Hennepin Health

2021 Comprehensive Diabetes Care Performance Improvement Project

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

Performance Improvement Projects

Description

The MCOs are required to conduct performance improvement projects (PIPs) designed to achieve significant improvement in clinical care and non-clinical care areas through ongoing measurements and interventions that have a positive impact on the members' health outcomes and member satisfaction. The PIPs are conducted over a three-year period and any improvements achieved must be sustained over time once the PIP has concluded. PIPs must comply with 42 CFR §438.330(b)(1) and (d) and Centers for Medicare and Medicaid Services (CMS) protocol titled "*CMS EXTERNAL QUALITY REVIEW (EQR) PROTOCOLS October 2019.*"

Process and documentation

Hennepin Health participates in the PIP collaborative initiatives with other Minnesota MCOs and stakeholders. Collaborative initiatives support consistent provider practices and provider and member messages to minimize consumer confusion, enhance member health care experiences, provide continuity of care, promote racial equity, and eliminate duplication of services. Stratis Health provides guidance and support for the PIP.

Each PIP is led by a health plan representative. The MCOs rotate the leadership role for each PIP. The Collaborative and Stratis Health staff meet twice a month during the PIP planning and implementation processes. Stratis Health is responsible for scheduling of meetings, maintaining meeting minutes, and guiding the development and implementation of the PIP, including the work plan. Health plan staff have access to the documents and meeting minutes maintained on the Stratis Health SharePoint site. Stratis Health also preserves webinars, toolkits, and other resources relevant to the specific PIP on its website that providers and members can access to view and print materials as needed during and after the conclusion of the PIP.

To monitor the success of the overall PIP and interventions, collaborative process measures and outcomes measures, using qualitative and/or quantitative data, are identified and analyzed annually. Each health plan may identify and monitor additional process and/or outcomes measures in addition to those identified by the Collaborative.

Each health plan's PIP proposal is submitted to and approved by DHS prior to the PIP implementation. Collaborative PIP strategies and interventions are developed and implemented. Each health plan may implement health-plan specific strategies and interventions relevant to their respective membership. The MCOs collaborate on the writing of the interim and final PIP reports submitted annually to DHS. Each health plan addresses health plan specific interventions and outcomes in the report.

Improvements seen as the result of a PIP strategies and interventions will be sustained over time. To support sustainability, Stratis Health maintains the collaborative PIP resources on its website. The Collaborative reviews these resources annually to ensure relevancy and will update the resources as appropriate. The individual MCOs promote the resources through various means including provider and member communication. In addition, each health plan continues to implement and revise the specific health plan strategies and interventions to sustain the improvements obtained through the PIP.

The 2018-2020 PMAP, MinnesotaCare and SNBC PIP topic selected by DHS was *"Preventing Chronic Opioid Use"*. The 2021-2023 "*Healthy Start for Mothers and Their Children*" for PMAP/MinnesotaCare population was implemented in January 2021. "*Comprehensive Diabetes Care"* is the SNBC 2021 – 2023 PIP topic which also began in January 2021.

PIP: 2021-2023 SNBC Comprehensive Diabetes Care

Rationale and purpose

This PIP is designed to promote health equity and decrease the racial disparities for SNBC members living with diabetes by providing information for members to self-manage their diabetes. The PIP is a collaboration of Minnesota MCOs ("the Collaborative") that includes Blue Plus, HealthPartners, Hennepin Health, Medica, South Country Health Alliance (SCHA), and UCare. Each participating MCO has established a goal aimed at improving the diabetes care measures of achieving a blood pressure in good control, A1c testing completed in the measurement year, A1c control and completing eye exams, as appropriate, with the focus on disparities, relevant to the individual MCO population.

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 health care, access to care, and to address social determinants. Hennepin Health works with internal SNBC Care Guide team members, external SNBC Care Coordination agencies, provider organizations and Accountable Health model partners (Hennepin County Public Health and Human Services, Hennepin Healthcare, and NorthPoint Health and Wellness Center) to address the individual member social determinants and barriers to care to facilitate comprehensive management for members living with diabetes. To be able to reduce the disparities in diabetes, current evidence-based programs are 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.[1] 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.

Diabetes is the sixth leading cause of death in Minnesota, and the leading cause of blindness, kidney failure, and lower-limb amputations. In Minnesota, glaring racial and ethnic disparities in diabetes exist that are reflected in the disease's prevalence, complication and death rates, and preventive care received by those who have diabetes.[1] The Minnesota Community Measurement 2019 Minnesota Health Care Disparities Report [2] highlighted two key findings related to diabetes:

- American Indian/Alaskan Native and Black patients living with diabetes have the lowest rates of HbA1c control.
- Black and Hispanic patients who live with diabetes have significantly lower rates of blood pressure control compared to the statewide average for the Optimal Vascular Care measure.

Disparities happen when the health of a group of people are negatively affected by factors like how much money they earn, their race or ethnicity, or where they live.[3] While Minnesota consistently ranks as one of the healthiest states in the nation, there continues to be wide variation in health care outcomes across and within certain communities. Racial and ethnic disparities in diabetes complications and diabetes-related deaths are made worse by a variety of factors including poor access to diabetes medicines, supplies, and preventive care. Lack of culturally and linguistically appropriate diabetes education materials and support systems, and lack of culturally diverse or culturally competent health care providers further impede effective diabetes management in these populations.[4]

Analysis

To review health care race and ethnic disparities, Hennepin Health leveraged data available through the DHS Medicaid enrollment application. Hennepin Health used the HEDIS® Comprehensive Diabetes Care (CDC) hybrid data as the entire SNBC eligible population is in the sample. In the hybrid methodology, clinical information is abstracted from the member's medical chart. This information complements the administrative (claims) data as it provides a complete picture of the care and services provided. Hennepin Health has access to the Hennepin Healthcare electronic medical record, Epic®. To minimize the impact of the lack of race, ethnicity, and language (REL) data, Hennepin Health utilized Epic® to obtain REL data for members who are seen at Hennepin Healthcare and NorthPoint Health & Wellness Center. The measures displayed in Table 1 below will be used to monitor the success of the PIP. The HEDIS® CDC 2020/CY2019 results will serve as the baseline. At the time of the writing of the 2021 Quality Management Evaluation, data rates were not yet available.

Table 1. Comprehensive diabetes care PIP measures

Measure	Description
HEDIS® CDC blood pressure control <140/90mm HG	The percentage of members ages 18–75 with diabetes (Type 1 and Type 2) and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.
HEDIS® CDC HbA1c 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.

Table 1. Comprehensive diabetes care PIP measures	
Measure	**Description**
HEDIS® CDC HbA1c control >9 (poor 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).
HEDIS® CDC 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.

Using 2019 data, racial disparities were identified by race and ethnic group for the various HEDIS® CDC measures as displayed in Table 2.

Table 2. Racial disparities by HEDIS® CDC measures				
Measures	**Blacks**	**American Indian**	**Asian/Pacific Islander**	**Hispanic**
HEDIS® CDC blood pressure control <140/90mm HG	Yes	Yes	No	Yes
HEDIS® CDC HbA1c testing	No	No	No	No
HEDIS® CDC HbA1c control >9 (poor control)	Yes	Yes	Yes	Yes
HEDIS® CDC eye exam	No	Yes	No	Yes

The Collaborative and Hennepin Health specific interventions focus on reducing racial disparities and improving the rates for the measures. Collaborative interventions include the development of an education and resources for members, care coordinators, community health workers, health coaches, and others. Examples of educational topics are nutrition, food disparity, MCO supplemental benefits and motivational interviewing. Some resources that may be developed are:

- Supplemental benefits for each MCO relevant to diabetes care such as fitness/wellness classes, technology available, healthy diet or cooking classes and weight management classes
- Access to care coordination or disease management resources for each MCO
- How to access resources to address social determinants of health as appropriate
- Transportation services available
- Incentives for diabetes care

The Collaborative is partnering with the Minnesota Cardiovascular Health and Diabetes State workgroup. Hennepin Health specific interventions include member education through Healthwise® Knowledgebase, an online health resource available on the Hennepin Health website. With Healthwise Knowledgebase, the member can research tests, medicine, and treatment. Members can use the interactive personal calculator, watch videos, or read about health-related topics. Information is based on the best, most up-to date medical research and is available in English or Spanish.

Hennepin Health is exploring with Hennepin County Health and Human Services, Hennepin Healthcare, and NorthPoint Health & Wellness Center potential process improvements to their current diabetic education programs to reduce barriers to receiving this education. Another Hennepin Health specific intervention included the development of a diabetes assessment to receive input and feedback from members in how they manage their diabetes in late 2021. The assessment comprises of six areas with a social determinants of health focus. Other interventions include promoting supplemental benefits like YMCA membership and incentive reward program vouchers for HbA1c testing and eye exams. Hennepin Health is working with members living with diabetes who are experiencing food insecurity to identify a source of food that best meets their needs.

Recommendations and next steps

Hennepin Health will continue to meet with the Collaborative twice a month throughout the PIP implementation. Both Hennepin Health and Collaborative interventions will be implemented according to the timeline submitted in the PIP proposal.

Care guides and care coordinators will reach out to members living with diabetes to complete the diabetes assessment primarily through phone communication starting in January 2022. Finally, Hennepin Health will partner with external agencies who have trained educators who can teach healthy eating and nutrition education sessions to members who are interested in learning on how to eat healthy. A unique component of partnering with the trained educators at a facility that has a dedicated kitchen space allows members to learn and engage in cooking a healthy meal together, led by the educator. This is a great opportunity for members to learn or re-learn healthy cooking and eating habits that can lead to improved health outcomes.

References:

[1] https://www.health.state.mn.us/communities/equity/ehdi/priority.html
[2] 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
[3] https://www.health.state.mn.us/diseases/diabetes/data/diabetesfacts.html
[4] https://www.health.state.mn.us/communities/equity/ehdi/priority.html

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