Hennepin Health

PMAP/MinnesotaCare Healthy Start Performance Improvement Project 2021-2023

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Hennepin Health
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Contents

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This Performance Improvement Project (PIP) is a collaboration of Minnesota Managed Care Organizations (MCOs) ("the Collaborative"). The MCOs participating in this collaboration for their PMAP and MinnesotaCare products are: Blue Plus, HealthPartners, Hennepin Health, South Country Health Alliance, and UCare. Stratis Health provides project development support and assistance to the Collaborative.

Summary

The PIP is intended to promote a "Healthy Start" for Minnesota children in the PMAP and MinnesotaCare populations by focusing on and improving services provided to pregnant people and infants, particularly in areas exhibiting the most significant racial and ethnic disparities. 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.

PIP Elements

The stated interventions for this project include the development of education, resources, and tools for care systems to improve birth outcomes and reduce disparities for their Medical Assistance members, and the development of community partnerships to support this work. The Collaborative implemented a variety of interventions in 2021 to support those goals.

Measures of Success

Hennepin Health Goal Statement

Hennepin Health seeks to promote pregnant people's health and a "Healthy Start" for Minnesota children in the PMAP and MinnesotaCare populations by focusing on and improving services provided to pregnant people and infants, specifically in ways to reduce health care and racial/ethnic disparities. Hennepin Health is working to decrease the health disparities experienced by our members in the areas of prenatal/postpartum care, well-child visits (15-30 months) and immunizations (ages 0 – 2 years of age).

Hennepin Health will work with its Accountable Health Model partners (Hennepin County Health and Human Services, Hennepin Healthcare, and NorthPoint Health and Wellness Center) and other health

care providers to address social determinants of health (SDoH) and barriers to care for pregnant people and children, ages 0 months to 2 years, in order to improve women's overall health and provide children with a healthy start in life. Pregnancy brings women at risk into the health care system and can provide opportunities for Hennepin Health and our provider patterns to address their health and social service needs.

Methods and Data Analysis

This research will attempt to measure closing disparity gaps by leveraging the HEDIS® families and children measure set listed below. Each MCO has identified specific metrics to measure targeted efforts. Hennepin Health has chosen the following to report:

- Timely Prenatal Care (PPC)
- Timely Postpartum Care (PPC)
- Childhood Immunization Status (CIS)
- Well Child Visits for Age 15 Months-30 Months (W30) (2020 Baseline)

The 2020 HEDIS® Prenatal and Postpartum Care (PPC) and Childhood Immunization Status (CIS) measures will serve as the baseline measurements for this PIP. HEDIS® is retrospective; therefore, HEDIS 2020 reflects calendar year 2019 activities. The HEDIS® naming convention changed since the drafting of the PIP proposal, so the measurement year is reflected in the data naming. Therefore *2021 HEDIS® Data* now actually represents data collected in calendar year 2021. Through the course of this report, we will be *comparing HEDIS data collected in 2019 to HEDIS® data collected in 2021. Data in this report that is labeled as 2019 data was labeled as 2020 data in the proposal* in line with the naming convention of the time**.** The pre-implementation year of 2020, which is also the first year of the COVID-19 pandemic, is not reflected in this data. The exception to this statement is that the baseline year for the W30 measure is collection year 2020, labeled as such. In 2020, the HEDIS measure changed from W15 to W30, so we are reporting the 2020 W30 data in the interest of continuity. Hennepin Health reported only one year of baseline data (vs multiple years to establish trending) because HEDIS® data specifications change and cannot be retroactively applied to previous years.

In the PIP proposal, Hennepin Health proposed that the final measure for this PIP be a non- HEDIS® claims-based measure, *low birth weight babies and/or babies requiring intensive care (LBW/IC)*. At the time of report writing, this measure is still being analyzed pending refinements of the criteria utilized to retrieve data from the Hennepin Health claims system. In lieu of reporting a comparison to the data that was presented in the proposal, Hennepin Health is conducting an in-depth record review of LBW/IC births that occurred at Hennepin Healthcare. The results of this record review will be included in the next PIP report.

As addressed in the paragraph above. Hennepin Health's MinnesotaCare product did not have an eligible population for the W15 and CIS measures in the baseline proposal data, nor for W30 measure in either year. The 2021 PPC data contains 9 MinnesotaCare members and the 2021 CIS only one MinnesotaCare member. The data below reflects only the Hennepin Health PMAP product except for

three MinnesotaCare members included in the PPC data. The following measures will be used to monitor the success of the PIP:

- HEDIS® PPC measure: The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facts of prenatal and postpartum care.
    - *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.
    - *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 7 and 84 days following delivery.
- HEDIS® W30 measure: the percentage of members who turned 30 months old during the measurement year and had at least two well-child visits with a primary care physician in the last 15 months. *Note: the W30 measure has replaced the W15 measure that was utilized in the proposal. Due to data warehousing issues, member-level data was not available for the W30 measure and therefore a race and ethnicity analysis could not be conducted on the measure. Hennepin Health made the decision to use internal claims data to analyze the W30 measure. The W30 data reflected in this report was collected according to W30 HEDIS® tech specs but without continuous enrollment criteria applied.*
- HEDIS® CIS Combo-10 measure: the percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV) and two influenza (flu) vaccines by their second birthday.

Table 1 below presents the measurement periods for the HEDIS PPC, W30, CIS Combo-10.

Table 1. HEDIS® PPC, W30, CIS Combo-10 Measurement Periods

Reporting Year	Measurement Period	PIP Intervention Year
2020	January 2019 – December 2019	Baseline (except W30)
2021	January 2020 – December 2020	Pre-implementation
2022	January 2021 – December 2021	Year 1
2023	January 2022 – December 2022	Year 2
2024	January 2023 – December 2023	Year 3

Data Analysis

Hennepin Health has provided baseline rates below for the entire measure population and drill down analysis on health care disparity in the health care disparity analysis section. As outlined in Table 2 below, the Healthy Start related HEDIS® measures changed little from 2019 to 2021. Given that the time between data years included the initiation of the COVID-19 pandemic, Hennepin Health is pleased with the findings. There was a small 2.9% decrease in CIS Combo-10 rates, no change in PPC-Prenatal rates,

and a slight increase in PPC-Postpartum and W30 rates. This provides a solid footing for our work to increase all these HEDIS rates as the PIP moves forward.

Table 2: Healthy Start HEDIS® Measures

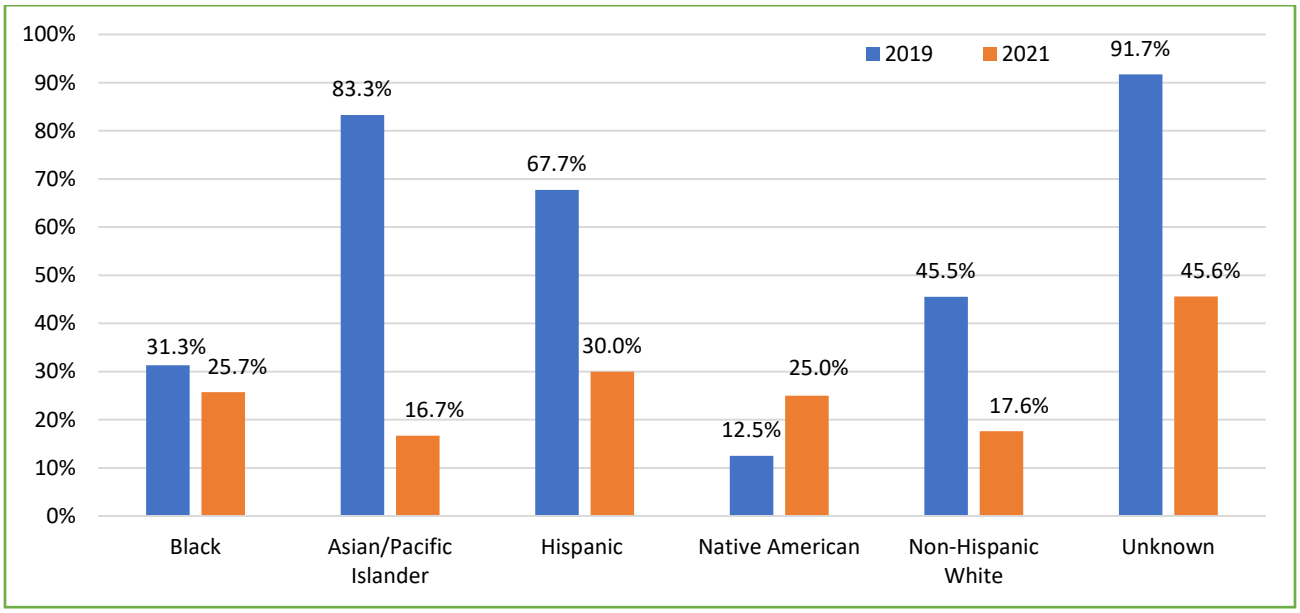
Year	Numerator	Denominator	Rate	Percent Change
CIS Combo-10				
2019	56	134	41.8%	**-2.9%**
2021	131	337	38.9%	
W30				
2020	190	364	52.2%	**+4.6%**
2021	245	431	56.8%	
PPC-Prenatal				
2019	234	274	85.4%	**0.0%**
2021	281	329	85.4%	
PPC-Postpartum				
2019	214	274	78.1%	**+1.8%**
2021	263	329	79.9%	

Healthcare Disparity Analysis

Hennepin Health is committed to reducing health inequity for our members. As such we have analyzed our Healthy Start related data for inequities. While we do see some, we find it difficult to draw many conclusions because of the small denominators related to our birthing population and the high population of members whose race is unknown to the MCO. Interpret the following data with caution. At the conclusion of the section is a table displaying the actual denominators in question for each measure (Figure 4).

Figure 1 below displays the CIS rates by Race for 2019 and 2021. All populations saw a significant rate decrease in 2021 compared to 2019, except the Native American population. The 2019 denominators for all populations are low with the total denominator being 134 as displayed in Table 2 below. The 2021 denominator for this measure was 337, representing a 151% increase in population size from 2019.

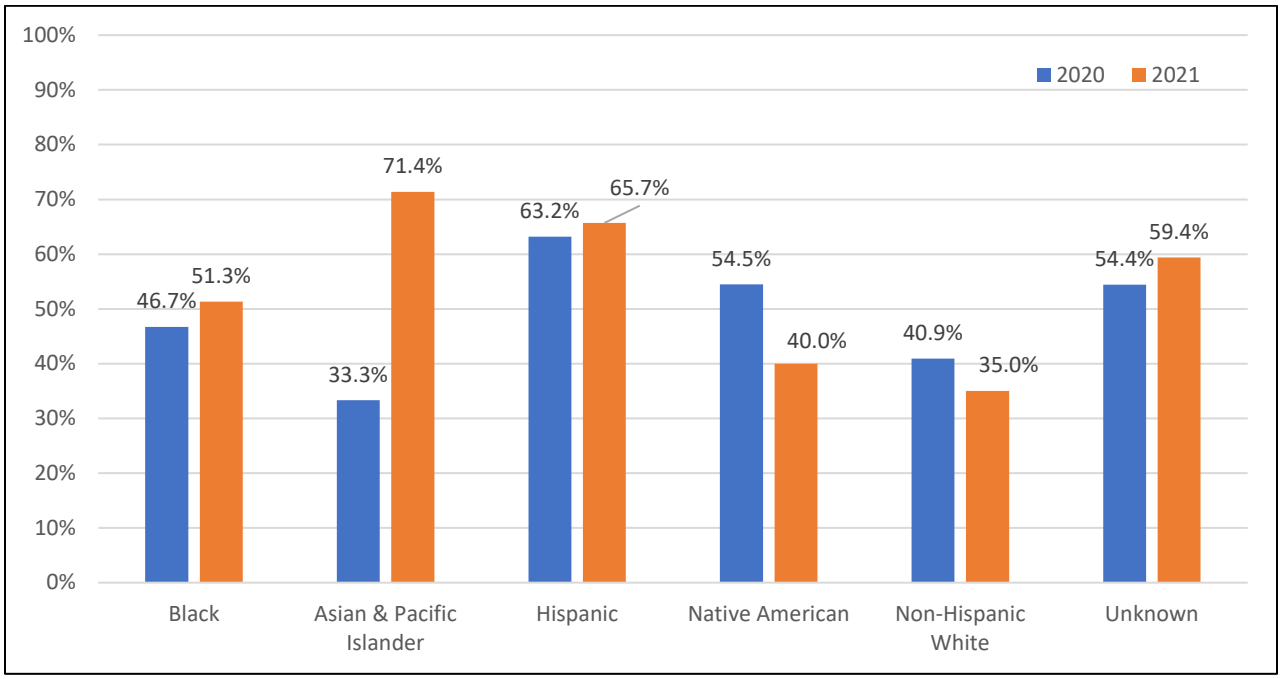
Figure 1: Hennepin Health CIS Rates by Race, 2019 and 2021



Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS CY 2021

Figure 2 below shows the W30 rates by race. Note again that the baseline year for this measure is 2020 (vs 2019 as for the other measures) and that the continuous enrollment criteria has not been applied. There was for all groups an increase in W30 rates from 2020 to 2021, which may reflect a return to normal after the onset of the COVID-19 pandemic and related drops in in-person clinical care. The only race groups who demonstrated a *decline* in W30 rates were American Indians and Non-Hispanic Whites, though for this measure we again have very low denominators for each group and a high number of "unknowns".

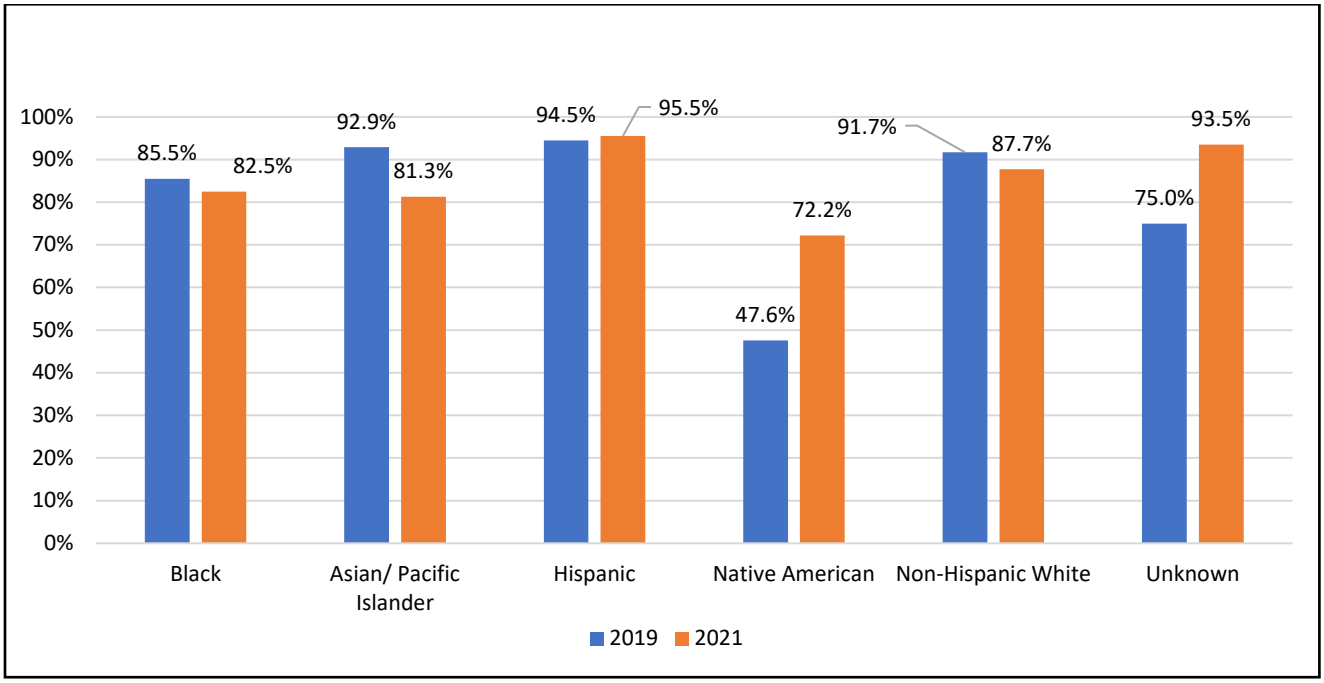
Figure 2: Hennepin Health W30 Rates by race, **2020** and 2021



For both HEDIS® prenatal and postpartum PPC rates, every race/ethnic group has a lower rate than the Non-Hispanic White members except for Hispanic members who have the highest rates of prenatal and postpartum care among the Hennepin Health membership. Indigenous people experience the most significant inequities amongst all racial groups for both prenatal and postpartum care.

The Native American population PPC-prenatal rate significantly increased from 47.6% in 2019 to a rate of 72.2% in 2021, representing an increase of 24.6%. The Black, the Asian/Pacific Islander, and the Non-Hispanic White populations saw a PPC-prenatal rate decrease from 2019 to 2021 of 3%, 11.6%, and 4%, respectively.

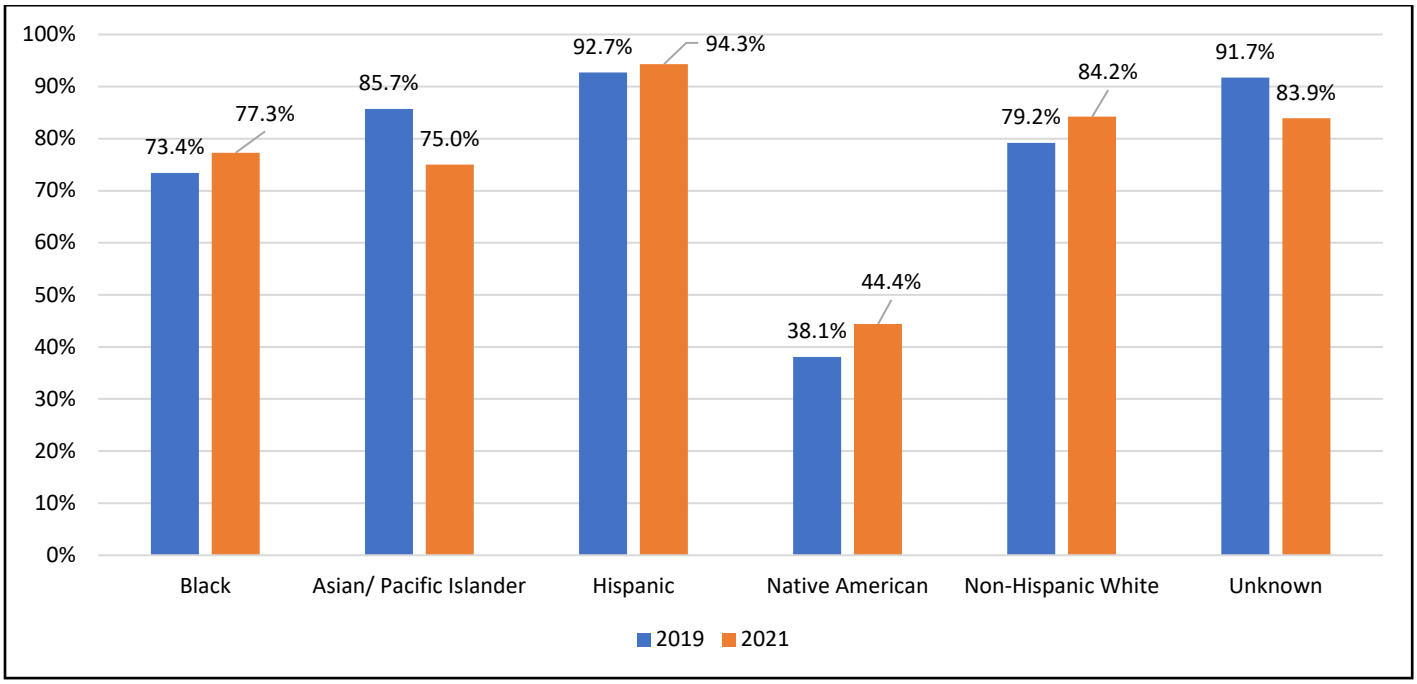
Figure 3: PPC-Prenatal Rates by Race, 2019 and 2021



All race/ethnic groups, except the Asian/Pacific Islander and the unknown groups, saw a slight increase in the HEDIS® PPC-postpartum rate. Asian/Pacific Islanders have the second smallest group size of all races attributed in the data. The Black, Hispanic, Native American, and Non-Hispanic White populations had a PPC-postpartum rate increase from 2019 to 2021 of 3.9%, 1.6%, 6.3%, and 5%, respectively. The Native American population PPC-prenatal rate decreased from 85.7% in 2019 to a rate of 75.0% in 2021, representing a decrease of 10.7 percentage points.

The small but impressive 1.8% increase in the PPC-postpartum rate from 2019 to 2021 was attributable to a mostly equitable increase in postpartum care across race groups. The sample size of each race/ethnic group sample size is small, so no conclusions can be drawn. Indigenous people experience the most prominent inequities amongst all racial groups for both prenatal and postpartum care.

Figure 4: PPC-Postpartum Rates by Race, 2019 and 2021



Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS CY 2021

Figure 5: Denominator by race for HEDIS measures, 2019 and 2021

Race	Year	PPC-Prenatal and Postpartum	CIS Combo-10	W30
Black	**2019**	124	64	107
	2021	154	74	76
Asian/Pacific Islander	**2019**	14	6	9
	2021	16	6	7
Hispanic	**2019**	55	31	57
	2021	53	13	35
Native American	**2019**	21	8	11
	2021	18	8	15
White	**2019**	48	11	22
	2021	57	17	20
Unknown	**2019**	12	14	158
	2021	31	219	278
Total	**2019**	**274**	**134**	**364**
	2021	**329**	**337**	**431**

Data Limitations

As discussed at length in the data analysis section, Hennepin Health is challenged in their Healthy Start data analysis by the very small denominators. We do not meet the 411 HEDIS® minimum cell size for the measures we are discussing in this PIP which presents difficulties in analyzing our race and ethnicity data. Such small denominators mean that our race and ethnicity data in particular is sensitive to fluctuations in membership or changes in the racial category assignments amongst our members.

A data limitation in each HEDIS® measure (except W30) is the hybrid collection methodology that the MCOs utilize. Hybrid allows the health plan to use a sample size of 411 to review compliance via medical record abstraction. To maintain protected health information (PHI), the nurses that abstract medical record information are only given the pieces to prove measure compliance, thus they would not have access to the patient's race/ethnicity.

Lastly, all the MCOs acknowledge collecting data on patient race, ethnicity, and language (REL) is an important step in reducing health care disparities, as clinical performance measures can then be stratified by REL to guide quality improvement efforts. To see success in this project, we encourage our Department of Human Services (DHS) partners to devise a strategy to strategically increase the availability and quality of data on race and ethnicity. This information is collected through the enrollment application and shared with health plans via the 834 monthly feeds. We would welcome additional conversation via our quarterly MCO-DHS Quality Workgroup meeting to discuss the critical gaps in data on race, ethnicity, and socioeconomic status in existing systems, and methods for filling those gaps.

Interventions and Measures of Success

As the lead MCO for the Healthy Start PIP, Hennepin Health has been deeply involved in each aspect of the Collaborative work of the PIP in addition to having developed initiatives specific to our specific health plan. The Collaborative has worked together 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 are developed with an MCO's specific resources and membership in mind. At Hennepin Health, we work to leverage our position in the Hennepin County systems that Medicaid members often rely upon as well as our Accountable Health Model partners - Hennepin Healthcare and NorthPoint Health and Wellness. Both the Collaborative and Hennepin Health have accomplished much in the beginning of the PIP with much more planned for the future.

Education

The collaborative developed an educational series to address topics that can impact birth outcomes and early childhood health with a focus on health equity and addressing racial bias. All Collaborative webinars are recorded and remain available for viewing on the Stratis Health website at this link. Webinars presented in 2021 were:

- *Racism's Roots in Medicine & How Implicit Bias Impacts Care* presented by Dr. Chomilo on April 7, 2021.

Implicit biases are associations outside of a person's conscious awareness that lead to a negative evaluation of another person on the basis of irrelevant characteristics such as race or gender. During this presentation, clinicians 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.

This webinar was attended by 289 individuals live, and an additional 340 people watch the recorded webinar later. 217 people completed the evaluation following the webinar. Of those, 94.4% of the evaluations indicated the information enhanced their knowledge and ability to apply new strategies in their work and 96% said the webinar helped them understand racism's roots in medicine and how implicit bias impacts the care people of color receive. Additionally, 93% said it increased their ability to begin to address their own biases to provide better care to their patients or clients.

- *Disparities in Childhood Health* 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-care. 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. They discussed what they have learned from their patients, how we can work together as a health care community and with BIPOC families to better serve the children in our care, and how to have these discussions with families.

  This webinar was attended by 77 individuals live, and an additional 82 people watch the recorded webinar at a later date. Of the 42 people who completed an evaluation, 90.5% of the indicated the information enhanced their knowledge and ability to apply new strategies in their work. Additionally, 88% said they were better able to identify strategies to improve their partnership with parents to meet health goals for their child.

- *Achieving Health Equity: Tools to Move Forward* presented by Dr. Veronica Gillispie-Bell on October 13, 2021.

  Clinicians and other maternal and child health providers are increasingly aware of and able to identify health inequities in their work. However, they often struggle with how to move from knowledge to action and take tangible steps towards dismantling medical racism from their position in the field. In this webinar, participants learned meaningful tools to eliminate health inequities in their own work and organizations.

  This webinar was attended by 72 individuals live and 48 people watched the recorded webinar at a later date. Over 97% of the evaluations indicated the information enhanced their knowledge and ability to apply new strategies in their work, and 94% indicated they were better able to understand the disparities that exist in maternal and child health. Overwhelmingly,

attendees felt the webinar increased their knowledge of tools to dismantle racism in their own workplace, but many commented that they felt overwhelmed, isolated, or unsupported.

Tools and Resources

Community Partnerships

During the planning stages of this project, 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 included MCO participation prior to the PIP but have strengthened over the course of the project thus far. Please find below a list of the guests we have hosted for discussion on strengthing our PIP work followed by a description of some of the community-based partnerships the Collaborative has focused on.

The Collaborative has hosted the following guests to strengthen our PIP work.

Name	Organization	Date
Debby Prudhomme	Everyday Miracles	11/19/2020
Dr. Nora Hall, Karen Gray, and Dr. Diane Banigo	Integrated Care for High-Risk Pregnancies (ICHRP)	2/4/2021
Chelsea Georgeson and Lucas Nesse	Minnesota Council of Health Plans (MCHP)	4/1/2021
Mark Gottwald	Minnesota Association of County Health Plans (MACHP)	4/22/2021
Dr. Katy Kozhimannel	University of Minnesota School of Public Health	5/20/2021
Karen Fog	Minnesota Department of Health (MDH) Family Home Visiting	9/16/2021
Dr. Nora Hall and Karen Gray	ICHRP	9/20/2021
Dawn Reckinger	MDH Family Home Visiting	10/7/2021

Integrated Care for High-Risk Pregnancies (ICHRP) – 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 - 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 towards 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 proposed in the governor's budget did not advance through the legislature before the end of the most recent session.

Everyday Miracles – 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) – 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 were tasked with providing direction to the Equity committee on health plan approaches to improving maternal and early childhood outcomes and decreasing disparities. The recommendation of this subcommittee will be included in the 2022 project update.

County Partnerships –

Regional Child and Teen Check-up – (C&TC) groups- Each part of the state has a group made up of MCOs and county C&TC staff from that area. Collaborative members attend the Metro Action Group (MAG) which is comprised of the 7-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) – 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.

Hennepin Health Interventions

New Pregnancy Packets - In an effort to connect with our pregnant members earlier in their pregnancy to provide services, Hennepin Health worked with Hennepin Healthcare to develop a new identification report and outreach mailer. Hennepin Healthcare built a report in their Epic® medical records system specifically for Hennepin Health that captures information on Hennepin Health members who are pregnant as identified through various laboratory tests and clinical diagnoses. Although the report only captures members who go to Hennepin Healthcare system for clinical care, it identifies members months sooner than can be captured through the Hennepin Health claims system.

The outreach packet contains a variety of helpful information such as how to access a free car seat, mental health resources, prenatal class referrals, fetal-alcohol spectrum disorder (FASD) education, safe sleep, Hennepin Health prenatal care incentive vouchers, and more. The new Epic report was designed in 2021 and at the time of this writing, the mailing packet has been approved by DHS and the printing/mailing processes are being finalized at Hennepin Health for implementation in 2022. Hennepin Health is using this process as an informal pilot project for the development of more intensive outreach services to newly pregnant members.

Hennepin County Public Health and Human Services - Hennepin Health has met several times with staff from different areas of the county including Hennepin County Child and Teen Checkup (C&TC) and Baby Tracks, the county's childhood immunization program. Hennepin Health also met several times with the Minnesota Visiting Nurses Association (MVNA) staff which is the organization based out of Hennepin Healthcare that conducts much of the county's home visiting services. The intent of our discussions was to build greater collaboration and communication between the different county areas to ensure Hennepin Health members are being offered the most helpful support services available to them. While we have established a solid foundation for further integration between our areas, some of our intended changes have been delayed due to shifts in the other county departments. In July of 2021, approximately half of the county's children eligible for C&TC outreach and support became ineligible because of the change to the Integrated Health Partnership (IHP) obligations in that the children who are designated to participating IHP health systems will now instead receive outreach from those health systems rather than the county. Hennepin Health intends to partner with the designated health systems once they have established their C&TC outreach processes.

Another complication has been that Hennepin County is terminating their contract with MVNA for home visiting services and moving the services directly to the county, effective January 1, 2023. The county is deep in the planning and hiring process and will involve Hennepin Health as the process moves forward to ensure our members are receiving home visiting nursing services to support them. The change has caused Hennepin Health to shift their planned approach to leveraging the county home visiting services for our members.

Barrier Analysis

Multiple barriers, both predicted and unforeseen while drafting the proposal for this project, have become evident throughout planning and implementation of interventions. Several, but not all, barriers are related to the COVID-19 pandemic.

Preliminary MDH data shows that the percentage of all 2-year-old children in Minnesota who are *not* caught up on their vaccinations has increased from 20.3% in 2019 to 30.9% in 2021.[1] Several circumstances caused by the pandemic are responsible for this increase.

- Our youngest members require a higher number of vaccinations to be up to date than do other age groups, and once they are behind schedule, it can be more difficult to catch up as the delays can cause an overwhelming and confusing backlog in the vaccination timeline.
- When the pandemic began, clinical services were disrupted but also parents were hesitant to bring kids for their well child checks for fear of catching COVID-19. Now that time has passed, some families have not caught their children up for a variety of reasons, including because of a general sense of vaccine hesitancy that has grown during the pandemic.
- Providers are sharing anecdotally that the increased social divisiveness experienced nationally is impacting well child check rates, as well.

Several barriers we have encountered were either known or suspected prior to starting the PIP.

- Transportation to appointments is an ongoing barrier across health plans according to C&TC workers we spoke to in the metro and surveyed in outstate Minnesota.
- C&TC workers in outstate Minnesota also cited the availability of appointments outside of regular business hours as a barrier to keeping current on pregnancy related exams and well child checks.
- Childcare was a known barrier to clinical care that persists across our population.
- 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 that it is logistically difficult to schedule interpreters, especially for languages that are less common in our geographic area. While we have not spoken to C&TC workers in greater Minnesota about issues with interpretation services, it stands to reason that the expanding immigrant communities in rural areas are also impacted by the lack of access to translation services.

Another barrier for our birthing members is access to culturally reflective doulas, if they even know about doulas at all. This is a barrier that the Collaborative has made a priority to address and has made significant progress on which is described in other sections of this report. One barrier regarding doula care that the Collaborative is not currently addressing but very aware of is the Medicaid reimbursement rates for doulas. The Collaborative is concerned about the sustainability of any efforts to increase the number of culturally reflective doulas for communities of color in Minnesota if doulas are unable to make a living as a birth worker once they are certified.

- While the Medicaid rate was increased for doulas in 2019, the doula community is reporting that it is still far too low for them to make a living by being a doula.

Organizations that employ doulas are reporting that it is difficult to retain doulas once they are certified for this same reason. There is a significant gap in time after a doula becomes certified and can begin

[1] Minnesota Department of Health "Pediatric Immunization Gaps due to the COVID-19 Pandemic"

providing support, and when the claim for those services is paid so the doula receives their salary. An additional barrier that cannot be overlooked is member experience with the health care system. People of color routinely report unease with the health care system due to past experiences feeling disrespected, ignored, or otherwise mistreated by racist care. This experience plays 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 is a deterrent to seeking prenatal care. Their fear of losing their baby is real and is reinforced by the experiences of others they know in the community.

Sustainability

Any webinars and training materials developed will be posted on the Stratis Health website for continued use and updated annually, provided they remain accurate and clinically relevant. Community partnerships will be fostered and maintained. Outreach efforts to members that are determined to be effective will be continued indefinitely.

While Hennepin Health may not have access to financial resources as do MCOs with commercial lines of business, Hennepin Health can leverage and integrate with county resources due to our position in the county system. Doing so results in our efforts being sustainable at a level that is unique to Hennepin Health.

Assessment of Short-term and Long-term Effects

The initiatives implemented within the scope of this project are intended to improve health outcomes for pregnant people and babies in the PMAP and MinnesotaCare populations. The MCO will evaluate the Collaborative interventions and MCO specific interventions to determine how to sustain these in the years to come. The MCOs use the Plan, Do, Study, Act (PDSA) quality cycle to evaluate the effectiveness of these programs on making internal changes and to sustain these initiatives.

Plan for 2022

Hennepin Health has several exciting initiatives to be implemented during the remainder of the PIP. As described earlier in the report, our new pregnancy outreach mailers will be in production before the end of 2022. The mailers will both provide an opportunity to connect with pregnant members and provide them with incredibly useful information. 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 our social services navigation team.

As described earlier in the report, Hennepin County is taking over the nursing home visiting programs currently administered by MVNA. Hennepin Health will be part of the planning and development of member referral services as the new program is developed.

Hennepin Health has a Clinical Quality Outcomes Committee (CQOC) comprised of clinicians from our Accountable Health Model partners - Hennepin Healthcare, NorthPoint Health and Wellness, and Hennepin County Health and Human Services. The CQOC guides Hennepin Health's clinical guidelines and direction. To collaborate most effectively with our Accountable Health Model partners, the CQOC is

forming a pregnancy workgroup to discuss how Hennepin Health can more effectively support our pregnant members who receive care at their organization and to learn more about the challenges they face in providing prenatal and postpartum care.

While our race and ethnicity data are challenging to interpret because of the small denominators, we do consistently observe that our Native American members are experiencing the most significant inequities in pregnancy outcomes. Hennepin Health has developed an internal workgroup to improve our outreach to and relationship with our Native American membership. Quality Management staff participates in the workgroup, and the participants are passionate about addressing inequities in maternal and child health for our Native American members. The workgroup is currently in the discovery and relationship building phase but intend to include maternal and child health as a focus of the work.

For the Collaborative, the work in 2022 will be focused on maintaining the 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 support.

To monitor the progress of interventions the Collaborative will work towards the following timeline:

- 1st Quarter 2022
    - Determine topics for care team Training Series in 2022
    - Host Doulas 101: A Valuable Part of the Care Team – How Doulas Support a Healthy Pregnancy webinar.
    - Collaborate with community partners and MDH/DHS to expand the certified doula training options to allow for a more culturally diverse curriculum.
    - Explore additional opportunities to improve C&TC rates by addressing administrative barriers in collaboration with MDH, DHS, and clinic partners.
- 2nd Quarter 2022
    - Identify opportunities to train and transition the C&TC outreach efforts from the county to Integrate Health Partnership (IHP) clinics.
    - Collaborate with MDH and DHS: Understand barriers to C&TC and the billing and what to do to educate parents on the importance of C&TC and providers to do proper billing.
    - Reconnect with ICHRP to identify collaborative opportunities.
    - Explore alternative ways of advertising the importance of well childcare through channels such as social media.
    - Determine topics for webinar series for maternal and child health disparities.
    - Schedule webinar presenters for 3rd and 4th quarter.
- 3rd Quarter 2022
    - Identify trainings and/or tools that could support the care team when addressing immunizations and catch-up schedules for individuals impacted by COVID-19.
    - Engage in training the IHP clinics as they implement C&TC outreach programs.
    - Research professional conferences for Collaborative presentations
    - Identify opportunities with regional C&TC groups.
    - Work on enhancing resources section of PIP page on Stratis Website.
- 4th Quarter 2022

- MCO’s will update any tools and resources developed throughout the year.
- Discuss milestones for 2022

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