Hennepin Health

2021 Healthy Start for Mothers and Their Children Performance Improvement Project

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Hennepin Health
300 South Sixth Street, MC 604
Minneapolis, Minnesota 55487-0604

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 member health outcomes and member satisfaction. The PIPs are conducted over a 3-year period and 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.*"

Process and documentation

Hennepin Health participates in the PIP collaborative initiatives with other Minnesota 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 support for the PIP.

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

Each health plan'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 health plan may implement health-plan specific strategies and interventions relevant to their respective membership. The MCOs collaborate on the writing of the interim and final PIP reports submitted annually to DHS. Each health plan addresses health plan specific interventions and outcomes in the report.

Improvements seen as the result of a PIP strategies and interventions will be sustained over time. To support sustainability, Stratis Health maintains the collaborative PIP resources on its website. The Collaborative reviews these resources annually to ensure relevancy and will update the resources as appropriate. The individual MCOs promote the resources through various means including provider and member communication. In addition, each health plan continues to implement and revise the specific health plan strategies and interventions to sustain the improvements obtained through the PIP.

The 2018-2020 PMAP, MinnesotaCare and SNBC PIP topic selected by DHS was *"Preventing Chronic Opioid Use"*. The 2021-2023 "*Healthy Start for Mothers and Their Children*" for PMAP/MinnesotaCare population was implemented in January 2021. "*Comprehensive Diabetes Care"* is the SNBC 2021 – 2023 PIP topic which also began in January 2021.

PIP: 2021 – 2023 PMAP and MinnesotaCare “Healthy Start for Mothers and Their Children”

Rationale and 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 (“the Collaborative”) that includes Blue Plus, HealthPartners, Hennepin Health, South Country Health Alliance (SCHA), and UCare. 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. To facilitate improvement, Hennepin Health supports joint collaborative interventions in addition to plan-specific strategies. Hennepin Health works with its Accountable Health Model partners (Hennepin County Public Health and Human Services, Hennepin Healthcare, and NorthPoint Health & Wellness Center) and other health care providers to address social determinants of health 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 infant and maternal deaths in Minnesota. As a short-term goal, the Governor’s Office seeks to “reduce infant and maternal deaths experienced by American Indians, African Americans, other communities of color, and Greater Minnesotans by 15% by 2022.”

Analysis

To review health care race and ethnic disparities, Hennepin Health leveraged data available through the DHS Medicaid enrollment application. Hennepin Health used the HEDIS® hybrid data for the prenatal and postpartum care (PPC) and childhood immunization status (CIS) Combo-10 measures as the entire PMAP/MinnesotaCare

eligible population is in the sample. For the well-child visits in the first 15 months of life (W15) measure, the HEDIS® administrative (claims) data methodology was used. Hennepin Health's claim data was the source for the non-HEDIS® low birthweight/intensive care (LBW/IC) data. Hennepin Health has access to the Hennepin Healthcare electronic medical record, Epic®. To minimize the impact of the lack of race, ethnicity, and language (REL) data, Hennepin Health utilized Epic® to obtain REL data for members who are seen at Hennepin Healthcare and NorthPoint Health & Wellness Center.

Hennepin Health established goals to promote racial equity and improve prenatal care, postpartum care, well-child visits, ages 0-30 months and Combo-10 immunization rates for children ages 0-30 months. Using 2019 data, racial disparities for Black individuals and American Indians were identified in these measures. The measures displayed in Table 1 below will be used to monitor the success of the PIP. Data results from 2019 will serve as the baseline. At the time of the writing of the 2021 Quality Management Evaluation, data to update these rates were not yet available.

Table 1. "Healthy Start" PIP measures

Measure	Description
HEDIS® - Timeliness of prenatal and postpartum care	During the measurement year: Timeliness of prenatal care: The percentage of pregnant people who deliver and receive a prenatal visit within the first trimester, on or before the enrollment start date or within 42 days after enrollment into a health plan. Timeliness of postpartum care: The percentage of pregnant people who deliver and had a postpartum visit on or between 7 and 84 days following the delivery.
HEDIS® well-child visits	The percentage of enrollees who turned 15 months old during the measurement year and who had the six or more well-child visits with a primary care provider during their first 14 months of life.
HEDIS® childhood immunization status – Combo-10	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis; three polios; one measles, mumps and rubella; three haemophilus influenza type B; three hepatitis B; one chicken pox; four pneumococcal conjugates; one hepatitis A; two or three rotavirus and two influenza vaccines by their second birthday.
Non-HEDIS® low birth weight/intensive care births	The percentage of infants born with a low birth weight (<2500 grams) and/or requiring a stay in the neonatal intensive care unit once delivered.

Using 2019 data, racial disparities were identified by race and ethnic group for the various PIP measures as displayed in Table 2.

Table 2. Racial disparities by HEDIS® CDC measures				
Measures	**Blacks**	**American Indian**	**Asian/Pacific Islander**	**Hispanic**
HEDIS® prenatal care	Yes	Yes	No	No
HEDIS® postpartum care	Yes	Yes	No	No
HEDIS® well-child visits (W15)	Yes	Yes	Yes	No
HEDIS® Combo-10 immunizations	Yes	Yes	No	No
Non-HEDIS® low birth weight/intensive care births	Yes	Yes	No	Yes

Collaborative and Hennepin Health specific interventions focus on reducing racial disparities and improving the rates for the measures. Collaborative interventions include the development of an education series and resources addressing the gaps in knowledge identified through research with various stakeholders.

Webinar topics have to date included implicit bias, tools to achieve health equity, and information on childhood health disparities. Future topics will include the benefits of using doulas and a child and teen checkup (C&TC) 101. The Collaborative is partnering with community and county partners such as Integrated Care of High-Risk Pregnancies (ICHRP) and the Metro Action Group (MAG). ICHRP's goal is to improve birth outcomes for Black/African American women in Minnesota. MAG consists of county public health and metro health plan staff who collaborate on child and teen-check-ups strategies, early childhood access to care and reducing disparities in pregnancy and child and teen health outcomes. Hennepin Health specific interventions include enrollee outreach for pregnancy and postpartum visits, immunizations, and well-child visits, enrollee education through Healthwise Knowledgebase® (an online health resource available on the Hennepin Health website), New Mothers packets and well-child and dental birthday cards.

Hennepin Health collaborates with the Accountable Health Model partners with the following programs:

- The Karibu Mama Mtoto Program at NorthPoint provides young African American women with a culturally relevant therapeutic structure to support healthy pregnancies and positive birth and well-child outcomes.
- The African American Doulas Program connects Black/African American women in north Minneapolis with Black/African American doulas for ongoing support.
- The Native and African American Women High Risk Pregnancy Support Pilot addresses health disparities and gaps and provides culturally congruent prenatal and postpartum care for Black/African American and American Indian women.

- The Redleaf Center for Family Healing promotes the parent-child relationship by supporting mental health and parenting capacity.
- Hennepin Health has partnered with Hennepin Healthcare to try to identify pregnant members earlier in their pregnancies. By producing a report in Epic® that searches medical records for tests and exams that confirm a pregnancy, Hennepin Healthcare can notify Hennepin Health about our members' pregnancies. Within the Hennepin Health system, Hennepin Health relies on claims to identify pregnant members making it difficult to reach members early in their pregnancy due to the claims lag and global pregnancy billing. While this new mechanism will not capture Hennepin Health members seeking care through other health systems, it captures many members and is a solid start for outreach efforts. Hennepin Health is finalizing a pregnancy packet and assessment that will be sent to the members identified through this process upon approval by DHS.

Hennepin County and the Hennepin Health Board have recognized the impact racial disparities have on the health outcomes of Black individuals and American Indian pregnant people, in particular, and support Hennepin Health in this project.

Recommendations and next steps

Hennepin Health will continue to meet with the Collaborative twice a month throughout the PIP implementation. Both Hennepin Health and Collaborative will continue to implement interventions according to the timeline submitted in the PIP proposal.

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