CMS Quality Improvement & DHS Performance Improvement Projects

As part of our contract agreement with the Minnesota Department of Human Services (DHS), South Country Health Alliance (South Country) conducts performance improvement projects (PIPs) designed to achieve, through ongoing measurements and intervention, significant improvement on member health outcomes and satisfaction. PIP topics are determined by DHS with discussions with all health plans and implemented following a cycle length determined by DHS along with annual status reports demonstrating progress toward achieving project goals. Additionally, the Centers for Medicare & Medicaid Services (CMS) require chronic care improvement programs (CCIPs) for AbilityCare and SeniorCare Complete. PIPs and CCIPs are similar but use slightly different formats based on DHS and CMS requirements.

A Healthy Start for Mothers and Children PIP 2021-2023

Planning for the PIP began in 2020 with an implementation date of January 1, 2021. This PIP topic was chosen by DHS and is intended to promote a “Healthy Start” for the health of our mothers and children ages (0-15 months) on our Families & Children (PMAP) and MinnesotaCare (MNCare) programs experiencing the effects of geographic disparities due to living in rural communities.

South Country is participating in the Managed Care Organization (MCO) Collaboration of other health plans focusing on similar goals and intervention. To facilitate improvement, the MCOs will support joint collaborative interventions as well as individual MCO specific strategies. Each participating MCO has established a goal aimed at improving prenatal care, postpartum care, well-child visits and/or combo 10 immunization rates with the focus on disparities, relevant to the individual MCO population.

Our goal is to see improvement in the rate of South Country members who receive a prenatal care visit in the first trimester, on or before their South Country enrollment start date or within 42 days of South Country enrollment, seeing improvement in the rate of South Country members who receive a postpartum care visit on or between seven and 84 days after delivery, and by seeing improvement in the rate of South Country members who have six or more well-child visits with a primary care provider (PCP) during their first 15 months of life. Success of the project will be achieved by seeing an improvement in the rates for these goals over the three-year lifespan of the project.

South Country membership is rural and is therefore uniquely positioned to focus much of its work on rural geographic disparities. However, many drivers of health disparity cut across many

groups whether these groups are defined by geographic location, ethnicity, race, socioeconomic status, or other characteristics. Interventions will have impact on various overlapping groups, and some will be more amenable to measurement than others, but always with a goal of addressing the needs of all affected by health disparities.

South Country's PMAP program is our medical assistance program, which has the largest membership. Medical Assistance is health care coverage for children, families, pregnant women, and adults under age 65 that meet Minnesota income requirements. Based upon 2019 data, the number of pregnant members eligible for the interventions each year would be 797 and the number of members ages 0-15 months old eligible for the interventions each year would be 1,600.

South Country's MinnesotaCare coverage is for people ages 0-64 with income slightly higher than the income standard for PMAP. Based on 2019 data, the number of pregnant members eligible for the interventions each year would be 46 and the number of members ages 0-15 months eligible for the interventions each year would be 10.

South Country will utilize the following HEDIS measures to gather, assess and evaluate the success of this project:

Timeliness of prenatal care — the percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. The measurement period includes deliveries of live births on or between October 8th of the year prior to the measurement year and October 7th of the measurement year.

Success of the project will be achieved by seeing improvement in the rate of South Country members who receive a prenatal care visit in the first trimester, on or before their South Country enrollment start date or within 42 days of South Country enrollment by an absolute 5.15% points above baseline over the three-year lifespan of the project. The goal will be obtaining a rate of 85.48%. This goal will be to use administrative and medical record review data gathered for the HEDIS prenatal hybrid measure.

An increase of an absolute 5.15% points (85.48%) will bring South Country closer to the average of all health plans in Minnesota, according to the MN Health Plan report measurement year (MY) 2019 Prenatal Hybrid Rate of 91.13% for PMAP/MNCare. Also, this increase is considered a significant increase using P-value = .05 and 95% confidence interval. South Country believes this is an attainable goal and a valid benchmark for project success. Approximately 33 additional members will need to obtain their prenatal care visit in South Country's PMAP/MNCare populations to achieve this goal.

Sample size for the overall goal is calculated assuming a two-tailed test of significance between two proportions (P - Value = 0.05, 80 percent power, two-tailed test of significance). For South Country's population, this is a sample size of 411. However, South Country uses a sample size of 432, given that members can be excluded from the denominator of the HEDIS prenatal measure

for various reasons. The table below presents the measurement periods for the HEDIS prenatal measure. It is important to note that HEDIS rates will not reflect a full year of this PIP's interventions until 2022. Thus, a complete picture of the impact of the PIP's interventions will not be available until 2023.

HEDIS Prenatal Measurement Periods

HEDIS Reporting Year	HEDIS Measurement Period	PIP Intervention Year
2018 - 2020	Deliveries: October 8, 2016 – October 8, 2019	Baseline (3-year trend)
2021	Deliveries: October 8, 2019 – October 8, 2020	Pre-implementation
2022	Deliveries: October 8, 2020 – October 8, 2021	Partial year after implementation (January 1, 2020 – October 8, 2021, deliveries)
2023	Deliveries: October 8, 2021 – October 8, 2022	Year 1
2024	Deliveries: October 8, 2022 – October 8, 2023	Year 2
2025	Deliveries: October 8, 2023 – October 8, 2024	Year 3

HEDIS Prenatal Baseline

South Country Health Alliance HEDIS® Rates	2017 (measure year) PMAP/ MinnesotaCare	2018 (measure year) PMAP/ MinnesotaCare	2019 (measure year) PMAP/ MinnesotaCare Final	2020 (measure year) PMAP/ MinnesotaCare Final	2021 (measure year) PMAP/ MinnesotaCare Final	Baseline 3-year trend
(PPC)Prenatal Care N	331	352	329	326	317	1012
(PPC)Prenatal Care D	423	418	420	416	417	1261
(PPC)Prenatal Care Rate Hybrid	78.25%	84.21%	78.33%	78.37%	75.84%	80.25 %

Summary results for the first year of PIP show that prenatal rates are stable between MY 2019 and MY 2020. This is expected in lieu of utilization patterns due to the COVID-19 pandemic impacting utilization across many services and measured outcomes. Also, MY 2021 rates have slight decrease compared to MY 2020 and this is expected due to the lingering impact of COVID-19 pandemic and increase in prenatal bundling codes being submitted from providers.

Postpartum care — the percentage of deliveries that had a postpartum visit on or between seven and 84 days after delivery.

The measurement period will be October 8th of the year prior to the measurement year and October 7th of the measurement year and will include deliveries of live newborns.

Success of the project will be achieved by seeing improvement in the rate of South Country members who receive a postpartum care visit on or between seven and 84 days after delivery by an absolute 5.78% points above baseline over the three-year lifespan of the project. The goal will be obtaining a rate of 81.43%. This goal will use administrative and medical record review data gathered for the HEDIS postpartum hybrid measure.

An increase of an absolute 5.78% points will bring South Country to the average of all health plans in Minnesota, according to the Minnesota Health Plan Report MY 2019 Postpartum Hybrid Rate of 81.60% for PMAP/MNCare. Also, this increase is a significant increase (P-value = 0.05, 95% confidence interval). South Country believes this is an attainable goal and a valid benchmark for project success. Approximately 46 additional members will need to obtain their postpartum visit in South Country's PMAP/MNCare populations to achieve this increase in percentage points.

Sample size for the overall goal is calculated assuming a two-tailed test of significance between two proportions (P- value = .05, 80 percent power, two-tailed test of significance). For South Country population, this is a sample size of 411. However, South Country uses a sample size of 432, given that members can be excluded from the denominator of the HEDIS Prenatal measure for various reasons.

The table below presents the measurement periods for the HEDIS postpartum measure. It is important to note that HEDIS rates will not reflect a full year of this PIP's interventions until 2022. Thus, a complete picture of the impact of the PIP's interventions will not be available until 2023.

HEDIS Postpartum Measurement Period

HEDIS Reporting Year	HEDIS Measurement Period	PIP Intervention Year
2018 - 2020	Deliveries: October 8, 2016 – October 8, 2019	Baseline (3-year trend)
2021	Deliveries: October 8, 2019 – October 8, 2020	Pre-implementation
2022	Deliveries: October 8, 2020 – October 8, 2021	Partial year after implementation (January 1, 2020 – October 8, 2021, deliveries)
2023	Deliveries: October 8, 2021 – October 8, 2022	Year 1
2024	Deliveries: October 8, 2022 – October 8, 2023	Year 2

2025	Deliveries October 8, 2023-October 8, 2024	Year 3

HEDIS Postpartum Baseline

South Country Health Alliance HEDIS Rates	2017 (measure year) PMAP/ MinnesotaCare	2018 (measure year) PMAP/ MinnesotaCare	2019 (measure year) PMAP/ MinnesotaCare	2020 (measure year) PMAP/ MinnesotaCare	2021 (measure year) PMAP/ MinnesotaCare	Baseline 3-year trend
(PPC)Postpartum Care N	304	307	343	335	345	954
(PPC)Postpartum Care D	423	418	420	416	418	1261
(PPC)Postpartum Care Rate Hybrid	71.87%	73.44%	81.67%	80.53%	82.54%	75.66 %

Summary results for the first year of PIP show that postpartum rates are slightly decreased comparing MY 2019 and MY 2020. This is expected in lieu of utilization patterns due to the COVID-19 pandemic impacting utilization across many services and measured outcomes. In MY2021, South Country surpassed its initial goal of increasing the postpartum rate to 81.60%. This rate has improved despite the impact of COVID-19.

South Country interventions that may be contributing to this increase are:

- Creating a separate incentive for members who attend a certain number of postpartum appointments.
- Providing outreach and education to providers and parents.
- Expanding and improving access to OBGYN and pediatricians through telehealth.

Well-child visits in the first 15 months — children who turned 15 months old during the measurement year and have six or more well-child visits.

The percentage of members who had six or more well-child visits with a primary care provider (PCP) during the first 15 months of life.

Success of the project will be achieved by seeing improvement in the rate of South Country members who have six or more well-child visits with a PCP during their first 15 months of life by an absolute 7.04% points above baseline over the three-year lifespan of the project. The goal will be obtaining a rate of 56.53%. This goal will be to use administrative data gathered for the HEDIS well child measure.

South Country believes an increase of an absolute 7.04% points is an attainable goal and a valid benchmark for project success. This increase is a significant increase (P- value = .05, 95% confidence interval). Approximately 28 additional members will need to obtain six or more well child

visits in South Country's PMAP/MNCare population to achieve this increase in percentage points.

There will be no sample size for this measure, as South Country will use all their members eligible population for the HEDIS well child visits for the goal rate.

The table below presents the measurement periods for the HEDIS well child in the first 30 months of life measure. It is important to note that HEDIS rates will not reflect a full year of this PIP's interventions until 2023, as the intervention for members turning 15 months in 2022 will go back to 2020. Thus, a complete picture of the impact of the PIP's interventions will not be available until 2023.

HEDIS Well Child Measurement Periods

HEDIS Reporting Year	HEDIS Measurement Period	PIP Intervention Year
2018 - 2020	Members turning 15 months: 2017 – 2019. Well child visits: October 2016 – December 2019	Baseline (Average of the 3 years)
2021	Members turning 15 months in 2020. Well child visits: October 2018 – December 2020	Pre-implementation
2022	Members turning 15 months in 2021. Well child visits: October 2019 – December 2021	Partial year after implementation
2023	Members turning 15 months in 2022. Well child visits: October 2020 – December 2022	Year 1
2024	Members turning 15 months in 2023. Well child visits: October 2021 – December 2023	Year 2
2025	Members turning 15 months in 2022. Well child visits: October 2022 – December 2024	Year 3

HEDIS Well Child Baseline

South Country Health Alliance HEDIS® Rates	2017 (measure year) PMAP/MinnesotaCare	2018 (measure year) PMAP/ Minnesota Care	2019 (measure year) PMAP/ Minnesota Care	2020 (measure year) PMAP/ Minnesota Care	2021 (measure year) PMAP/ Minnesota Care	Baseline 3-year trend
(W30) Well-child Visits in the first 15 months of life (6) N	123	209	261	122	155	593
(W30) Well-child Visits in the first 15 months of life (6) D	254	385	555	318	391	1194
(W30) Well-child Visits in the first 15 months of life (6) Rate	48.43%	54.29%	47.03%	38.36%	39.64%	49.67%

For MY 2019 well child visits in the first 15 months rates have decreased compared to MY 2020. This is expected in lieu of utilization patterns due to the COVID-19 pandemic impacting utilization across many services and measured outcomes. The MY2021 rate showed an increase from MY2020 but was still lower than the baseline rate. MY 2022 rates will be monitored and would expect trending to increase from MY 2021.

Collaborative Interventions include:

The project is designed to work with a broad variety of partners to improve access and coordination of resources to support mothers in receiving the right care, at the right time, in the right setting. Interventions include developing an educational series of webinars, pregnancy benefit training and development of a pregnancy packet. Details of these efforts are provided below.

- "Racism's Roots in Medicine & How Implicit Bias Impacts Care" was held for staff and providers on Wednesday, April 7, 2021, with expert presenter Dr. Nathan Chomilo, who is the medical director for the state of Minnesota's Medicaid and MinnesotaCare programs and general Pediatrician and internal medicine hospitalist. The webinar presented attendees with education around implicit biases outside of a person's conscious awareness that could lead to a negative appraisal of another person based on irrelevant characteristics like race or gender. During this presentation, attendees learned

about how health care professionals display implicit biases towards patients, the impact these biases have on patient experience and outcomes, and how to begin to address their own biases to provide better care.

- "Achieving Health Equity: Tools to Move Forward" was held for staff and providers on Wednesday, October 13, 2021, with Dr. Veronica Gillispie-Bell, who is a board-certified obstetrician & gynecologist and associate professor. The webinar presented attendees with meaningful tools to eliminate health inequities in their own work and organizations.

- "Disparities in Childhood Health" was presented by Andrea Singh, MD, and Jason Maxwell, MD, on July 28, 2021. This webinar looked at disparities in childhood health such as immunizations and well-child checks. Clinicians and public health entities have a role in finding solutions to improving these gaps in care. Doctors Maxwell and Singh shared what works for them with their patients and some of the strategies they have used to try to bridge this gap.

- "How Doulas Support a Health Pregnancy" was held for staff and providers on March 23, 2002, with Akhmiri Sekhr-Ra and Kaytee Crawford. This webinar included information about coula certification, the role of a doula in supporting birthing persons, doulas and perinatal care team, and health equity with doulas.

The collaborative had discussions with several groups who were interested in collaborating with us in various ways or invited us to join existing efforts. Some of these collaborations already included MCO participation but have strengthened over the course of the project thus far.

The collaborative has hosted the following guests to strengthen our PIP work:

Name	Organization
Debby Pruhomme	Everyday Miracles
Dr. Nora Hall, Karen Gray, and Dr. Diane Banigo	Integrated Care for High-Risk Pregnancies (ICHRP)
Chelsea Georgeson and Lucas Nesse	Minnesota Council of Health Plans (MCHP)
Mark Gottwald	Minnesota Association of County Health Plans (MACHP)
Dr. Katy Kozhimannel	University of Minnesota School of Public Health

Karen Fog	Minnesota Department of Health (MDH) Family Home Visiting
Dr. Nora Hall and Karen Gray	ICHRP
Dawn Reckinger	MDH Family Home Visiting

Integrated care for high-risk pregnancies (ICHRP) was created by the MN legislature in 2015 with the explicit purpose of improving birth outcomes in MN. The collaborative has had conversations with ICHRP leaders and individual members who welcomed our interest in joining their efforts to improve birth experiences for African American women. The collaborative and ICHRP have been meeting and sharing information since the initiation of the PIP. During the most recent conversation, the two groups have determined that the most logical area to work together on is that of early identification of pregnant people. Interventions are more effective when initiated earlier in a pregnancy but the people who need interventions most (such as those delaying prenatal care for any reason) are those that we find out are pregnant later in their pregnancy, or even not until they have given birth. At the time of this writing, ICHRP is in process of establishing 501c3 status as well as expanding their programs for urban Native American women. The collaborative will continue to have conversations with ICHRP about how we can support and amplify their work and next steps to collaborate on early identification of pregnant people.

Doulas are a covered service for Minnesota Medicaid members. The benefits of this support and outcomes measures are clear, yet utilization of this service is low. The collaborative has worked with the Birth Equity Community Council (BECC) and MDH to move toward expanding the MDH doula training registry, which is the list of acceptable doula training organizations for certifying doulas to bill Medicaid. The expansion will allow for more culturally specific doula training to meet the birth support needs of communities of color in Minnesota. The collaborative also worked with BECC with the support of Dr. Chomilo to remove the NPI billing requirement for doulas so that more organizations and individual doulas can be made available to the Medicaid population, but the change did not advance through the legislature before the end of the most recent session.

Everyday Miracles is an organization whose mission is to improve birth outcomes and reduce health disparities by providing evidence-based education, compassionate and culturally aware support, and a non-judgmental, caring community. Their services include birth education, lactation support, prenatal yoga, and birth doula support. The collaborative has worked in tandem with Everyday Miracles via BECC to improve doula access for Medicaid populations of color and increase access to culturally congruent doula support for all birthing people. The collaborative utilized Everyday Miracles to provide the presenters for our doula informational webinar.

MDH QUIT Program for Pregnant Women – the Collaborative has worked with MDH to distribute information to our provider networks on their clinician training for helping pregnant people quit using tobacco.

Minnesota Council of Health Plans (MCHP) has attended multiple collaborative PIP meetings to discuss ways to collaborate on maternal and child health equity initiatives. Recently, several members of the collaborative served on a subcommittee of the MCHP Health Equity Committee and was tasked with providing direction to the Equity Committee on health plan approaches to improving maternal and early childhood outcomes and decreasing disparities. The collaborative and MCHP are also working together on a social media strategy to increase child and teen checkups and child immunization rates.

Regional child and teen check-up (C&TC) groups — the state has a group made up of MCOs and county C&TC staff from that area. Collaborative members attend the Metro Action Group, which is comprised of the seven-county metro area C&TC workers. At the beginning of the PIP, the collaborative also surveyed C&TC workers in Greater Minnesota to assess what they perceived as the most significant barriers to well-child checks and prenatal/postpartum for the families they serve with transportation and childcare being the most prominent issues presented. Currently, the structure of C&TC outreach is in flux as some of the responsibility has shifted to participating Integrated Health Partnership (IHP) clinics. Some counties have lost staff due to the change and are restructuring their outreach, and IHPs are still establishing their outreach systems. The collaborative will work with all parties to facilitate C&TC outreach to our members.

Birth Equity Community Council (BECC) is a Ramsey County initiative to support birth equity for communities of color. The collaborative has worked with them to explore and problem-solve billing issues for community trained doulas. Please see the above section on doulas to learn more about what the collaborative has done and accomplished in this area.

<u>South Country interventions include:</u>

- A checklist to help navigate the path to a healthy start for mothers and baby.
- A list of the community care connectors in each South Country's counties along with their contact information.
- Pregnancy benefits 411 — provides a side-by-side view of the difference in pregnancy benefits between PMAP and MinnesotaCare.
- Pregnancy benefit training –South Country's Healthy Start for Mothers and Children internal meetings discussed and developed a training video that is available to our county partners to educate on the additional benefits available to pregnant moms when they are enrolled in PMAP at first notification of their pregnancy. Historically, we have seen members who are pregnant, who were enrolled in MinnesotaCare and did not transition to PMAP. The PMAP plan would provide them with the maximum benefits available to promote the healthiest pregnancy outcomes. The video was created in 2021, in collaboration with our county partners, to provide the product benefits available to pregnant members enrolled on PMAP, along with information on the pregnancy packet

to be given out to pregnant moms. The training was also sent to the South Country county financial worker supervisors and shared with county supervisors and the community care connectors. The pregnancy packets that are available to the county staff include:

    - A South Country pregnancy brochure that provides a summary of information and resources about the health care benefits available to pregnant women and crucial advice for a healthy pregnancy by addressing the importance of regular prenatal check ups.
    - A South Country Take Charge brochure that provides details about each of the Take Charge wellness programs available to help South Country members achieve their best personal health and wellness goals.
    - A South Country incentive voucher reward for members who keep the recommended number of prenatal appointments and one for those attending a postpartum appointment. See our website for more details: Wellness Programs – South Country Health Alliance (mnscha.org).

- Provider newsletter articles were published to educate and remind providers to complete a depression screening and inform providers of the number of times a depression screening can be completed before an authorization is required. We also educated providers on the "Best Practice Guidelines for Perinatal Depression Screening." Other articles in the newsletter included: Prenatal Genetic Screening, Hepatitis C and Clinical Practice Guidelines, as well as education about the PIP.
- South Country has a guide called Embracing Life, which is available online — Embracing Life Online – South Country Health Alliance (mnscha.org) or in printed booklet. This guide contains helpful tips and resources for new moms both during and after their pregnancy.
- A baby's 1st year calendar that can be given to moms on baby milestones, the C&TC visit schedule, and the childhood vaccination schedule.
- Monthly outreach to members identified as newly pregnant with materials about baby's health care, our Car Seat Program, Breast Pump Program, tobacco cessation, our Embracing Life booklet and other wellness program information.
- Referral lists of all newly identified pregnant members to county public health agencies to complete outreach for family home visiting programs and return communication back to South Country for high-risk case management services.
- We worked to expand and improve access to OBGYN and pediatricians through telehealth. We held a Facebook campaign to increase awareness about telehealth. We also created a web document and Facebook posts for education on what a postpartum telehealth appointment could look like.
- South Country collaborated with member counties to create Healthy Teeth, Healthy Baby kits and then distributed to all member counties requesting kits. These kits can be used by counties to distribute to families to support dental health. Additionally, we

encouraged members through our member newsletter to get in for preventive dental visit.
- An Educational mailing was sent to parents informing them of what to say and the benefits of scheduling and attending well-child visits.
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South Country remains committed to advocating for pregnant members access to routine prenatal care and birthing facilities. We will continue to actively promote, educate, and assist all our pregnant members on the importance of prenatal care to support a healthy start for moms and babies.

Comprehensive Diabetes PIP 2021-2023

The comprehensive diabetes PIP planning began in 2020 with an implementation date of January 1, 2021. This PIP topic was chosen by DHS and is intended to promote an improvement in the diabetic health of our members on MSC+, SeniorCare Complete, SingleCare, SharedCare and AbilityCare with a focus on health disparities.

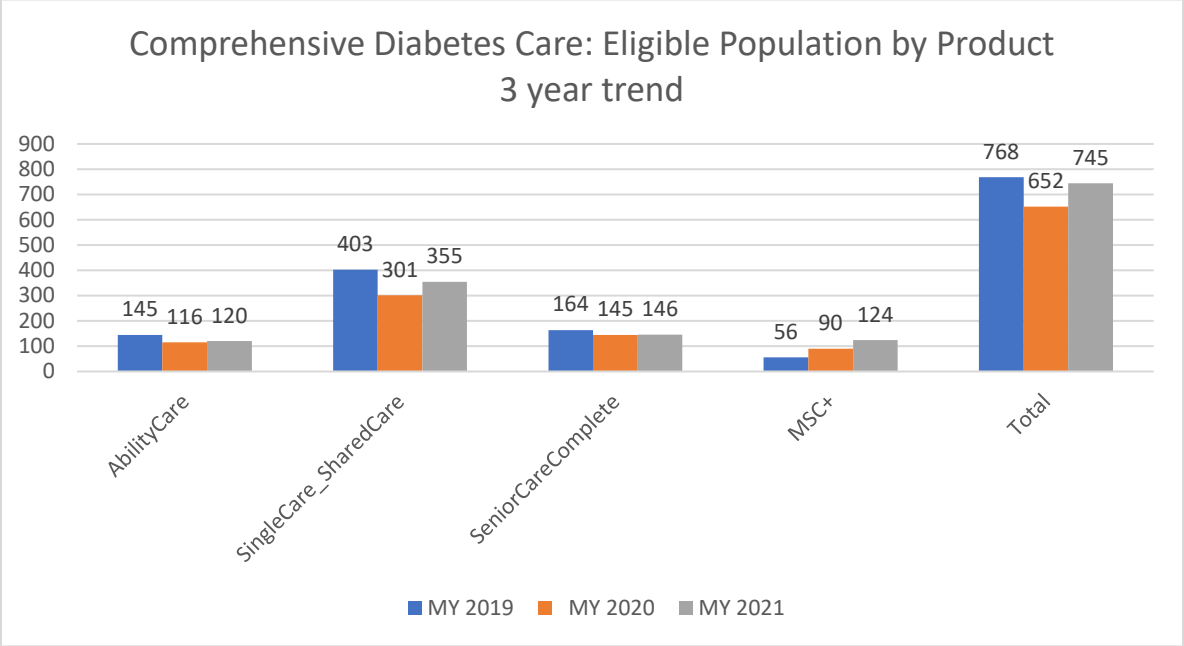
Our goal is to improve members' self-management of their diabetes for those living in rural communities and experiencing geographic health disparities. Success of the project will be achieved by having a decrease in the Hba1c poor control (>9%) rate of South Country members over the three-year lifespan of the project. We will evaluate using HEDIS data and producing yearly rates for SeniorCare Complete and SNBC members living in rural communities experiencing geographic health disparities.

South Country is also involved with a Managed Care Organization (MCO) Collaborative Workgroup, which supports joint collaborative interventions. Interventions may involve specific strategies including member and provider specific interventions, along with county and community collaboration.

The South Country Population

- SNBC - AbilityCare: Dual-eligible enrollees ages 18 to 64 who have both their Medicaid and Medicare benefits administered by South Country. Based on HEDIS MY 2019, the number of members with diabetes in the eligible population each year would be about 145.
- SNBC – SingleCare and SharedCare: Enrollees ages 18 to 64 who are not eligible for Medicare and have Medicaid benefits administered by South Country. Based on HEDIS MY 2019, the number of members with diabetes in the eligible population each year would be about 403.

- MSC+: Enrollees aged 65 and over who have Medicaid benefits administered by South Country and may have Medicare benefits administered by another health plan. Based on HEDIS MY 2019, the number of members with diabetes in the eligible population each year would be about 56.
- SeniorCare Complete: Dual-eligible enrollees ages 65 and older who have both their Medicaid and Medicare benefits administered by South Country. Based on HEDIS MY 2019, the number of members in eligible population each year would be about 164.



Measures

South Country will utilize the following HEDIS measure to gather, assess, and evaluate the success of this project. The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

Numerator — comprehensive diabetes care HbA1c poor control (>9.0%): HbA1c level performed during the measurement year is >9.0% or is missing or was not done during the measurement year (i.e., 2019, 2020). A lower rate indicates better performance for this indicator.

For SeniorCare Complete a decrease of an absolute 8.17% points (15.38%) will bring South Country just above the lowest health plan in Minnesota, which is according to the Minnesota Health Plan Report MY 2019 Comprehensive Diabetes Rate of 12.50%. South Country believes these are attainable goals and valid benchmarks for project success. Approximately 61

additional members will need to decrease their HbA1c > 9% in South Country's SeniorCare Complete population to achieve this decrease in percentage points.

For SNBC, a decrease of an absolute 5.85% points (31.56%) will bring South Country closer to the average of all health plans in Minnesota, according to the Minnesota Health Plan Report MY 2019 Comprehensive Diabetes Rate of 30.20% for SNBC. Approximately 33 additional members will need to decrease their HbA1c > 9% in South Country's SNBC population to achieve this decrease in percentage points.

These decreases are considered statistically significant decreases using P-value = .05 and 95% confidence interval. South Country believes these are attainable goals and valid benchmarks for project success. The sample size for the overall goal is calculated assuming a two-tailed test of significance between two proportions (P - Value = .05, 80 percent power, two-tailed test of significance). For South Country's population, this is a sample size of 411. However, South Country uses a sample size of 453, given that members can be excluded from the denominator of the HEDIS comprehensive diabetes care for various reasons.

The table below presents the HEDIS comprehensive diabetes care HbA1c >9 rates.

South Country Health Alliance HEDIS® Rates SeniorCare Complete	2017 (measure year)	2018 (measure year)	2019 (measure year)	2020 (measure year)	2021 (measure year)	Baseline 3-year trend
Comprehensive Diabetes Care-Poor Control (>9.0%) N	65	27	46	102	31	138
CDC) Comprehensive Diabetes Care-Poor Control (>9.0%) D	249	173	164	145	143	586
Comprehensive Diabetes Care-Poor Control (>9.0%) Hybrid	26.10%	15.61%	28.05%	70.34%	21.68%	23.54%

South Country Health Alliance HEDIS® Rates SNBC	2017 (measure year)	2018 (measure year)	2019 (measure year)	2020 (measure year)	2021 (measure year)	Baseline 3-year trend
Comprehensive Diabetes Care-Poor Control (>9.0%) N	182	182	226	305	142	590
Comprehensive Diabetes Care-	501	536	540	417	467	1577

Poor Control (>9.0%) D						
Comprehensive Diabetes Care-Poor Control (>9.0%) Hybrid	36.33%	33.96%	41.85%	73.14%	30.41%	37.41%

For MY 2020, it shows that the diabetes poor control rates have increased comparing MY 2020 to prior years. This is expected in lieu of utilization patterns due to the COVID-19 pandemic impacting utilization across many services and measured outcomes. Moreover, this rate represents members latest HbA1C result in measurement year or if no results have been identified through hybrid pursuit or administrative claims. The MY 2021 SeniorCare Complete rate is trending below the MY 2019 and the baseline rate and decreasing in a direction that is on target with reaching the goal rate of 15.38% for MY 2023. The MY 2021 SNBC rate was trending below the MY 2019 and baseline rate. Also, the MY 2021 rate of 30.41% is below the goal rate of 31.56% for MY 2023.

Collaborative interventions include:

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.

- A webinar on Tuesday, October 26, 2021, was held "The Challenges of Achieving Optimal Diabetes Results: Barriers, Disparities, and Strategies for Care Coordination Success." The goal of the presentation series was to provide care coordinators, case managers and other professionals working with Minnesota Senior Health Options (MSHO) and Special Needs Basic Care (SNBC) members information to understand the impact of diabetes better and enhance their skillsets when working with members with

diabetes.

- A webinar on Tuesday, August 17, 2021, was held – “Meeting the Challenges of Diabetes: Updates with the Pharmacists.” This training is the second in a series to help care coordinators/case managers better understand diabetes, its impact on people living with diabetes, and how to best support members to best manage their condition. This training aimed to ensure that care 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.

- A webinar on Tuesday, March 2, 2021, was held – “Meeting the Challenges of Diabetes: Core Basics.” This training is the first of a series of activities during this project that will help care coordinators/case managers better understand diabetes, its impact on people living with diabetes, and how to best support members to best manage their condition. This training will give care coordinators, case managers, and other professionals working with MSHO and SNBC members to understand the impact of diabetes and enhance their skill set when working with members with diabetes.

- An “Implicit Bias & the Pursuit of Health Equity” training was held for staff and providers on August 8, 2022, with Dr. Talee Vang. This webinar looked at the process by which implicit bias is formed and how bias impacts health disparities.

- A “Transforming Food Shelves to Meet Clients Needs with Super Shelf” training was held for staff and providers on September 20, 2022. This webinar discussed how food shelves and other hunger resources are important for supporting healthy eating for food insecure people who live with diabetes. It also expands the understanding of the food needs, preferences and health concerns of people who are food insecure in Minnesota.
- A “Food is Medicine – Integrating Effective Nutrition Interventions into the Healthcare System: A Concept Whose Time Has Come” training was held for staff and providers on June 28, 2022, with Dr. Dariush Mozaffarian. This webinar focused on food insecurity as a social determinant of health and contributor to chronic disease prevention and management. It also provided information about how health care clinicians and systems are finding new clinical and community interventions to improve patients’ access to quality nutrition and education.

- A “Meeting the Challenges of Diabetes: Consequences of Disease Progression” training was held for staff and providers on May 11, 2022. This training provided care coordinators, case managers and other professionals working with Minnesota Senior Health Options (MSHO) and Special Needs Basic Care (SNBC) members information to

understand the impact of diabetes better and enhance their skillsets when working with members with diabetes.

For clinicians, care coordinators and other staff who 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 2021, the MCOs 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 that are included on the benefits grid include:

- Supplemental benefits for each plan relevant to diabetes care, such as fitness/wellness classes, technology available, a 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 the social determinants of health.
- Transportation services available.
- Incentives for diabetes care.

This information template is posted on each individual MCO's care coordination resource hub, which is the main location where care coordinators access tools and resources while working with members. The resource was publicized across each organization through trainings and newsletters. South Country shared this resource with many community partners and member counties. While the partnering organization may vary by MCO, we have worked collaboratively to promote the availability of these resources for our members.

South Country interventions include:

- Education to members on the South Country diabetes benefits available to them and other outreach on managing diabetes.
- Our Be Active program benefit includes all seniors (SeniorCare Complete and MSC+) and SNBC (AbilityCare, SingleCare and SharedCare) members. This benefit gives members the opportunity to receive up to a $20 reimbursement a month toward a health club membership. See our website for more details: Wellness Programs – South Country Health Alliance (mnscha.org).
- We created a diabetes brochure to provide information to members on South Country specific resources available to members. Brochures were distributed to member counties per their request for use with members.

- We provided education on the use of statins and encouragement for members to discuss this with their health care provider.
- We expanded and improved access to preventive services, home and community-based services, social supports, and care management through telehealth.
- We created and provided diabetes tools and resources and researched new options available to members in their home such as: web applications, texting, and videoconferencing services.
- We collaborated with Sibley County Latinx members on MSC+ or MSHO with a diagnosis of diabetes.
- We collaborated with Hy-Vee to promote virtual grocery stores for members with diabetes in English and Spanish.
- We utilized social media to create awareness throughout the year and during National Diabetes Month in November
- We started developing a food diary for diabetics for our members.
- We partnered with Sterling Pharmacies partnered to develop the A1C At Home Testing Program as a supplemental benefit for AbilityCare and SeniorCare Complete members. The program includes an in-home kit with four strips for quarterly testing (prescribed by a physician). It is designed to provide members with the ability to test and monitor their A1C levels at home as well as receive education and follow-up from a pharmacist regarding their results.

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. South County will evaluate the collaborative interventions and our plan-specific interventions to determine how to sustain these in the years to come.

Chronic Care Improvement Project (CCIP): Colon Cancer and Breast Cancer Screenings

This CCIP was implemented on January 1, 2022, and will continue through December 31, 2024, with the goal to increase the percentage of South Country SeniorCare Complete and AbilityCare members who are up to date on their colorectal and breast cancer screenings.

Colon Cancer Screening

We have 61.54% (216/351) of SeniorCare Complete members and 70.92% (178/251) of AbilityCare members who are up to date with a colon cancer screening in MY 2020 HEDIS.

In MY 2022, the eligible population for colon cancer screenings for AbilityCare is 322 members and SeniorCare Complete is 421 members.

There are projected to be 147,950 individuals newly diagnosed with CRC in the United States in 2020, including 104,610 cases of colon cancer and 43,340 cases of rectal cancer. Although the majority of these occur in individuals aged 50 years and older, 17,930 new cases of CRC (12%) will be diagnosed in individuals aged younger than 50 years. In addition, there will be an estimated 53,200 CRC deaths in 2020, including 3640 decedents (7%) aged younger than 50 years.[1]

Beginning at age 50, both men and women at average risk for developing CRC should have a colonoscopy every 10 years. The risk of developing CRC increases with age, with more than 90 percent of cases occurring in persons aged 50 or older.[2]

South Country Health Alliance has a goal to increase the SeniorCare Complete COL HEDIS rate by 6.77% during the three-year measurement period. The three-year (MY 2018-2020) average HEDIS rate for Senior Care Complete is 61.72%.

Additionally, South Country Health Alliance has a goal to increase the AbilityCare COL HEDIS rate by 7.69% percent during the three-year measurement period. The three-year (MY 2018-2020) average HEDIS rate for AbilityCare is 69.60%.

South Country Members – Colon Cancer Screening (COL)				
Product	**MY 2019**	**MY 2020**	**MY 2021**	**Baseline3 year rate (MY 2018-MY2020)**
AbilityCare	**73.68% (210/285)**	**70.92% (178/251)**	**74.33% (194/261)**	**69.60%**
SeniorCare Complete	**67.69% (264/390)**	**61.54% (216/351)**	**65.96% (248/376)**	**61.72%**

The HEDIS MY 2021 COL rate for SeniorCare Complete is 65.96% and is trending above the MY2020 rate, but the MY 2021 rate is lower compared to MY 2019. The AbilityCare MY 2021 rate is 74.33% and is now trending above the baseline rate, MY 2019 and MY 2020 rate. It appears that both the AbilityCare and SeniorCare Complete rates will rebound fully from impact on services and rates from pandemic to attain goal rate by MY 2024.

Breast Cancer Screening

[1] Colorectal cancer statistics, 2020 - Siegel - 2020 - CA: A Cancer Journal for Clinicians - Wiley Online Library

[2] ASGE | Colorectal Cancer Screening

We have 76.26% (106/139) Ability Care members and 59.81% (128/214) Senior Care Complete members who are up to date with a breast cancer screening in MY 2020 HEDIS.

In MY 2022, the eligible population for breast cancer screenings for AbilityCare is 144 members and SeniorCare Complete is 224 members.

Aside from some forms of skin cancer, breast cancer is the most common cancer among American women, regardless of race or ethnicity. Screening can improve outcomes: Early detection reduces the risk of dying from breast cancer and can lead to a greater range of treatment options and lower health care costs.[3]

Being a woman and getting older are the main risk factors for breast cancer.[4] All women need to be informed by their health care provider about the best screening options for them. When members are told about the benefits and risks of screening, they can decide with their health care provider whether screening is right for them and if so, when to have it.[5]

All South Country SeniorCare Complete and AbilityCare members ages 18+ live within our rural eight-county service area. The rural nature of our service area poses different environmental and life challenges, such as affordable and adequate housing, access to healthy food, lack of workforce to serve our population, lack of public transportation and shortages of and distance to see health care professionals and access to hi-tech medical equipment coupled with high need.

South Country Health Alliance has a goal to increase the AbilityCare breast cancer screening HEDIS rate by 9.21% during the three-year measurement period. The three-year (MY 2018-2020) average HEDIS rate for Ability is 76.97%.

Additionally, South Country Health Alliance has a goal to increase the SeniorCare Complete HEDIS rate by 8.41% during the three-year measurement period. The three-year (MY 2018-2020) average HEDIS rate for SeniorCare Complete is 68.14%.

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[3] Breast Cancer Screening - NCQA
[4] What Are the Risk Factors for Breast Cancer? | CDC
[5] What Is Breast Cancer Screening? | CDC
[8] Cancer Screening Guidelines by Age | American Cancer Society

South Country Members – Breast Cancer Screening (BCS)				
Product	**MY 2019**	**MY 2020**	**MY 2021**	**Baseline3 year rate (MY 2018-MY2020)**
AbilityCare	**75.32% (119/158)**	**76.26% (106/139)**	**74.29% (104/140)**	**76.97%**
SeniorCare Complete	**71.86% (166/231)**	**59.81% (128/214)**	**62.15% (133/214)**	**68.14%**

The HEDIS MY 2021 breast cancer screening rate for SeniorCare Complete is 62.15%. It appears that the rate is slowly starting to rebound from pandemic, but the MY 2021 rate is still lower compared to MY 2019. The HEDIS MY 2021 breast cancer screening rate for AbilityCare is 74.29% and has been maintaining stability for the past three years. This is noteworthy given the small denominators for AbilityCare and impact to rates from COVID 19.

Interventions for the CCIP

In 2022, education was given to care coordinators on the CCIP and the different types of screenings, and training was done about the importance of screening at the annual care coordination training and throughout the year.

Additionally, in 2022 South Country reached out to members directly to provide education and information through a bi-annual mailing to members eligible for the CCIP who have not had a colon cancer screening or breast cancer screening within the recommended timeframe. The mailing focused on the importance of breast cancer screening and colon cancer screening and the different types of screenings: the fecal occult blood test, flexible sigmoidoscopy, colonoscopy, CT colonography, and the FIT-DNA test. There were approximately 3,200 members who were mailed this information during the first half of 2022 and in the second half of 2022.

South Country has been collaborating with the American Cancer Society (ACS) to co-sponsor education, materials, and outreach to members to further the outreach and to impress upon members the importance of screenings. In 2022, South Country did various social media and Facebook posts to create awareness and educate members and other stakeholders about colorectal cancer and breast cancer screenings. We also participated in Colorectal Cancer Awareness Month in March and Breast Cancer Awareness Month in October. We collaborated with the ACS and other organizations to create more awareness around these screenings during these specific months and throughout the year conducted outreach to members. Information was also included in the South Country member newsletter about the importance of preventive care visits and consulting with providers on recommended medical tests and screenings.

We also included an article in our provider newsletter informing providers about the South Country chronic care improvement project related to colorectal cancer screenings and breast cancer screenings with a focus on AbilityCare and SeniorCare Complete members. In addition, we sent an update to providers via newsletter on the clinical practice guidelines, which can be referenced in detail on website through Provider Manual – South Country Health Alliance (mnscha.org). These guidelines include a focus on adult prevention and screenings and specific references for conditions such as diabetes.

Furthermore, our member newsletter contained information about new health promotions in 2022, which included a colorectal cancer screening promotion. Members on AbilityCare and SeniorCare Complete can get a $25 gift card when they complete a colorectal cancer screening through a fecal occult blood test, flexible sigmoidoscopy, colonoscopy, CT colonography, and/or a FIT-DNA test and return the completed voucher signed by a provider. Also, a breast cancer screening promotion is offered. Members age 50+, or as recommended by a provider, who complete an annual mammogram and return the completed voucher signed by a provider can get a $25 gift card. Both health promotions will be continued in 2023 and the eligible age range for members has been expanded for the colorectal cancer screening to 45-75 years of age or as recommended by a provider. Five AbilityCare and 11 SeniorCare Complete members received a health promotion incentive for completing a colorectal cancer screening for dates of service in 2022. Twenty-eight AbilityCare and 38 SeniorCare Complete members received a health promotion incentive for completing a breast cancer screening (mammogram) for dates of service in 2022.

In 2022, a provider survey was sent to a randomly selected group of providers. The intent was to better understand providers' understanding of the possible barriers for patients to complete colorectal cancer screenings to better inform South Country to assist and support providers through education to members to improve the rate of patients getting colorectal cancer screenings.

The barriers reported by providers for reasons they believed that patients do not get colorectal cancer screenings included:

- Transportation;
- The distance to location;
- Language barriers;
- Office hours;
- Patient anxiety/hesitancy;
- COVID-19;
- Insurance/paperwork;
- Cost; and
- Appointment availability.

South Country will use the survey feedback to update outreach to support increasing members going in for health screenings as recommended by their physicians/providers through direct member outreach and collaboration with providers.

Analysis

Overall, the interventions have supported the rates from decreasing dramatically lower during the pandemic. Increased efforts will continue to encourage members and providers to continue screening with an emphasis on various screening options and the importance of keeping up with recommended screenings. Measurement Year 2022 HEDIS rates will be reviewed once final in 2023.

In HEDIS measurement 2022 specifications had an update to the colorectal screening (COL) age range for the eligible population. The change expanded the eligible population age range from 50-75 to age 45-75. This may impact results and comparing year-to-year goals as this is a significant change in specifications age range. South Country has shifted to targeting this expanded age range and American Cancer Society recommends people at “average risk” should start colon cancer testing at age 45[8.]

Next Steps

Going into 2023, we plan to increase the collaboration with the ACS for all screenings and expand the different kinds of posts and documents we have been using to create more awareness and education around the importance of cancer screenings. Also, there is a focus on returning to “normal” so that members are going to see their provider for preventative visits and screenings as recommended by their provider.

South Country will conduct and monitor our PIPs and CCIPs regularly through internal meetings and with other stakeholders to determine the appropriateness of current interventions and to generate ideas for new or improved initiatives. We will implement a new CCIP in 2024 and two PIPs in 2024. We will continue to participate in the PIP MCO collaborative initiatives that coordinate topics and designs between MCOs.