Reducing Disparities in Diabetes Care

DHS, in collaboration with the Managed Care Organizations selected Diabetes for this 3 year PIP based on data that shows that Diabetes is the sixth leading cause of death in Minnesota, and the leading cause of blindness, kidney failure, and lower-limb amputations. The Minnesota Community Measurement 2019 Minnesota Health Care Disparities Report highlights two key findings related to diabetes:

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

MCOs participating in this collaboration for their SNBC, MSHO & MSC+ products include: Blue Cross Blue Shield of Mn, HealthPartners, Hennepin Health, Medica, South Country Heath Alliance and UCare. Stratis Health provides project development support and assistance to the Collaborative.

This PIP focuses on decreasing the health disparity gap in HEDIS® Comprehensive Diabetes Care, Blood Pressure Control measure year-over-year from 2021 thru 2023 by improving member's self-management of their Diabetes. To be able to reduce the disparities in Diabetes we will look to the already present evidence-based programs 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.

Medica completed an analysis of the disparity shown in the HEDIS Blood Pressure Control measure between Caucasians and Populations of Color. While disparity is shown when looking at both the administrative and hybrid data, for this project Medica will use the broader and more comprehensive administrative measure that also includes those members who fall into the hybrid data. Since the project has an emphasis on closing disparity gaps, the administrative measure more accurately represents the disparity gaps and will better show progress to close the gaps year over year. Success will be achieved by seeing a decrease in the health disparity gap comparing the rate of 'Population of Color' to 'Caucasian' from the MSHO/SNBC baseline of 6.84% to 3.83% over the course of the 2021 – 2023 project.

For the purposes of this project:

Population of Color will include those who identify as:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander

Caucasian will include those who identify as:

- White

Project Interventions

This project includes both Medica specific and collaborative interventions in partnership with the participating MCO's. Collaborative interventions include:

- Care Coordinator Education and Training: The MCO Collaborative will plan an education series for Care Coordinators that will focus on better equipping them with the knowledge and skills to help members with managing their diabetes. Training will be designed to address a wide variety of topics related to diabetes, but also attempt to level set some basic foundational knowledge about diabetes. Examples of diabetes training topics to include: Diabetes 101, Nutrition, Race and Ethnicity, Food Disparity, Resources, MCO Supplemental Benefits, Motivational Interviewing, etc.
- Care Coordinator Tools and Resources: This project will create a tool that could serve as an information hub to find relevant resources and supplemental benefits that would enhance and support the care of our members. This tool will be similar to other Collaborative grids that have been developed that have received positive feedback from care coordinators, county and clinic staff. The Collaborative is focused on ensuring continual attention to opportunities to include resources that promote health care equity, and culturally tailored resources. Some of the resources that we anticipate including are:
    - Supplemental benefits for each plan relevant to diabetes care such as fitness/wellness classes, technology available, healthy diet or cooking classes and weight management classes
    - Access to care coordination or disease management resources for each plan
    - How to access resources to address social determinants of health as appropriate
    - Transportation services available

Medica specific project interventions include:

- Prescription Monitoring Program: Medica offers a prescription monitoring system called SCREENRX® through our pharmacy benefit manager Express Scripts (ESI) that is offered for members enrolled in MSHO, SNBCI and SNBC. The use of predictive modeling is used to proactively identify the right patients for outreach, helping them to stay medication adherent and more effectively manage their diabetes. Member interventions include: live phone calls; email reminders; follow-up letters; specialist pharmacy counseling, etc. The SCREENRX program features:
    - Early detection of members at risk for being non-adherence, and offers tailored interventions to improve adherence
    - Addresses barriers to medication non-adherence including behavioral, clinical and cost.
    - Aims to decrease hospitalizations, complications, and adverse effects of diabetes

- Medica Disease Management Program: Medica has comprehensive programs designed to assist those members living with complex and chronic medical conditions. Medica's Disease Management Program focuses on members with Adult Asthma, Cardiac Conditions, and Diabetes. The goal is to increase member management of the health condition to improve the member's overall health and their knowledge about their condition. Members enrolled in MSHO, MSC+, SNBCI, and SNBC are eligible for all three targeted condition programs. For this PIP, the focus will be on the Diabetes Education and Management part of the program.

  Disease Management (DM) utilizes a predictive modeling program to identify members who may benefit from engagement in the program. Additionally, Care Coordinators can make a referral to the program for members who they believe can benefit from additional education and support to better manage their diabetes.

- Medica Additional Benefits: Medica offers additional benefits that are uniquely designed to improve the overall health of our MSHO, MSC+, SNBC SNP and SNBC members. Offered in addition to the services covered under Medical Assistance, as well as under Original Medicare for MSHO and SNBC SNP, these extra benefits aim to offer unique services and support in sync with the needs of these populations and their health care needs. Several of these additional benefits that will be offered in 2021 definitely align to support the goals of this Diabetes PIP.

Medica is continuously engaged in looking for ways to help members improve their health, and overall quality of life. Efforts to bring this education and resources to populations of color is essential to the ongoing work to close the health equity gaps now and in the future. Activities and interventions initiated for this PIP, are evaluated for continuation based on their success and effectiveness.

The initiatives implemented within the scope of this project are intended to improve Seniors and SNBC enrollee members self-management of their diabetes. Additionally, this project will reduce the disparities by addressing factors such as nutrition and physical activity. Medica will evaluate the Collaborative interventions and plan specific interventions to determine how to sustain these in the years to come.

Plan for 2021

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

- 1st Quarter 2021
  - Meet with the members of the 2030 Minnesota Cardiovascular Health and Diabetes State Plan. Learnings will drive education and training.
  - Discovery/research of resource for community organizations and state-funded community support services.
- 2nd Quarter 2021
  - Develop tools and resources for the various audience members – Care Coordinators, PCP, etc.
  - Determine topics for webinar series for diabetes management and disparities.
  - Schedule webinar presenters for 3rd and 4th quarter.

- 3rd Quarter 2021
    - Host first care coordinator webinar on diabetes management. First webinar will be a 101 scope with additional webinars to drill further down to barriers identified via our data analysis.
    - Publish supplemental benefits grid under tools and resources.
- 4th Quarter 2021
    - Host webinar on disparities in Diabetes.
    - Discuss milestones for 2022