Hennepin Health
your community health plan

2021-2023 PMAP/MinnesotaCare Healthy Start for Mothers and Their Children Performance Improvement Project

September 1, 2024

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 satisfaction. The PIPs are conducted over a three-year period. 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*". DHS encourages MCOs to participate in the PIP collaborative initiatives that coordinate PIP topics and designs between MCOs. This group is known as the "Collaborative".

Process and Documentation

Hennepin Health participates in the "Collaborative" with other Minnesota Health Care Program (MHCP) 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 administrative support for the PIPs.

Each PIP is led by a MCO representative with the leadership role rotating. The Collaborative and Stratis Health staff meet twice a month during the PIP planning and implementation processes. Stratis Health is responsible for meeting scheduling, maintaining minutes, and guiding the development and implementation of the PIP, including the work plan. Health plan staff have access to the documents and minutes maintained on the Stratis Health SharePoint site. Stratis Health preserves and maintains the collaborative webinars, toolkits, and other resources relevant to the past and current specific PIPs on its website so providers and members can have access to view and print materials as needed during implementation and after the conclusion of each 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 MCO may identify and monitor additional process and/or outcomes measures in addition to those identified by the Collaborative.

Each MCO'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 MCO implements health plan specific strategies and interventions relevant to their respective members. The MCOs collaborate on the writing of the interim and final PIP reports, addressing their specific interventions and outcomes, which are submitted annually to DHS.

Improvements seen as the result of the PIP strategies and interventions are to be sustained over time. Annually, the Collaborative reviews and updates, as appropriate, previous and current PIP resources to ensure relevancy. The individual MCOs promote the resources through various means including provider and member communication. In addition, each MCO continues to implement and revise the specific health plan strategies and interventions to sustain the improvements obtained through the PIP.

The 2021-2023 PMAP/MinnesotaCare PIP topic selected by DHS is *Healthy Start for Mothers and Their Children* which was implemented, effective January 2021. *Comprehensive Diabetes Care* is the SNBC 2021 – 2023 PIP topic which also began in January 2021. The information below is the final report on the two PIP topics.

PMAP/MinnesotaCare Healthy Start for Mothers and Their Children

Purpose

This PIP is designed to promote a "healthy start" for Minnesota children in the PMAP and MinnesotaCare populations by focusing on and improving services provided to pregnant members and infants, particularly in areas exhibiting the most significant racial and ethnic disparities. The PIP is a collaboration of Minnesota MCOs that includes Blue Plus, HealthPartners, Hennepin Health, South Country Health Alliance (SCHA) and UCare. Medica join the "Collaborative" in 2022. Each

participating MCO established a goal aimed at improving prenatal care, postpartum care, well-child visits and/or Combo-10 immunization rates with the focus on racial and ethnic disparities relevant to the individual MCO population. To facilitate improvement, Hennepin Health supports collaborative interventions in addition to its Plan specific strategies. Hennepin Health works with its Accountable Health Model (AHM) partners (Hennepin County Public Health and Human Services, Hennepin Healthcare, and NorthPoint Health and Wellness Center) and other health care providers to address social drivers and barriers to care for pregnant members and children, ages 0 to 30 months, to improve overall health and provide children with a healthy start in life.

According to the Office of Governor Walz in his One Minnesota Plan message, "Every year in Minnesota about 350 infants die before their first birthday. A disproportionate share—about 145 infants annually in recent years—are African American, American Indian, and other infants of color. Infant mortality rates have remained generally unchanged over the past two decades. About 30 women die during or within one year of giving birth. Mothers of color and indigenous mothers are disproportionately represented in these figures". The Governor cites these numbers as part of his call to action and sets forth the goal of ending preventable maternal and infant deaths in Minnesota.

Analysis

The analysis will measure the closing of racial and ethnic disparity gaps by leveraging the PMAP HEDIS® measures as listed below. Hennepin Health chose the following HEDIS® measures to report.

- Timely Prenatal Care (PPC)
- Timely Postpartum Care (PPC)
- Childhood Immunization Status (CIS) Combo-10
- Well-Child Visits for Age 0-15 months (W30 - 15 months) and Ages 15 Months - 30 Months (W30 - 30 months) (2020 Baseline)

The MinnesotaCare product did not have an eligible population for the W30 – 15 months and CIS Combo-10 measures in the 2019 baseline data or the W30 – 30 months measure in 2019 or 2021. In 2023, 7 MinnesotaCare members were in the PPC measure. The 2021 CIS Combo-10 measure had no MinnesotaCare members. The data below reflects only the PMAP product except for the MinnesotaCare members included in the PPC data.

Baseline rates are provided below for the entire HEDIS® measure population and the race/ethnic data in the health care disparity analysis section. As outlined in Table 1 below, the "*Healthy Start"* HEDIS® measures rates changed from 2019 to 2023. Given that the time between data years included the COVID-19 pandemic, it was anticipated the rates would decrease which was evidenced particularly in CIS Combo-10 rates as it is difficult to catch up on childhood immunizations. The CIS Combo-10 rate decreased by 2.6% while the PPC-Prenatal rates dropped by 2.2% between 2019 and 2023. Rate increases were noted in the measures for PPC-Postpartum (2.6%), W30 – 15 months (0.3%), and W30 – 30 months (6.4%). This provides a solid base to increase these HEDIS® rates as the PIP moves forward.

Table 1. *"Healthy Start"* HEDIS® Measures Rates

Measure	Year	Numerator	Denominator	Rate	Percent Change
CIS Combo-10	2019	56	134	41.8%	**-2.6%**
	2021	131	338	38.9%	
	2022	124	346	35.8%	
	2023	135	344	39.2%	
W30 – 15 Months	2019	30	59	50.8%	**+0.3%**
	2021	126	284	44.4%	
	2022	144	303	47.5%	
	2023	163	319	51.1%	
W30 – 30 Months	2020	190	364	52.2%	**+6.4%**
	2021	245	431	56.8%	
	2022	195	336	58.0%	

Table 1. *"Healthy Start"* HEDIS® Measures Rates					
Measure	**Year**	**Numerator**	**Denominator**	**Rate**	**Percent Change**
	2023	177	302	58.6%	
PPC - Prenatal	2019	234	274	85.4%	**-2.2%**
	2021	281	329	85.4%	
	2022	322	372	86.5%	
	2023	297	357	83.2%	
PPC - Postpartum	2019	214	274	78.1%	**+2.6%**
	2021	263	329	79.9%	
	2022	306	372	82.3%	
	2023	288	357	80.7%	

Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS® CY2019, CY2021, CY2022, CY2023

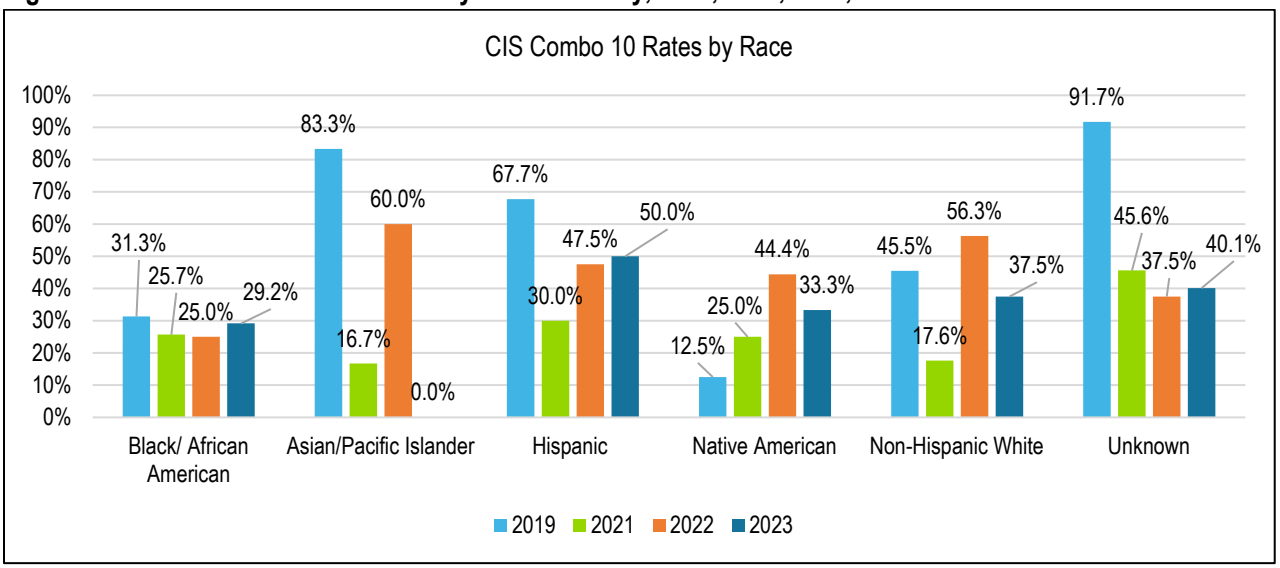
Healthcare Disparity Analysis

Reducing health inequities for members is a key priority of Hennepin Health and the "healthy start" related data was analyzed for inequities. While some health care disparities were seen, it was difficult to draw many conclusions because of the small denominators related to the birthing, newborn and infant populations, as well as the high population of members whose race is unknown to the MCO. In 2022, "multirace" became available as a category for analysis in the data. Hennepin Health decided not to include this category in the following race data breakdown for two reasons: there was no trend data available and there was not enough information available to know if the people within the category shared any cultural similarities or social drivers of health. It should also be noted individuals of Hispanic ethnicity could be of any race; therefore, some individuals may be counted in both the Hispanic and a race category, which may lead to the sum of a measure being a larger number than is presented as the total. The data should be interpreted with caution. At the conclusion of the section is a table displaying the actual denominators in question for each measure (Table 2). For each measure, the Index of Disproportionate Under-Representation (IDU) was calculated to identify disparity subpopulations in terms of their receipt of evidence-based health care relative to the general Hennepin Health population. The IDU was calculated by dividing the subpopulation's percent of the total denominator by the subpopulation's percent of the total numerator and results over 100% indicate a disparity subpopulation. The CIS Combo-10 rate is the only *Healthy Start* HEDIS® measures that did not improve during the PIP time frame, which was in line with expectations as immunization rates decreased across the health care sector nationally[1] and in Minnesota[2]. When considering CIS Combo-10 by race, the rates for all races dropped from 2019 to 2023, except for the Native American group (2023: 33.3%, N=1) (Figure 1). The highest rate was for eligible Hispanic members at 50% (2023: N=14). Groups were found to be disproportionately underrepresented in the vaccination rates were the Black/ African American (IDU: 134.55), Non-Hispanic White (IDU: 104.65) and Native American (IDU: 117.73). The numerator for the Asian group was so small or nonexistent (zero) that it defied proper IDU calculation.

[1] Vaccination Coverage with Selected Vaccines and Exemption Rates Among Children in Kindergarten — United States, 2021–22 School Year | MMWR (cdc.gov)

[2] Childhood Immunizations MN Public Health Data Access - MN Dept. of Health - MN Data

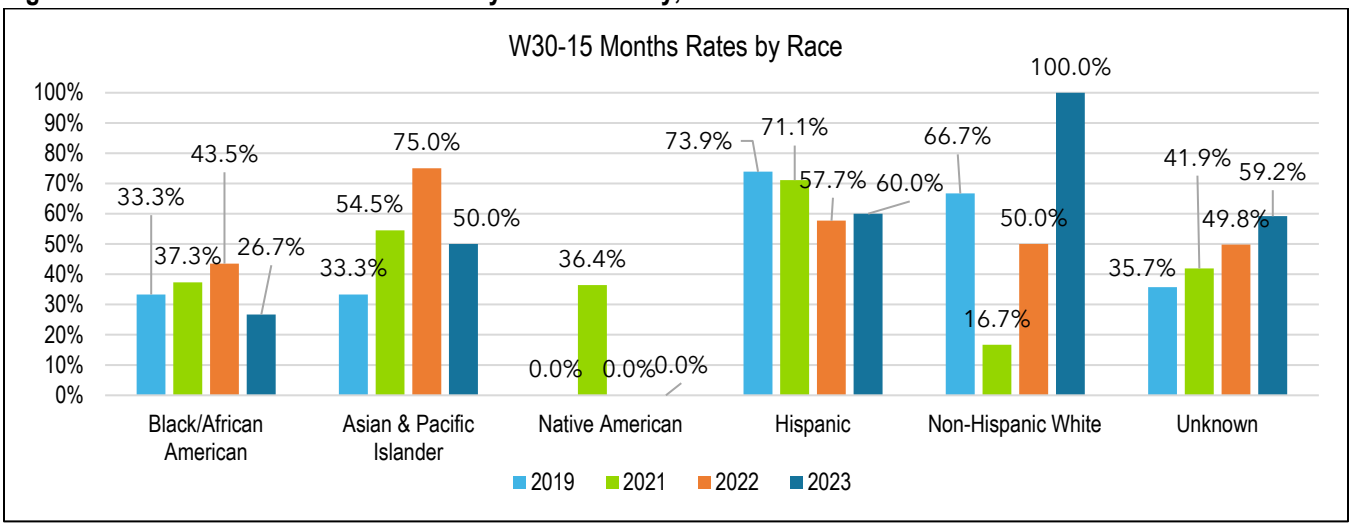
Figure 1: HEDIS® CIS Combo-10 Rates by Race/Ethnicity, 2019, 2021, 2022, and 2023



Data Source: Hennepin Health HEDIS® CY 2019, CY 2021, CY2022, CY2023; Hennepin Health Data Warehouse

The W30-15 months overall rate increased slightly as compared to 2019 by 0.3% points. While some gains were observed for Asian and Pacific Islander members (2023: 50%, N=1), rates decreased for the Black/ African American (26.7%, N=4) and Hispanic (60%, N=21) groups. In 2019, 2022 and 2023, no eligible Native American members met the W30-15 months criteria. The declining rates for the Black/ African American group in 2023 resulted in an IDU of 191.61; therefore, they remain disproportionately underrepresented. The Asian/ Pacific Islander group is also disproportionately under-represented with an IDU of 102.19. Clearly, with no members in the numerator, the Native American members are also significantly underrepresented in this measure in such a way that surpasses the IDU. See data in Figure 2 below.

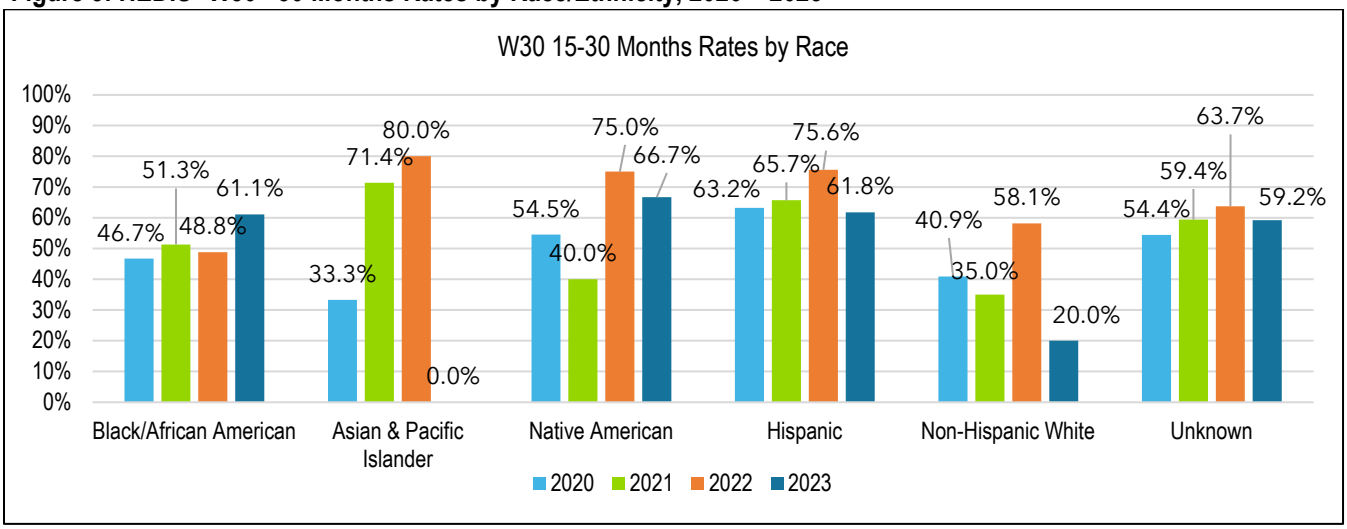
Figure 2. HEDIS® W30 – 15 Months Rates by Race/Ethnicity, 2020 - 2023



Data Source: Hennepin Health HEDIS® CY 2019, CY 2021, CY2022, CY2023, Hennepin Health Data Warehouse

The W30 15 – 30 months rate improved for the Black/ African American (61.1%, N=11) and Native American (66.7%, N=2) populations. There was no eligible Asian and Pacific Islanders population in 2023. As experienced in 2020 (35%), the 2023 (20%, N=1) rate for Non-Hispanic Whites declined as compared to the rate in 2019. See Figure 3 below for graphic representation. Due to the drop in the rate of Non-Hispanic White population, there is no observed disproportionate underrepresentation in the W30-15 months rate.

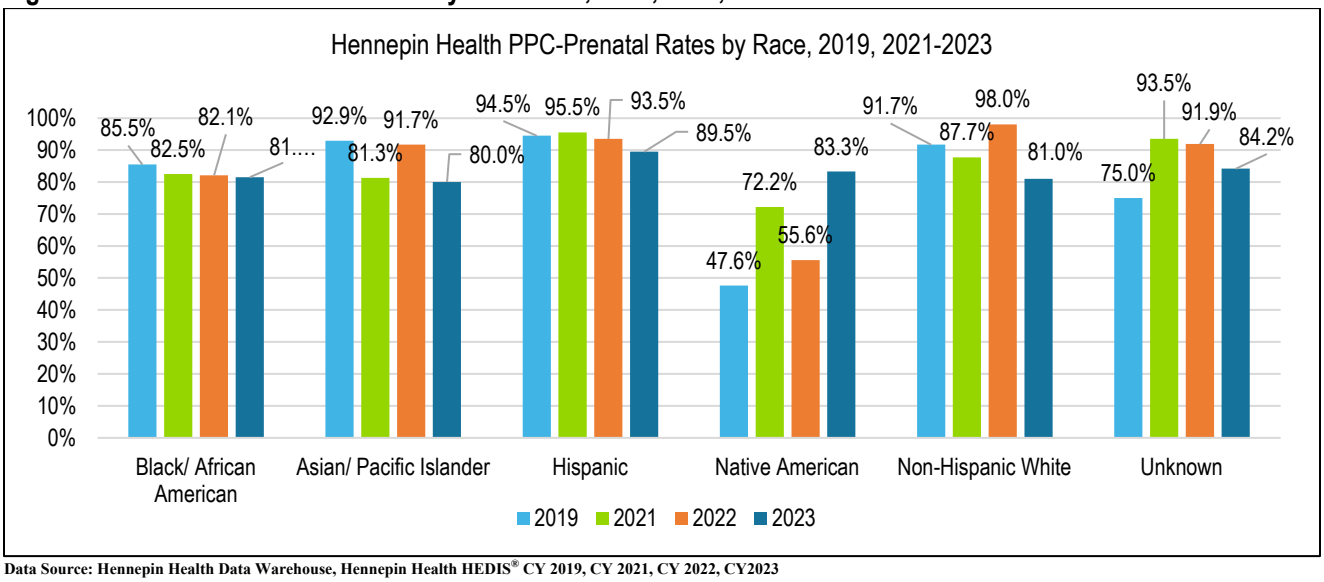
Figure 3: HEDIS® W30 –30 Months Rates by Race/Ethnicity, 2020 – 2023



Data Source: Hennepin Health HEDIS® CY 2020, CY2021, CY2022, CY2023, Hennepin Health Data Warehouse

The PPC-Prenatal rate has stayed relatively stable since 2019 (Figure 4). When examining the rate by race, the Native American group rate improved from 47.6% in 2019 (N=21) to 83.3% in 2023 (N=15). While the rate appeared to be a significant increase that impacts the overall PPC-Prenatal rate, the increase arose from an additional 5 members who were compliant with prenatal care as compared to 2022 rates. The Black/ African American population prenatal rate remained close to the rate in 2022, although, there was a significant reduction in the population in 2023. The Asian/Pacific Islander population saw a PPC-Prenatal rate decrease of 12.9% from 2019 to 2023. Hispanic people had the highest prenatal visit rate of all members at 89.5%. As in 2022, the 2023 rate for the Non-Hispanic White group declined as compared to 2019. The Black/ African American and Native American groups were found to be disproportionately underrepresented (IDU: 102, and IDU:104 respectively). The sample size of each race/ethnic group was small, so no conclusions could be drawn.

Figure 4: HEDIS® PPC-Prenatal Rates by Race 2019, 2021, 2022, and 2023

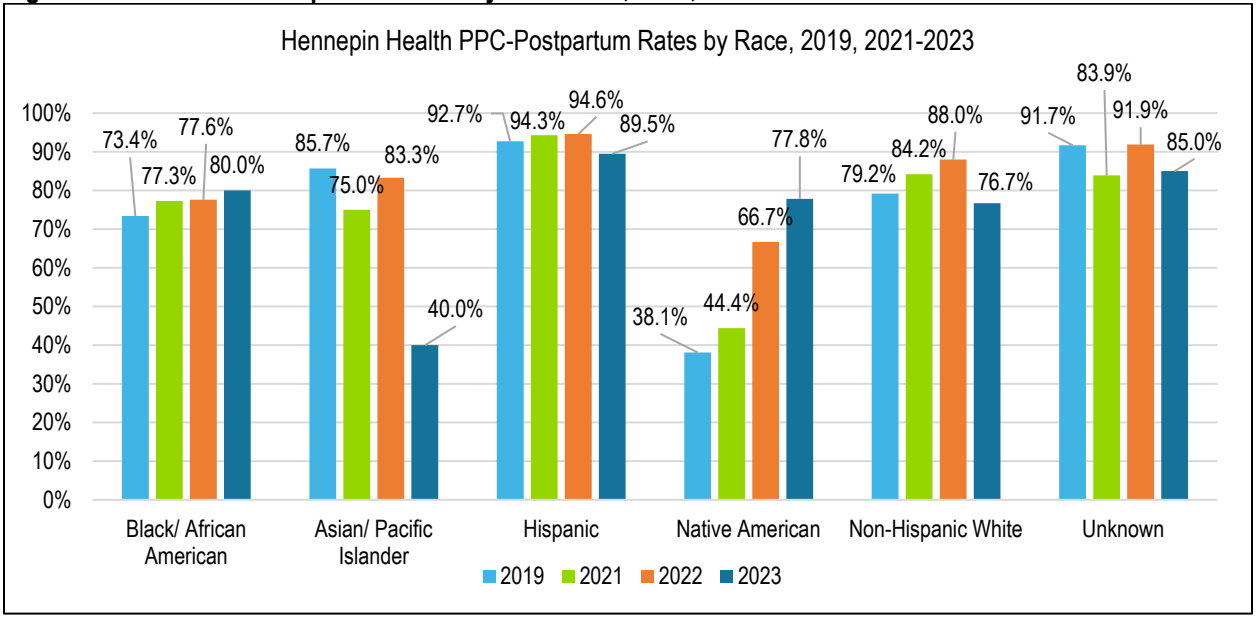


Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS® CY 2019, CY 2021, CY 2022, CY2023

The PPC-Postpartum rates by ethnicity reflected a similar but not identical story (Figure 5) when compared to the PPC-Prenatal rates. For this metric, the Hispanic members consistently demonstrated the highest postpartum rates of any race or ethnic group, most recently 89.5% (N=68) in 2023 (note that this rate may include members from other race categories, as Hispanic ethnicity can be of any race). Again, the Native American members demonstrated an improvement in PPC-Postpartum rates from 38.1% in 2019 to 77.8% in 2023 which is a 39.7%-point increase. Similarly, a 6.6%-point improvement was observed in the Black/ African American group (80%, N=64). There was a little disproportionate underrepresentation

observed in the Black/ African American (IDU: 101), and Native American (IDU: 104) groups. The most notable disproportionate representation was observed in the Asian population (N= 4, IDU: 202).

Figure 5: HEDIS® PPC-Postpartum Rates by Race 2019, 2021, 2022 and 2023



Data Source: Hennepin Health HEDIS® CY 2019, CY 2021, CY2022, CY 2023

Table 2. Denominator by Race/Ethnicity for HEDIS® PPC and CIS COMBO-10 Measures, 2019, 2021 - 2023			
Race	**Year**	**PPC**	**CIS – Combo-10**
Black/ African American	2019	124	64
	2021	154	74
	2022	134	88
	2023	85	24
Asian/Pacific Islander	2019	14	6
	2021	16	6
	2022	12	5
	2023	10	3
Hispanic	2019	55	31
	2021	53	13
	2022	92	40
	2023	77	28
Native American	2019	21	8
	2021	18	8
	2022	18	9
	2023	18	3
Non-Hispanic White	2019	48	11
	2021	57	17
	2022	50	16
	2023	43	8
Unknown	2019	12	14
	2021	31	219
	2022	86	184
	2023	187	304

Table 2. Denominator by Race/Ethnicity for HEDIS® PPC and CIS COMBO-10 Measures, 2019, 2021 - 2023			
Race	**Year**	**PPC**	**CIS – Combo-10**
Total	2019	274	134
	2021	329	337
	2022	392	342
	2023	357	344

Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS CY2019, CY2021, CY2022, CY2023

Table 3. Denominator by Race/Ethnicity for HEDIS® W30, 2020 - 2023			
Race	**Year**	**W30 – 15 Months**	**W30 – 30 Months**
Black/ African American	2020	15	107
	2021	67	76
	2022	62	84
	2023	15	18
Asian/Pacific Islander	2020	3	9
	2021	11	7
	2022	4	5
	2023	2	3
Hispanic	2020	23	57
	2021	45	35
	2022	26	41
	2023	35	34
Native American	2020	1	11
	2021	11	15
	2022	6	8
	2023	2	3
Non-Hispanic White	2020	3	22
	2021	18	20
	2022	24	43
	2023	2	5
Unknown	2020	14	158
	2021	310	278
	2022	201	171
	2023	297	161
Total	2020	59	364
	2021	462	431
	2022	303	336
	2023	319	302

Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS CY 2020, CY2021, CY 2022, and CY2023

Data Limitations

A data limitation for each HEDIS® measure, other than Well-Child Visit, is the hybrid collection methodology that is used. Hybrid methodology allows the MCO to use a sample size of 411 to review compliance via medical record abstraction, though the Hennepin Health population is small enough that the 411 sample size is an exhaustive sampling for the *Healthy Start* related measures.

The National Committee for Quality Assurance (NCQA), which oversee HEDIS®, began to stratify certain HEDIS® measures by race and ethnicity, starting in measurement year (MY) 2022. Hennepin Health provided the DHS enrollment race and ethnicity data to NCQA. DHS sends the members' enrollment data, including race and ethnicity, monthly. In addition, DHS

collaborates with the Centers for Medicare and Medicaid Services (CMS) to obtain race and ethnicity data for Medicaid members who choose not to identify their race and ethnicity. However, there are still about 10% of individuals whose race and ethnicity are unknown. Upon receiving the HEDIS® files from the QM department, the Data Analytics team matches each record based on name and birthdate and then populates the HEDIS® data with the available race and ethnicity data.

The nature of data relating to pregnancy is a limitation, as well. Rather than being a finite measurable event, such as screening or a lab test, pregnancies are a 10-month event. Having a notable impact on pregnancy outcomes and pregnancy related measures is not only challenging from an intervention perspective, but also in terms of the inherent amount of time it takes to have observable changes in the data. Attributing pregnancy data changes to specific interventions is challenging due to the constantly changing target audience.

Another limitation experienced over the past 3-years of PIP has been the pause on, and then the requirement for redetermination of coverage. This process could result in members being in counties that MCOs may not support, and the changing members makes it harder to evaluate effectiveness.

All the MCOs agreed that collecting data on member's race, ethnicity, and language (REL) was key to reducing health care disparities, as it could help identify and address gaps in quality based on these factors. More REL data was observed to be collected for certain HEDIS® measures, and each MCO tried to access this data as possible. It would be ideal if DHS could follow NCQA HEDIS® and CMS standards for defining and grouping this data to simplify all processes.

Barrier Analysis

Multiple barriers, both predicted and unforeseen, while drafting the proposal for this project, became evident throughout planning and implementation of interventions. Several, but not all, barriers were related to the COVID-19 pandemic. Barriers made evident during the beginning of the pandemic persisted and created additional barriers as the pandemic waned.

Immunization and well-child visit barriers - MDH data showed the percentage of 2-year-old children in Minnesota who were *not* up to date on their vaccinations increased from 19.3% in 2019 to 30.8% in 2023[3]. Several circumstances caused by the pandemic and its aftermath were responsible for the decline including:

- The youngest members require a higher number of vaccinations to be up to date than other age groups, and once they are behind schedule, it could be more difficult to catch up as the delays cause an overwhelming and confusing backlog in the vaccination timeline.
- Children were not caught up on childhood vaccinations for a variety of reasons, including a general sense of vaccine hesitancy that had increased during the pandemic. Parents expressed concerns and hesitancy about vaccine safety as well as necessity. This hesitancy could cause delayed vaccinations or even refusal of all vaccines.
- Providers saw a trend that while children were not meeting the measure by age two, they were getting the full set of vaccinations by age 4 or in time to start school, reflecting parental choice to space vaccinations further than the recommended schedule.
- Providers shared anecdotally the increased social and political divisiveness experienced nationally related to vaccinations and was impacting well-child visit rates, as well.
- Members and providers reported access to appointments was still a problem resulting in delays for time-sensitive measures. These delays were attributed to staffing issues throughout the health care system and persistent and systemic staff turnover.
- Access to telehealth appointments largely relied on reliable technology and, for many of our members, access to interpreter services. Both of those variables were not always available, making telehealth appointments less accessible. Additionally, while telehealth visits were appropriate for some care, it was generally not acceptable for well-child visits due to the developmental and other screenings that must be included in the visits.
- Transportation to appointments continued to be an ongoing barrier. While transportation was available, many members were not aware of the service, and access to the service in rural areas was particularly challenging.

[3] Current Childhood and Adolescent Immunization Coverage Rates - MN Dept. of Health (state.mn.us)

- Lack of appointment availability outside of regular business hours was a barrier to keeping current on well-child checks.
- Childcare was a barrier to clinical care that persisted across member populations.
- During meetings with the Metro Action Group (MAG), county C&TC workers in the seven-county metro area described lack of access to interpreters as a significant barrier to timely quality care for both medical and dental services. They described it was logistically difficult to schedule interpreters, especially for languages that were less common in a certain geographical area. Also, it made sense the expanding immigrant communities in rural areas were also impacted by the lack of access to translation services.

Maternal Health Barriers – Some real or perceived barriers for receiving early prenatal care and postpartum care, included:

- Delayed start of prenatal care due to lack of insurance coverage and fears of the high costs of care. The process of applying for and enrolling in Medicaid can be confusing and lengthy, further delaying care.
- Personal, familial or cultural beliefs or priorities, placing less value on early prenatal care or on postpartum care. Subsequent pregnancies give pregnant people a feeling of less urgency to be seen early because of having experienced it all already.
- Lack of evening and weekend appointments making it difficult to get accessible care that fits into work schedules.
- Postpartum being a challenging time physically, mentally and emotionally and care for the infant is often prioritized over the birthing person's health care.
- Social factors impacting decisions to seek care could include indecision over plans for pregnancy, lack of support system, chemical use and fear of 'system' involvement, and other drivers of health such as food and housing security may take precedence over prioritizing prenatal or postpartum health care.

Provider Trust

- People of color routinely reported unease with the health care system due to past experiences feeling disrespected, ignored, or otherwise mistreated by racist care. This experience played a role in their likelihood to seek important care such as prenatal and postpartum care as well as preventive care for their children.
- For pregnant people, fear of being reported to 'the system' for drug or alcohol use was a deterrent to seeking prenatal care. Their fear of losing their baby was real and reinforced by the experiences of others they knew in the community, and sometimes their own childhood experiences of being removed from their families.

Doula Support - Regarding barriers for our birthing members, the Doula community expressed that access to culturally reflective doulas and awareness of doulas continued to be a barrier. The Collaborative made this barrier a priority to address and achieved considerable progress, which is described in other sections of this report. One barrier regarding doula care addressed by the Collaborative is the Medicaid reimbursement rates allowing doulas to make a viable living as a birth worker once they are certified. While the Medicaid rate was increased for doulas in 2019, it was a slight increase, leading to another increase passed by the legislature in 2023 with an effective start date of January 1, 2024.

Also, included in that legislation was the elimination of the requirement for doulas to bill under a National Provider Identifier (NPI) number of a clinician. However, the process for doulas to register as stand-alone providers proved cumbersome and complicated requiring them to obtain their own Unique Minnesota Provider Numbers (UMPI). Along with those barriers, doulas were also required to contract with all MCOs to serve the members. This administrative process was yet another barrier. Doula providers have a unique ability to increase the accessibility of health care to members; however, the identified barriers served as hinderance to providing much needed care.

Organizations that employ doulas reported that it was difficult to retain doulas once they were certified for this same reason. There was a significant gap in time after a doula becomes certified and could begin providing support, and when the claim for those services was paid so the doula receives their salary.

Process Barriers - The ability to access accurate translated material for members who speak languages other than English was a barrier. The process of validating the quality of translated materials created delays in getting the information to members. In some cases, translations that appear to use 'Google Translate' were created rather than by qualified medical translators. This concern necessitated the implementation of local review processes that were both time-consuming and costly, but necessary to ensure members received accurate, culturally relevant information.

The nature of pregnancy related data was a challenge, but not only from a methodological perspective. Given that pregnancies are long events of nearly a year in length (postpartum period included), acquiring data and attributing it to interventions happens over a longer period. This made the process of evaluating whether to continue or modify interventions more difficult.

Interventions

As the lead MCO for the *Healthy Start* PIP, Hennepin Health was deeply involved in each aspect of the Collaborative PIP work in addition to having developed Hennepin Health specific initiatives. The monthly meetings continued to create a platform for joint MCOs PIP process planning and implementation of the workplan. The Collaborative worked to address large scale systemic issues in prenatal and early childhood care such as clinician bias and increasing access to culturally congruent doula care. Alternatively, the MCO-specific initiatives were developed with MCO's specific resources and membership as a focus.

The Collaborative continued with its educational series that address topics impacting birth outcomes and early childhood health with a focus on health equity and addressing racial bias. All Collaborative webinars were recorded and remain available for viewing on the Stratis Health website[4]. In June 2023, a webinar on *Alcohol Use and Pregnancy: The Importance of Screening and Brief Intervention* was presented by Kendra Gludt, MPH, Director of National Programs at Proof Alliance. The webinar addressed the topic of Fetal Alcohol Spectrum Disorder (FASD), the need for prenatal alcohol exposure screening and brief intervention to reduce alcohol use during pregnancy. There were 113 participants including care coordinators, nurses, public health, health educators, social workers, and community health workers. Approximately 94% of webinar evaluation respondents indicated the webinar enhanced their knowledge and offered new strategies and tools to apply, or consider applying, in their work settings.

Additionally, the Collaborative partnered to release an educational blog: *A Reminder from your Healthcare Provider: Come back to get caught up* whose content has been translated into Spanish, Somali and Hmong. This educational resource directed at families with young children was posted on the Minnesota Council of Health Plans (MCHP) site in December 2022 in English with an accompanying voice recording to address concerns of health literacy. The blog content was translated into Spanish, Somali and Hmong in 2023. Although there were no mechanisms to track audio hits or materials downloaded from the blog, hits for visiting the site were recoded as follows: English (1200), Hmong (9), Somali (165), and Spanish (78).

Since the beginning of the project, the Collaborative has had discussions with several groups interested in collaborating in various ways or invited the Collaborative to join existing efforts. Some collaborations included MCO participation prior to the PIP, but have strengthened over the course of the project, and have proven vital to the PIP in identifying community needs and interventions. The partnerships resulted in several webinars that furthered relevant knowledge for the shared providers, as well as statewide policy changes that improved access to doula care. In 2023, the guests received at the collaborative platform came from Proof Alliance, Minnesota Indian Women's Resource Center, DHS Integrated Care for High-Risk Pregnancies (ICHRP), Doula Write Thing Project, MHCP, and the DHS Benefit Policy office.

The Collaborative has worked with the Birth Equity Community Council (BECC) and several Collaborative members serve on the doula policy subcommittee of the council. In 2023, members of the Collaborative supported BECC in their efforts during the 2023 legislative session to increase the Medicaid reimbursement rates for doulas and remove the NPI billing requirement. The Collaborative worked with the MCHP to gain council support for the legislation through the group's official lobbying channels. Both parts of the legislation passed with an effective date of January 1, 2024. The Collaborative continued to support BECC as work continued on how this would be rolled out and what the implications of the NPI change would be for the doulas. Moreover, proactive moves were made to start building partnerships for the 2nd cycle of the *Healthy Start* PIP

[4] Performance Improvement Project (PIP): Healthy Start for Minnesota Children - Stratis Health

starting in 2024 which has a specific focus on community informed measurements. Two experienced researchers from Health Partners Institute, Maren Henderson and Meghan JaKa, shared information with the Collaborative on both theoretical approaches and strategies they have used to achieve community engagement. In the same vein, meetings were held with several areas of the Minnesota Department of Health (MDH) Child and Family Health Division to learn about their resources and how they may be able to share these resources with the provider community and those working with MCO members.

As stated earlier, maternal and perinatal care was identified as a clinical priority across the AHM organizations in 2021. The maternal/perinatal workgroup was formed to identify and implement strategies that can effectively support pregnant members who receive care at AHM partner organizations and to address challenges faced in providing prenatal and postpartum care. The workgroup established a monthly meeting and developed a group charter. With the underlying assumption that experiences of AHM partners are representative of experiences for its members and clinicians' contributions are reflective of patient experiences, the deliberations of the group highlighted key barriers to care. The complexity of the Medial Assistance (MA) application process and the confusion and delay caused in the presumptive eligibility process emerged as some key identified barriers. Additionally, Care Coordinators from North Point were not following their patients to the Hennepin Healthcare System (HHS) when referred for continuity of care. The work group decided to explore the opportunity of recruiting a care coordinator for pregnant members to provide the needed support for members to navigate all systems including those outside of the AHM system. The presumptive eligibility issue could be better solved at the DHS level.

In addition to elevating maternal and child health outcomes through the AHM partnership, Hennepin Health continued to pursue avenues to connect with pregnant members earlier in their pregnancies. Hennepin Health continued to explore using the new pregnancy identification report that was developed in Epic® in partnership with Hennepin Healthcare. The report captures Hennepin Health members who are pregnant and receiving care at Hennepin Healthcare through the review of various laboratory tests and clinical diagnoses. Although the report only captured members who use HHS for clinical care, it identified pregnant members, months earlier than could be captured through the Hennepin Health claims system. The report provided a target population for the outreach pregnancy mailer packet developed with a view to proactively connecting members with available resources to help keep them on track with recommended maternal and child health care needs. The pregnancy mailer packet provided a variety of information including how to access a free car seat, mental health resources, prenatal class referrals, fetal-alcohol spectrum disorder (FASD) education, safe sleep practices, Hennepin Health prenatal care rewards program vouchers, and more. The mailer packet did not launch in 2023 as planned due to challenges including the transition of Hennepin Healthcare Minnesota Visiting Nurses Association (MVNA) home visiting program to Hennepin County Public Health and Human Services Department (January 2023). As such, Hennepin County Public Health and Human Services Department developed and implemented a new referral process and materials in early 2023. Other challenges included material printing and staff resources to create the new pregnancy packet. These challenges necessitated a pivot to preparing a letter with minimal printed materials while incorporating a QR code for access to the relevant resources. At the time of writing this report, Hennepin Health's new case management platform, HealthEdge's GuidingCare®, has launched and work is on the way to automate the pregnancy mailer packet. In the interim, the manual mailing of the resource has already commenced. Hennepin Health plans to develop a less labor-intensive and more robust outreach services to newly pregnant members in 2025. Healthwise Knowledgebase® tool resources continued to be made available to Hennepin Health members through the member website and members could request the materials in a printed format by contacting the Member Services team.

Hennepin Health continued to work with the Hennepin County Public Health department and met with staff from different areas, including Hennepin County C&TC and Baby Tracks, the county's childhood immunization program. Similar meetings were held with the former Hennepin Healthcare MVNA staff who transitioned to the county and took over the home visiting services. The discussions were aimed at building greater collaboration and communication between different county areas to ensure members were offered and provided access to the services and resources they needed. Hennepin Health continued to provide newborn information to Baby Tracks. As at the time of reporting, a representative from Hennepin County's Baby Tracks and Immunization is part of the Maternal and Perinatal Workgroup which has incorporated child health as a focus area.

With the challenge presented in termination of services being provided by the Hennepin Healthcare MVNA, family home visiting (FHV) services moved to Hennepin County Public Health, effective January 1, 2023. In the second half of 2022, the

county was focused on developing the FHV program and hiring staff which diverted focus from the planned collaboration. This change necessitated a shift in Hennepin Health's planned approach to leveraging the county FHV services for members. Unfortunately, this collaboration did not fully materialize due to the transition process challenges that limited the availability of the FHV program staff and leadership. At least 68 Hennepin Health members were referred to the FHV program in 2023.

Next Steps

Several exciting initiatives will be implemented during the 2nd 3-year cycle of the *Healthy Start* PIP. The Collaborative work in 2024 will be focused on maintaining and expanding relationships developed with community partners, the development and delivery of educational webinars and tools, and increasing member utilization of community resources such as doula services and well-child visits. In addition, a plan for community informed measurement and associated activities will be launched. Overall, community-informed measurement is having groups of people most negatively impacted by structural inequities engaged by collecting member input on their interactions with the health care system and developing community-informed measures for the project.

As mandated by DHS, the Collaborative plans to develop intervention tracking measurements (ITM) as a mechanism to assess implementation and effectiveness of interventions through regular tracking. The ITM strategy will evolve over the course of the PIP cycle as more directives are received from DHS and more insights are gathered through pilots of small tests of change. Interventions will be adjusted, adopted, abandoned, and/or spread as needed based on their relevance to reaching the goals set for identified measures.

Hennepin Health will continue to incentivize visits for prenatal care, postpartum care and well-child checkups, as well as CIS Combo-10 immunizations through gift card rewards program. As described earlier in the report, the new pregnancy/prenatal outreach letter will be launched and sent out manually until automation is achieved in HealthEdge GuidingCare®. The letter will provide an opportunity to connect with pregnant members and provide them access to useful and important information about maternal and child health. It will also be used as a pilot to ascertain how useful the pregnancy report created by Hennepin Healthcare is in terms of early identification of pregnant members. If useful, it may serve as the basis for targeted outreach efforts by the Social Services Navigation team. The postpartum mailer packet will continue to be sent out manually with plans for automation in HealthEdge GuidingCare®.

Hennepin Health will continue to work closely with the AHM partners to facilitate the *"healthy start"* work. Hennepin Health will continue supporting Public Health as they launch their county-wide home visiting services, including the development of the home visiting referrals services. The support will include facilitating member access to the programs and mitigating potential interruption to enrollment and services. Hennepin Health will initiate interventions that promote an increase in referrals to the FHV program to promote better health outcomes for the birthing and infant populations. The intervention will closely track program referrals and enrollments to gauge effectiveness of the adopted strategies.

Hennepin Health's collaboration with AHM partners will continue through the Maternal and Perinatal Workgroup where child health will be incorporated as a priority. The provision of mobile access to care for children, including well-child checks and immunizations will be pursued.

Other planned interventions include:

- Engaging Hennepin Health's Enrollee Advisory Council to promote maternal and child health.
- Improving understanding of NICU births and improving their outcomes
- Promoting health equity through education, providing access to car seats and exploring safe sleep initiatives.
- Promoting the use of the doula service to the birthing population and reducing administrative barriers for doula engagement with Hennepin Health members.

The Hennepin Health internal workgroup will continue to meet to identify ways to connect and build a solid relationship with the Native American members. Please see the Population Health Management section for more information about this workgroup.

Hennepin Health
your community health plan

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