Medica

Reducing Disparities in Diabetes Care Performance Improvement Project

The Minnesota Department of Human Services (DHS), in collaboration with Minnesota Managed Care Organizations (MCOs), selected Diabetes for this three-year Performance Improvement Project (PIP) that runs from 1/1/21 through 12/31/23. The topic was chosen 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 collaborative PIP for their Special Needs BasicCare (SNBC and Integrated SNBC (SNBCI)), Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) products include: Blue Plus, 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 the HEDIS® Comprehensive Diabetes Care, Blood Pressure Control (CDC-BP Control) measure year-over-year from 2021 through 2023 by improving members' self-management of their Diabetes. To reduce the disparities in Diabetes we look to the already present evidence-based programs to address the many factors that influence health, such as access to nutritious foods and options for physical activity. The PIP takes a multi-faceted approach that includes both health care and non-health care approaches to improve Diabetes and addresses the social and environmental factors that affect vulnerable populations.

Medica Goal

Medica completed an analysis of the disparity shown in the HEDIS CDC-BP Control measure between Caucasians and Populations of Color. Results indicated a disparity of 6.84%, with lower rates of blood pressure control among Populations of Color. 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.[1]

For the purposes of this project:

Populations of Color will include those who identify as:

- American Indian or Alaskan Native
- Asian
- Black or African American

[1] CDC-BP rates are calculated using administrative data rather than hybrid data.

- 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 MCOs.

Collaborative interventions include:

- Care Coordinator Education and Training: The MCO Collaborative kicked off an education series for Care Coordinators that focuses on better equipping them with the knowledge and skills to help members manage their diabetes. Some of the trainings that took place in 2021 include: Meeting the Challenges of Diabetes: Core Basics; Updates with the Pharmacists; Diabetes Management: Barriers, Disparities and Strategies for Care Coordination Success. The Collaborative will continue to provide additional webinar trainings in 2022 including:
  - Consequences of Disease Progression
  - Food is Medicine (This webinar is a collaboration between the MCOs and Minnesota Department of Heath Diabetes Team.
  - Implicit Bias and Diabetes Care
  - Diabetes Management and People with Limited English Proficiency

- 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

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. Predictive modeling proactively identifies 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, and specialist pharmacy counseling. The SCREENRX program:

    - Focuses on early detection of members at risk for being non-adherence with 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 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 predictive modeling 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+, SNBCI and SNBC members. Offered in addition to the services covered under Medical Assistance, as well as under Original Medicare for MSHO and SNBCI, 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 offered in 2022 align to support the goals of this Diabetes PIP, including gym memberships, nutrition programs, foot care, and others.

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 MSHO, MSC+ and SNBC members' self-management of their diabetes. Additionally, this project aims to reduce 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.