phase rates provide baseline or pre-intervention data. Table 8 depicts the Hennepin Health-PMAP AMM baseline rates by race and shows the change in rates with the HEDIS 2016 measurement period added. The rates fluctuated among all races for HEDIS 2016 when compared to HEDIS 2015 rates. The rate increased for Whites by 4.80%, for Native Americans by 7.61%, and for Hispanic by 100% while it decreased for Blacks by 12.27% and for Asians by 55.56%. There were also enrollees falling into two or more race categories with a 20% rate as compared to no categories for that in previous years.

The racial gap for Black as compared to White went from -3.68% to -20.75%, two or more races is at -27.46%, Asian went from 57.34% to -3.01%, Native American went from -25.27% to -22.46%, and Hispanic went from not applicable to +52.54%. The changes in the small numerator and denominator numbers affected the rate and racial gap by creating an inflated negative or positive rate thus making the rates unstable. Rates for enrollees whose race was unable to be determined were not included. Since the HEDIS 2016 measurement period is from May 2014 – April 2015, it does not reflect the enrollee interventions that began in June 2016.

| Table 8. Hennepin Health-PMAP AMM Baseline Rates by Race for HEDIS 2014 – 2016 | | | | | |
|---|---|---|---|---|---|
| **Race** | **HEDIS Rates by Year (Hennepin Health – PMAP)** | **Numerator** | **Denominator** | **Rate** | **Racial Gap compared to White** |
| White | 2014 | 33 | 71 | 46.47 % | NA |
| White | 2015 | 32 | 75 | 42.66 % | NA |
| White | 2016 | 84 | 177 | 47.46 % | NA |
| Black | 2014 | 45 | 111 | 40.54 % | -5.93 % |
| Black | 2015 | 46 | 118 | 38.98 % | -3.68 % |
| Black | 2016 | 39 | 146 | 26.71 % | -20.75 % |
| Two or More Races<br>Note: There were no eligible enrollees for two or more races in years 2014 and 2015. | 2016 | 2 | 10 | 20.00 % | -27.46 % |
| Asian | 2014 | 5 | 12 | 41.66 % | -4.81% |
| Asian | 2015 | 3 | 3 | 100 % | 57.34 % |
| Asian | 2016 | 4 | 9 | 44.44 % | -3.01 % |
| Native American / Alaskan / Hawaiian | 2014 | 14 | 39 | 35.89 % | -10.58% |
| Native American / Alaskan / Hawaiian | 2015 | 4 | 23 | 17.39 % | -25.27 % |
| Native American / Alaskan / Hawaiian | 2016 | 6 | 24 | 25.00 % | -22.46 % |
| Hispanic | 2014 | 0 | 7 | 0 % | NA |
| Hispanic | 2015 | 0 | 1 | 0 % | NA |
| Hispanic | 2016 | 1 | 1 | 100 % | +52.54 % |

HEDIS 2014 and 2015 AMM Continuation Phase rates provide baseline or pre-intervention data. Table 9 depicts the Hennepin Health-SNBC AMM baseline rates by race and shows the change in rates with the HEDIS 2016 measurement period added. Rates remained the same for Native Americans, Hispanics, and rates decreased for the other races. Rates decreased by 3.33% for Whites, 9.18% decrease for Blacks. For Asians the rate for 2016

was 0%, which is a decrease from the 2015 rate of 33.33%, although the denominator in this race category is very small.

The racial gap for Black as compared to White went from +0.04% to -5.45%, Asian went from 0% to -30%, and Native American went from +16.67% to +20.00%. For the Two or More Races and Hispanic categories, there were no eligible enrollees. The changes in the small numerator and denominator numbers affected the rate and racial gap by creating an inflated negative or positive rate thus making the rates unstable.

Since the HEDIS 2016 measurement period is from May 2014 – April 2015, it does not reflect the enrollee interventions that began in June 2016.

**Table 9. Hennepin Health-SNBC AMM Baseline Rates by Race for HEDIS 2014 – 2016**

| Race | HEDIS Rates by Year (Hennepin Health – SNBC) | Numerator | Denominator | Rate | Racial Gap compared to White |
|---|---|---|---|---|---|
| White | 2014 | 13 | 37 | 35.13 % | NA |
| White | 2015 | 9 | 27 | 33.33 % | NA |
| White | 2016 | 9 | 30 | 30.00 % | NA |
| Black | 2014 | 19 | 60 | 31.66 % | -3.47 % |
| Black | 2015 | 28 | 83 | 33.73 % | +0.04 % |
| Black | 2016 | 27 | 110 | 24.55 % | -5.45 % |
| Two or More Races | 2014 | 1 | 1 | 100 % | +64.87 % |
| Two or More Races | 2015 | 2 | 4 | 50.00 % | +16.67 % |
| Two or More Races | 2016 | 0 | 0 | 0 % | NA |
| Asian | 2014 | 1 | 3 | 33.33 % | -1.80 % |
| Asian | 2015 | 1 | 3 | 33.33 % | 0 % |
| Asian | 2016 | 0 | 6 | 0 % | -30.00 % |
| Native American / Alaskan / Hawaiian | 2014 | 6 | 14 | 42.85 % | +7.72 % |
| Native American / Alaskan / Hawaiian | 2015 | 1 | 2 | 50.00 % | +16.67 % |
| Native American / Alaskan / Hawaiian | 2016 | 2 | 4 | 50.00 % | +20.00 % |
| Hispanic | 2014 | 1 | 2 | 50.00 % | +14.87 % |

| Table 9. Hennepin Health-SNBC AMM Baseline Rates by Race for HEDIS 2014 – 2016 | | | | | |
|---|---|---|---|---|---|
| **Race** | **HEDIS Rates by Year (Hennepin Health – SNBC)** | **Numerator** | **Denominator** | **Rate** | **Racial Gap compared to White** |
| Hispanic | 2015 | 0 | 0 | 0 % | -33.33 % |
| Hispanic | 2016 | 0 | 0 | 0 % | NA |

**Barriers**

As shown in Table 7, 71.52% of Hennepin Health-PMAP enrollees and 66.17% of Hennepin Health-SNBC enrollees could not be reached by phone for the following reasons:

- The enrollee did not have a phone,
- The phone was disconnected,
- The enrollee was no longer at that number, and
- There was no ability to leave a voice mail message or the enrollee phone did not accept incoming calls.

In addition, 4.41% of Hennepin Health-PMAP and 19.38% Hennepin Health-SNBC enrollees preferred no calls once they were reached. That leaves a small percentage of enrollees actually reached during outreach calls and where an impact on compliance might occur. Looking at those percentages, outreach calls are not as effective as anticipated in the original proposal, which may contribute to less than anticipated outcomes.

Other factors that may contribute to lack of compliance with medication adherence is that the Hennepin Health-PMAP population have high levels of alcohol and/or other drug use, mental illness, and stress due to a lack of basic needs such as housing and food. There is also a high rate of homelessness for this population. Often for Hennepin Health-PMAP enrollees, their primary focus is addressing these psychosocial needs prior to addressing their medical needs. Developing a trusting relationship with health care practitioners/programs who are outside of their usual "trusted" support system can be difficult for individuals with mental illness. Additionally, this population typically does not have an adequate social support system available to them, often having lost contact and/or alienating their family or friends. These individuals generally seek medical care only when an acute medical illness arises. Once the acute medical illness is addressed, they generally do not seek ongoing primary and preventive care services. Many Hennepin Health-PMAP enrollees live in what some might call "survival mode": thinking only of the present day and what their needs are in that moment. Aversion to thinking long term is often a major barrier to enrollees receiving primary/preventive health care services. This was reflected by the reasons enrollees for both Hennepin Health-PMAP and Hennepin Health-SNBC gave

for not taking their medications. Enrollees in both products also experienced the following, which made it difficult to be compliant with taking their medications:

- No primary care provider or psychiatrist
- Felt they had a physical problem and not a mental health problem
- Continued drinking alcohol so they stopped taking their medication
- Memory issues so forgot to take their medications
- Missed provider appointments so unable to get a timely refill
- On advice from their provider, halved the dosage of their medication or began taking on an as needed basis so did not get refills as frequently
- Dental concerns they wanted to deal with first
- Family issues or were too stressed to take their medications
- Housing issues so couldn't focus on their mental health
- Did not feel they needed their medications

Since enrollee engagement calls are not as effective as originally anticipated, Hennepin Health is exploring whether other options for enrollee interventions would be more useful such as contacting the prescribing provider to alert them that the enrollee has not refilled their medication.

Another challenge for this study is that using claims data to determine eligible enrollees does not account for discontinued medications. Therefore, the medication may still show up on the data report showing the enrollee as non-compliant for refilling prescriptions. In order to determine if medications are discontinued, staff utilize the Epic medical record. Currently, the Hennepin Health contractual agreement with Hennepin County Medical Center, who owns the Epic records, does not allow Hennepin Health staff to access medical record information via Epic for SNBC enrollees to verify if medications are current. During calls, SNBC enrollees often state they are no longer taking that medication. If staff had been able to verify the medications in Epic prior to making outreach calls, the data would have been more accurate. Hennepin Health is working on getting staff access to Epic records for SNBC enrollees but it is unknown when that may occur.

***Recommendations and Next Steps***

Hennepin Health will continue to focus on reducing racial disparity between the Black and the Native American populations and the White population for depression management. As potential psychosocial issues are identified, in addition to medication adherence compliance, Hennepin Health will continue to work with our partner organizations to address these issues. This could allow enrollees to change their focus from meeting psychosocial needs to addressing their medical well-being/medication compliance.

Additionally, alternative enrollee interventions will be discussed with the Quality Management Committee as the telephone outreach calls have not been as effective as anticipated. Hennepin Health will also work with the Minnesota Department of Human

Services to address whether alternative enrollee intervention strategies may be considered for the duration of this project.