



2024-2026 PMAP/ MinnesotaCare Healthy Start Performance Improvement Project

First Interim Report

September 1, 2025



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Performance Improvement Projects

Description

The Managed Care Organizations (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 an 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 2024-2026 PMAP/MinnesotaCare PIP topic selected by DHS is *Healthy Start for Mothers and Their Children* which was implemented, effective January 2024. *Diabetes and Depression* is the SNBC 2024 – 2026 PIP topic which also began in January 2024. 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), Itasca Medical Care (IMCare), Medica and UCare. 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 and 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)

The MinnesotaCare product did not have an eligible population for the W30 – 15 months and CIS Combo-10 measures in the baseline proposal data.. The 2024 PPC data contains eight MinnesotaCare members. The 2024 CIS data does not have any eligible MinnesotaCare

members. The W30-15 data includes three eligible members and the W30-30 contains one eligible member in the MinnesotaCare program. The data below reflects only the Hennepin Health PMAP product except for members in the MinnesotaCare program in the PPC and W30 measures which are included in the PPC and W-30 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 2021 to 2024. It was anticipated that the impacts of the COVID-19 pandemic would continue to manifest in low rates for the measures, 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% while the PPC-Prenatal rates dropped by 0.1% when comparing 2024 to the baseline in 2021. Rate increases were noted in the measures for PPC-Postpartum (3.9%), W30 – 15 months (5.3%), and W30 – 30 months (9.5%). This provides a solid base to increase these HEDIS® rates as the PIP moves

Table 1. Hennepin Health Healthy Start HEDIS® Rates, 2021-2024				
Year	Numerator	Denominator	Rate	Percent Change from 2021
CIS Combo-10				
2021	131	337	38.9%	↓ -2%
2022	124	346	35.8%	
2023	135	344	39.2%	
2024	111	301	36.9%	
W30 (0-15 months)				
2021	126	284	44.4%	↑ +5.3%
2022	144	303	47.5%	
2023	163	319	51.1%	
2024	157	316	49.7%	
W30 (15-30 months)				
2021	245	431	56.8%	↑ +9.5%
2022	195	336	58.0%	
2023	177	302	58.6%	
2024	185	279	66.3%	
PPC-Prenatal				
2021	281	329	85.4%	↓ -0.1%
2022	322	372	86.5%	
2023	297	357	83.2%	
2024	284	333	85.3%	
PPC-Postpartum				
2021	263	329	79.9%	↑ +3.9%
2022	306	372	82.3%	
2023	288	357	80.7%	
2024	279	333	83.8%	

forward.

Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS® CY2021, CY2022, CY2023, CY2024

Healthcare Disparity Analysis

Reducing health inequities for members is a key priority of Hennepin Health. As such, the “Healthy Start” related data has been analyzed for inequities. While we do see some health care disparities, it is difficult to draw many conclusions because of the small denominators related to our birthing, newborn and infant populations, as well as the high population of members whose race is unknown to Hennepin Health. In 2022, “multiracial” became available as a category for analysis in the data. Hennepin Health has chosen not to include this category in the following race data breakdown for two reasons: there is no trend data available, and there is not enough information available to know if the people within the category share any cultural similarities or social drivers of health. It should also be noted that individuals of Hispanic ethnicity can be of any race; in previous years, Hispanic was reported in the race analysis resulting in the sum of a measure being a larger number than is presented as some individuals were counted in both the Hispanic and a race category. Effective 2024, Hispanic will be reported as an ethnicity only. 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 (**Error! Reference source not found.2Error! Reference source not found.**).

For each measure, Hennepin Health calculated the Index of Disproportionate Under-Representation (IDU) to identify disparity subpopulations in terms of their receipt of evidence-based health care relative to the general Hennepin Health population. The IDU is 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.

CIS Combo-10

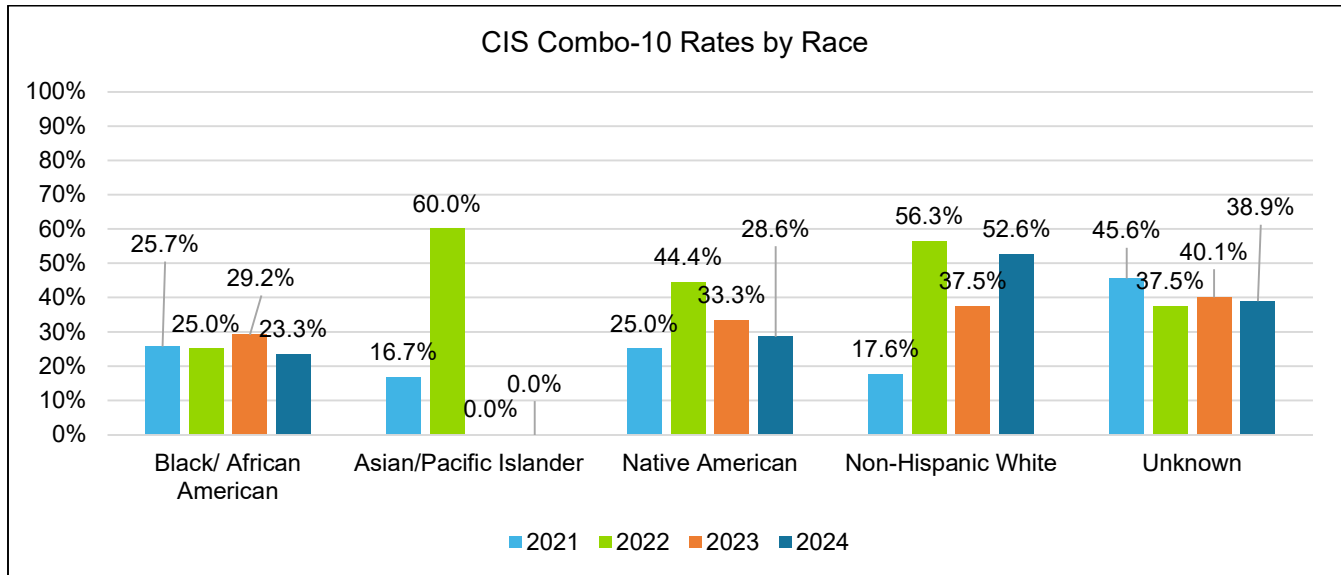
The CIS Combo-10 Rate is the only “Healthy Start” HEDIS® measure that has not improved during the “Healthy Start” PIPs time frames. This is in line with expectations given that immunization rates are down across the healthcare system, both nationally¹ and in Minnesota². When considering CIS Combo-10 by race, rate increases were observed in the Native American group (2024: N=2) and the Non-Hispanic White/Caucasian group (2024: N=20) (See **Error! Reference source not found.** below). The rate for the Black/African American group down by 2.4% when compared to 2021. In total, 42 members identified with the Hispanic ethnicity of which 59.5% (2024: N=25) met the CIS Combo-10 measure goal. The remaining 259 members identified as non-Hispanic, of which 33.2% (2024: N=86) met the measure goal. Groups that were found to be disproportionately underrepresented in the vaccination rates were the Black/ African American (IDU: 172.76%), Asian/Pacific Islander (IDU: 118.95%), and the American Indian/ Alaska Native (IDU: 158.60%).

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¹ <https://www.cdc.gov/mmwr/volumes/72/wr/mm7245a2.htm>

² <https://www.health.state.mn.us/people/immunize/stats/child/coverdatatime.html>

Figure 1: HEDIS® CIS Combo-10 Rates by Race/Ethnicity, 2021-2024

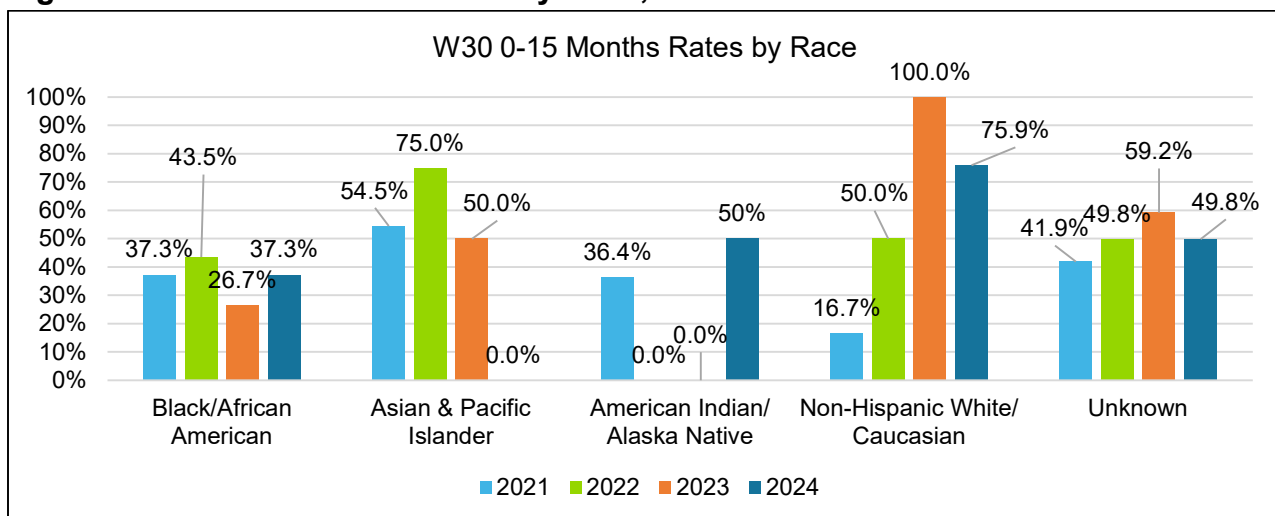


Data Source: Hennepin Health HEDIS® CY 2021, CY2022, CY2023, CY2024; Hennepin Health Data Warehouse

W30-15 months

The overall rate for W30-15 months increased by 5.3% when compared to the 2021 rate. The increase in the well-child visits can be partly attributed to the member outreach intervention implemented in partnership with Hennepin Healthcare’s Pediatric Mobile Clinic. As illustrated on Figure 2 below, gains were observed in all populations except for the Asian and Pacific Islander group whose rates decreased significantly. It is important to note that there was only one member in the denominator for the Asian/ Pacific Islander population, which is not statistically significant. The Black/African American population rate remains the same as it was in 2021 (37.3%). There were 37 Hispanic and 272 Non-Hispanic ethnic identifying members in the measure. Fifty-nine percent of the Hispanic ethnic group and 48.9% of non-Hispanic members were on track with their well-child visits, 0-15 months. The Black/ African American group continue to be underrepresented with an IDU of 133.24%. With only one Asian/ Pacific Islander member in the data and none meeting the W30-15 requirement, this group is underrepresented in the measure in a way that surpasses the IDU calculations.

Figure 2: W30 0-15 Months Rates by Race, 2021- 2024

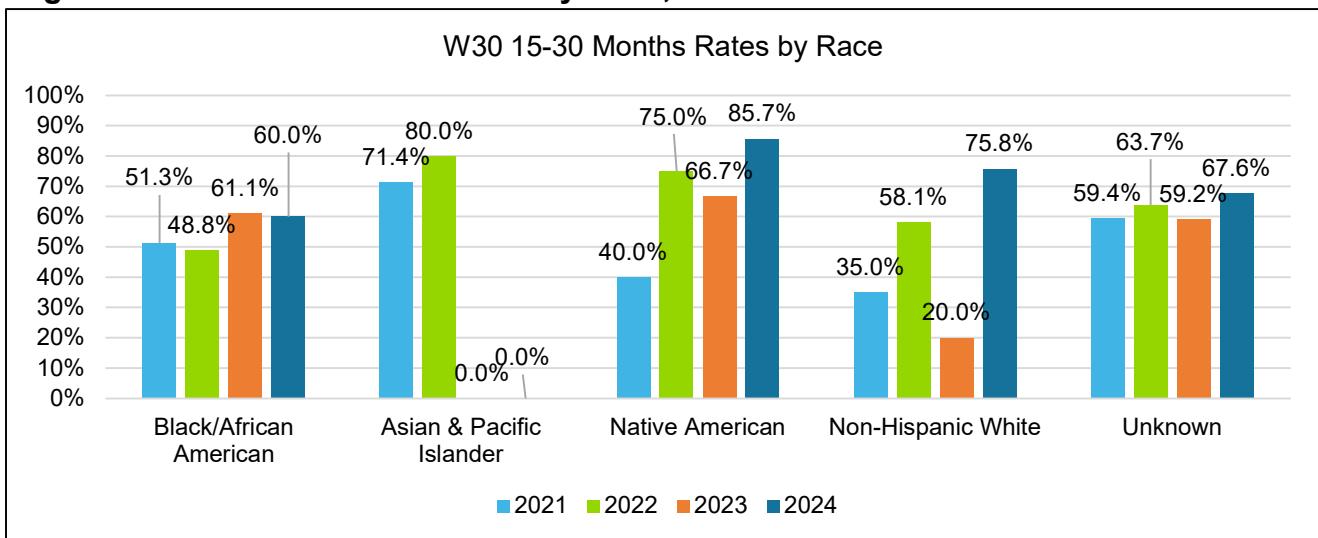


Data Source: Hennepin Health HEDIS® CY 2021, CY2022, CY2023, CY2024, Hennepin Health Data Warehouse

W30 15-30 Months

The Hennepin Health W30 15 – 30 months rate improved significantly for all populations except for the Asian/Pacific Islanders population in 2024. The increase in the well-child visits across the board can be partly attributed to the member outreach intervention implemented in partnership with Hennepin Healthcare’s Pediatric Mobile Clinic. It is important to note that there were only two members in the denominator for the Asian/ Pacific Islander population, which is not statistically significant. See Figure 3 below for a graphic representation of the rates from 2021 to 2024. There were 34 Hispanic and 241 Non-Hispanic ethnicity identifying members in the measure. Eighty-two percent of the Hispanic ethnic group and 65% of non-Hispanic members were on track with their well-child visits, 15-30 months. The Black/African American population was found to be disproportionately underrepresented in this measure with an IDU of 110.51%. With only two Asian/Pacific Islander members in the data and none meeting the W30-30 requirement, this group is underrepresented in the measure in a way that surpasses the IDU calculations.

Figure 3. W30 15-30 Months Rates by Race, 2021 - 2024



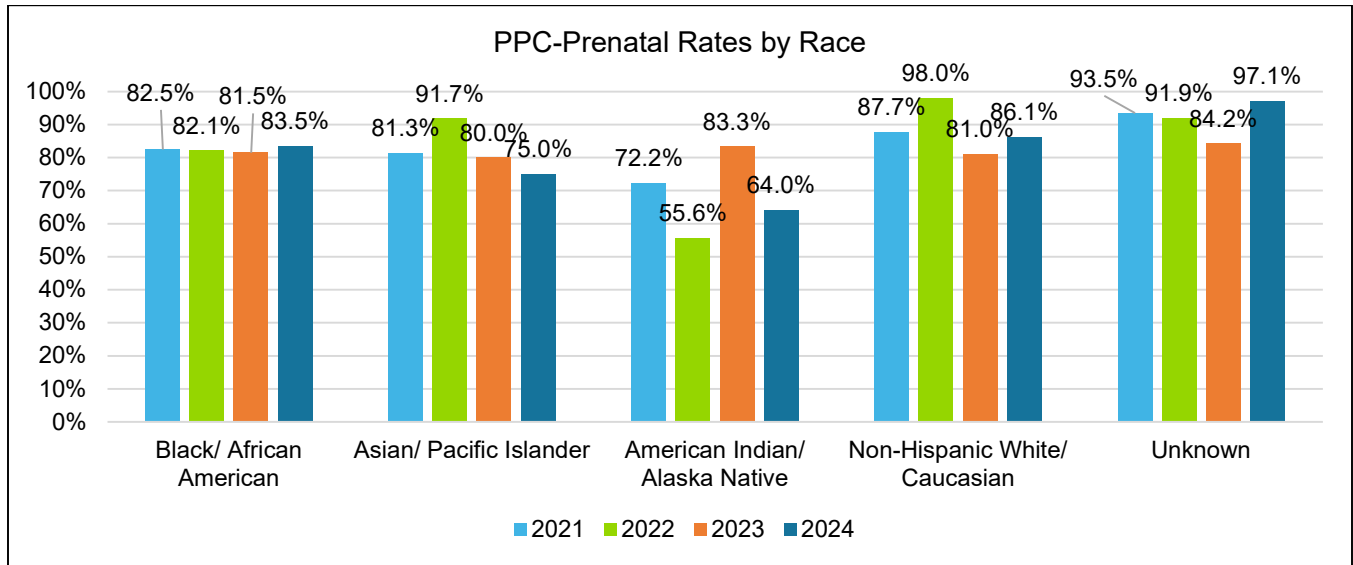
Data Source: Hennepin Health HEDIS® CY2021, CY2022, CY2023, CY2024, Hennepin Health Data Warehouse

PPC-Prenatal

The PPC-Prenatal rate has stayed relatively stable since 2021 (Table 1 above). As illustrated in Figure 4 below, when examining the rate by race, a slight 1% improvement was observed in the Black/African American group (83%: N=96). There were declines in rates for the Asian/Pacific Islander, American Indian/ Alaska Native and Non-Hispanic White/Caucasian groups by 6.3%, 8.2% and 1.6% respectively when compared to the rates in 2021. There were 89 Hispanic and 244 Non-Hispanic ethnic identifying members in the measure. Ninety-four percent of the Hispanic ethnic group and 82% of non-Hispanic members were on track for this measure. The Black/ African American, Asian/ Pacific Islander and American Indian/ Alaska Native groups were found to be disproportionately underrepresented with IDU: 102.16%, IDU:113.71% and IDU: 133.26% respectively. The sample size of each race/ethnic group is small, so no conclusions can be drawn.

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Figure 4. PPC-Prenatal Rates by Race, 2021 - 2024

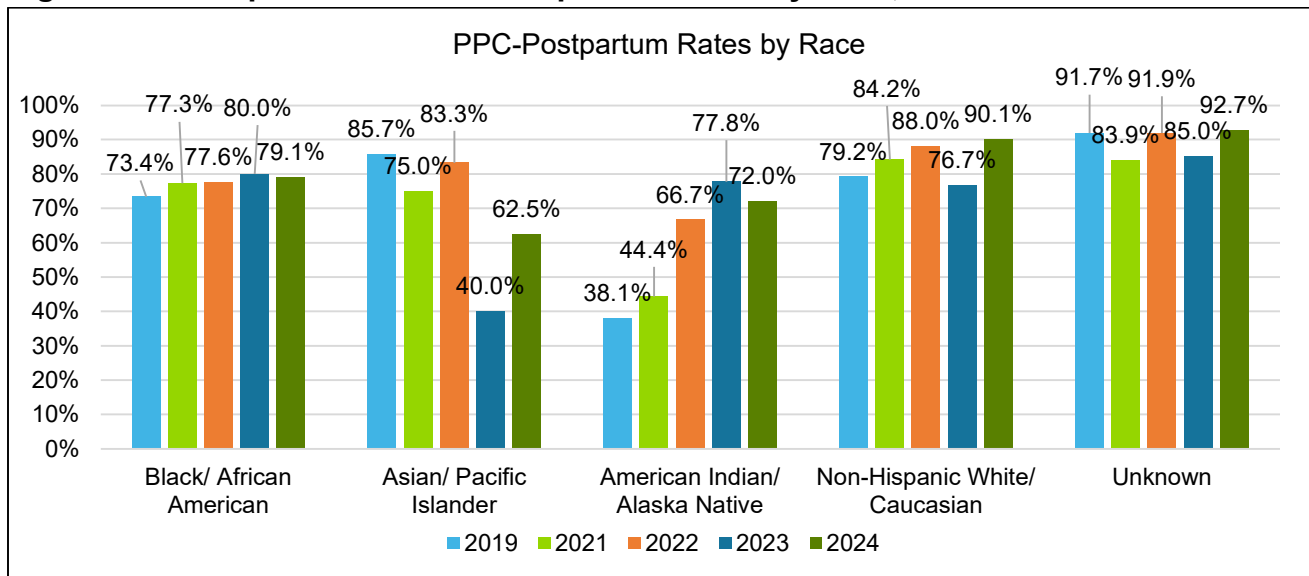


Data Source: Hennepin Health HEDIS® CY 2021, CY2022, CY2023, CY2024 Hennepin Health Data Warehouse

PPC Postpartum

Improved rates were observed for all races except for the Asian/ Pacific Islander group which dropped from 85.7% in 2021 to 62.5% in 2024 (N=5). There were 89 Hispanic and 244 Non-Hispanic ethnic identifying members in the measure. Ninety-three percent of the Hispanic ethnic group and 80% of non-Hispanic members were on track for this measure. The Black/ African American, Asian/ Pacific Islander and American Indian/ Alaska Native groups were found to be the disparity populations with IDU: 105.88%, IDU:134.05% and IDU: 116.37% respectively. The sample size of each race/ethnic group is small, so no conclusions can be drawn.

Figure 5. Hennepin Health PPC-Postpartum Rates by Race, 2021 - 2024



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

Table 2. Healthy Start HEDIS® Sample Sizes by Race and Ethnicity, 2021-2024					
Race	Year	PPC	CIS – Combo-10	W30 – 0-15 Months	W30 – 15-30 Months
Black/ African American	2021	154	74	67	76
	2022	134	88	62	84
	2023	85	24	15	18
	2024	115	61	59	75
Asian/Pacific Islander	2021	16	6	11	7
	2022	12	5	4	5
	2023	10	3	2	3
	2024	8	9	1	2
American Indian/Alaska Native	2021	18	8	11	15
	2022	18	9	6	8
	2023	18	3	2	3
	2024	25	8	6	7
Non-Hispanic White/Caucasian	2021	57	17	18	20
	2022	50	16	24	43
	2023	43	8	2	5
	2024	101	38	29	33
Unknown	2021	31	219	310	278
	2022	86	184	201	171
	2023	187	304	297	161
	2024	69	185	215	148
Total	2021	329	337	462	431
	2022	372	134	303	336
	2023	357	344	319	302
	2024	333	301	316	279

Data Source: Hennepin Health HEDIS® CY 2021, CY2022, CY2023, CY2024, Hennepin Health Data Warehouse

Data Limitation

A data limitation in each measure other than Well Child Visit is the hybrid collection methodology.-Hybrid allows the health plan to use a sample size of 411 to review compliance via medical record abstraction. To maintain PHI, the nurses that abstract from medical records are only given the pieces to prove measure compliance, thus they would not have access to the patient’s race/ethnicity. To address this limitation, our method will be to produce two rates - Hybrid and Administrative. The hybrid rate provides this project with a project goal that is statistically valid. The admin rate provides the opportunity to analyze race and ethnicity as it is reported through the enrollment file (834).

The nature of data relating to pregnancy is a limitation, as well. Rather than being a finite measurable event, such as a screening or a lab test, pregnancies are nearly a year long. 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 potential barrier over the past 3 years of these PIPs has been the hold on, and then the requirement for redetermination of coverage. This process could cause members to be in counties that MCOs may not support, and the changing membership makes it harder to evaluate effectiveness.

All the MCOs agree that collecting data on patient race, ethnicity, and language (REL) is key to reducing health care disparities, as it can help identify and address gaps in quality based on these factors. We have seen more REL data in HEDIS measures and each MCO is trying to get as much of 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.

Barriers and Challenges

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. Barriers made evident during the beginning of the pandemic have persisted and have created additional barriers as the pandemic has waned.

Immunization and well-child barriers - MDH data shows that the percentage of 2-year-old children in Minnesota who are *not* up to date on their vaccinations has increased from 24.5% to 31.8% in 2024. Several circumstances caused by the pandemic and its aftermath are responsible for this decline in complete vaccinations.

- Our youngest members require a higher number of vaccinations to be up to date than other age groups, and once they are behind schedule, it is more difficult to catch up as the delays can cause an overwhelming and confusing backlog in the vaccination timeline.
- Children may not be caught up on childhood vaccinations for a variety of reasons, including a general sense of vaccine hesitancy that has increased during the pandemic. Parents have expressed concerns and hesitancy about vaccine safety as well as necessity. This hesitancy can cause delayed vaccinations or even refusal of all vaccines. Vaccine hesitancy increased during the pandemic and appeared to continue as shown in the decline in the vaccination rates. According to results of the “Healthy Start” survey, many do not believe that vaccines are necessary especially those for influenza or Covid for young children.
- Providers have seen a trend that while children are not meeting the measure by age two, they are 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 are sharing anecdotally that the increased social and political divisiveness experienced nationally related to vaccinations is impacting well-child visit rates, as well.
- Members and providers report that access to appointments is still a problem resulting in delays for time-sensitive measures. These delays have been attributed to staffing issues throughout the healthcare system and persistent and systemic staff turnover.
- Access to telehealth appointments largely relies on reliable technology and, for many of our members, access to interpreter services. Neither of those variables are always

available, making the telehealth appointments less accessible. Additionally, while telehealth visits can be appropriate for some care, they are generally not acceptable for well-child visits due to the developmental screening and other screenings that must be included in the visits.

- Transportation to appointments is an ongoing barrier. While transportation is available, many members are not aware of the service, and access to the service in rural areas is particularly challenging. In addition, issues with the reliability of taxicab services may cause delays in drop-offs at appointments, potentially leading to appointment cancellation.
- Lack of appointment availability outside of regular business hours as a barrier to keeping current on well-child checks, as well, as parents/ guardians who cannot get off work for appointments.
- Childcare is a barrier to clinical care that persists across our population.
- Many people polled in the survey have shown a low to moderate barrier for lack of trust or culturally appropriate care.

Maternal Health Barriers – There can be many real or perceived barriers for receiving early prenatal care and postpartum care, such as:

- When someone finds out they are pregnant, they may delay starting prenatal care if they do not have insurance because of fears of the costs of care. The process for applying for and enrolling in Medicaid can be confusing and lengthy, further delaying care.
- Personal, familial, or cultural beliefs or priorities may place less value on early prenatal care or on postpartum care. Subsequent pregnancies may also 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 can make it difficult to get care that is accessible to fit into work schedules.
- Barriers from the “Healthy Start” survey include lack of childcare, fear of exposure to illness, and lack of comfort with the healthcare system or provider.
- Postpartum can be a challenging time physically, mentally, and emotionally and care for the infant is often prioritized over the postpartum person’s health care. Other barriers found from the survey for postpartum care include not being able to get time off work and transportation issues.
- Social factors impacting decisions to seek care could include indecision over plans for pregnancy, a lack of support system, chemical use and fear of ‘system’ involvement, and other social drives of health such as food and housing security may take precedence over prioritizing prenatal or postpartum health care.

Provider Trust - An additional barrier that cannot be overlooked for all these issues is the members' experience with the healthcare system. People of color routinely report unease with the healthcare system due to past experiences of 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, and sometimes, their own childhood experiences of being removed from their families.

Doula Support - Regarding barriers for our pregnant members, we have heard from the doula community that access to culturally reflective doulas and awareness of doulas continues to be a barrier. This is a barrier the Collaborative has made a priority to address and has made considerable progress on, 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 has proved cumbersome and complicated requiring them to obtain their own Unique Minnesota Provider Numbers (UMPI). Along with those barriers, doulas must also have contracts with all the MCOs to serve our members. This administrative process is yet another barrier. Doula providers have a unique ability to increase the accessibility of health care to our members, however, these identified barriers are hindering them from providing much needed care.

Organizations that employ doulas report 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 providing support, and when the claim for those services is paid so the doula receives their salary.

Feedback from the Community Baby Shower listening sessions on Doula services included that “pregnant individuals consistently shared how their experience with doula services added a great value to their pregnancy journey”. Many mothers/ pregnant people, who did not receive doula services during their first pregnancies but did in their subsequent pregnancies saw a drastic improvement in care as advocacy from the doula enabled them to be more competent about their prenatal care options and have more autonomy in their health care decisions. Additionally, a participant mentioned that the support of her doula was “indispensable” during the birthing process. The birth plan that she had discussed with her doula was implemented exactly as planned which made labor a pleasant experience. It was iterated multiple times how important it was for pregnant individuals to have someone understand their needs and advocate for them. The impact of doula support extends beyond prenatal care and childbirth as many received community and health plan resource information from their doula in which they would have never known was available to them. Overall, it can be easily concluded that doulas have been the most helpful throughout their pregnancy which is why it is essential for the MCO Collaborative to continue to advocate for doulas and eliminate barriers that hinder the provision of this service³.”

Process Barriers

As noted above, the ability to access accurate translated material for members who speak languages other than English is a barrier. The process of validating the quality of translated materials creates delays in getting the information out to members. In some cases, we have seen translations that appear to use ‘Google Translate’ rather than qualified medical translators. This concern has necessitated the implementation of local review processes that are both time consuming and costly, but that are necessary to ensure members receive accurate, culturally relevant information.

³ [Health Plan Performance Improvement Plan \(PIP\) Team - Baby Shower Event - All Documents](#)

As described in the methods section, the nature of pregnancy related data is a challenge, but not only from a methodological perspective. Because pregnancies are long events of nearly a year in length when accounting for the postpartum period, acquiring data and attributing it to interventions happen over a longer period. This makes the process of evaluating whether to continue or modify our interventions more difficult.

Another significant barrier is members' experience with the health care system. People of color often feel uneasy due to past experiences of disrespect or mistreatment, affecting their likelihood to seek prenatal, postpartum, and preventive care for their children.

MCO Interventions

Hennepin Health implemented interventions to support its goals of improving birth outcomes, maternal and child health. Despite ongoing financial resource considerations, we continue to explore the idea of employing a pregnancy support navigator (a Community Health Worker position) to assist our pregnant members in accessing available supports. In the meantime, we are considering interdepartmental strategies to support this role with current staff. Hennepin Health continued with implementation of the non-HEDIS® claims-based of *low-birth-weight babies and/or babies requiring neonatal intensive care (LBW/IC)* (Confidential data). The second non-HEDIS measure of *referrals to Hennepin County’s Family Home Visiting (FHV) program*.

Family Home Visiting (FHV) Program Referrals

Following the termination of Hennepin Healthcare’s MVNA contract in 2022, the provision of FHV services transitioned to Hennepin County Public Health to enhance and support referrals to the county’s FHV Program, effective January 1st, 2023. By 2024, Public Health’s role was solidified. Hennepin Health began its collaboration with Public Health to increase referrals to the FHV program, aiming to achieve better health outcomes for members.

To increase referrals, Hennepin Health launched interventions at different levels in 2024. At the level of the health plan, the following initiatives were implemented:

- i. Prenatal and Postpartum Mailer packets – Hennepin Health continued its outreach mailer to new parents and launched a prenatal mailer packet for pregnant people. The packets provide prenatal and postpartum support resources. Informational flyers about the FHV program were included in the packet which also provided prenatal and postpartum support resources, newborn care information, childhood immunizations information, and earning rewards for preventive care (e.g. postpartum care visits, cervical cancer screening, and well-child visits). Table 3 below illustrates increases in rewards program incentives and infant car seats issued to members for some services relevant to the PIP.

Table 3. Rewards Program Incentives and Infant Car Seats: 2023 - 2024		
Incentives	2023	2024
Prenatal Care Visits	13	18
Postpartum Care Visits	17	27
Child and Teen-Checkups visits by 15 months and 15-30 months	12	6
Childhood Immunizations	3	2
Car Seats	153	192

Data Source: Hennepin Health QM Department Tracking; Essette®

- ii. Website Promotions – FHV information and referral information was posted on Hennepin Health’s maternal and child health webpages. A provider bulletin was prepared which highlighted the FHV resource to the attention of providers who care for Hennepin Health members.
- iii. Education – Hennepin Health’s Social Navigation team was educated about the FHV program so eligible members to the program can be referred.

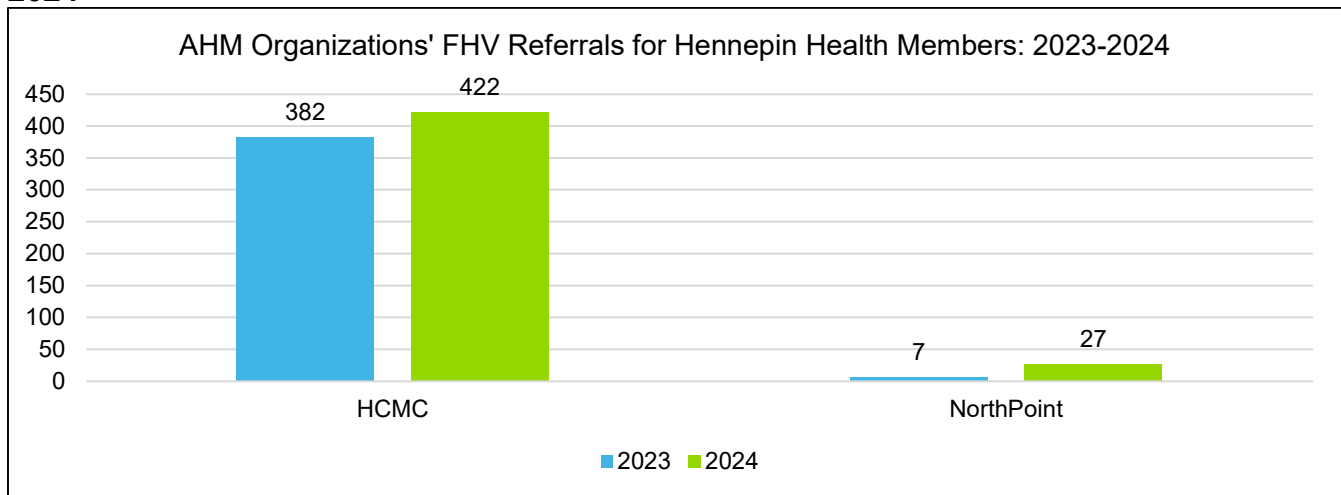
The FHV program was also promoted at the Accountable Health Model (AHM) partner organizations. Through the platform of the Hennepin Health Maternal/Perinatal Clinical Priority (MPCP) workgroup, the FHV program was discussed with the goal to identifying mechanisms to increase referrals within the AHM. Discussion about the program was facilitated by Meredith O’Brien, Hennepin County Family Health Area Manager, who also is a member at the MPCP Workgroup. The MPCP is informed of FHV referrals trends for Hennepin Health members. Table 4 below provides an overview of AHM partner organizations referrals to the FHV program across all MCOs from 2023 to 2024. Figure 6 illustrates an increase in FHV referral rates for Hennepin Health members at Hennepin Healthcare by 10.5% and at NorthPoint by 285.7% when compared to the rates in 2023.

Table 4. Accountable Health Model (AHM) Organizations Referrals to the FHV Program 2023 - 2024

Organization	2023	2024
Hennepin Healthcare	710	2,849
NorthPoint	62	192

Data Source: Hennepin County Public Health

Figure 6. Referral of Hennepin Health Members from AHM Partner Organizations, 2023-2024



Data Source: Hennepin County Public Health

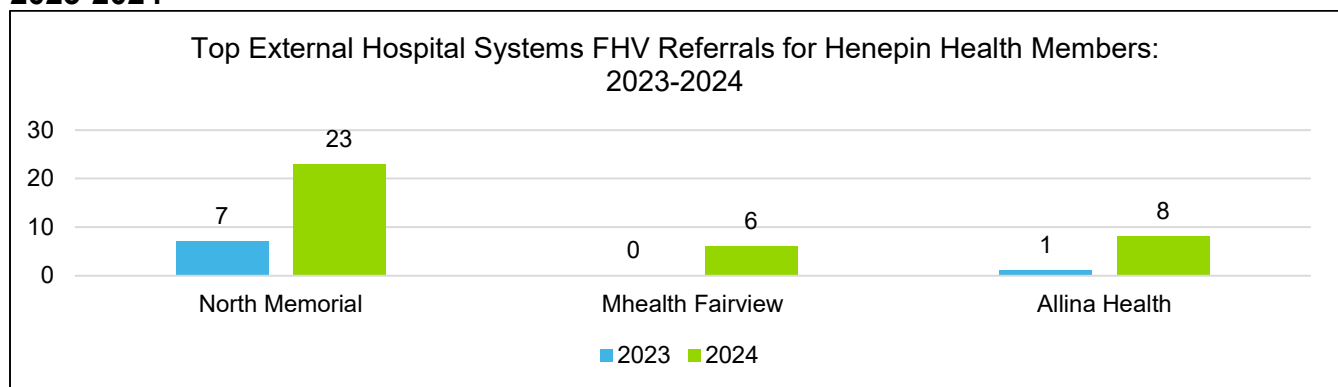
Additionally, Hennepin Health reached out to key external hospital systems that our members use for their care to ensure that they also have access to FHV program resources. The top hospital systems identified through a pareto analysis were Allina Health, North Memorial and M Health Fairview. Meetings were held with these systems to discuss the FHV program as well as other resources they may have for families and children they care for. The objective was to connect these systems with Hennepin County Public Health so that the providers were educated about the program and would send referrals to the program. Table 5 below provides an overview of the top external hospital systems referrals to the FHV program across all MCOs

from 2023 to 2024. Figure 7 below illustrates referral trends (2023-2024) of Hennepin Health members across the top 3 external hospital systems that care for Hennepin Health members. Although the numbers are very small, there was a noticeable increase in members referred to the FHV program across these external systems.

Table 5. External Hospital Systems Referrals to the FHV Program 2023 - 2024		
Organization	2023	2024
Allina Health	43	82
M Health Fairview	32	62
North Memorial	213	232

Data Source: Hennepin County Public Health

Figure 7. Top External Hospital Systems FHV Referrals for Hennepin Health Members: 2023-2024



Data Source: Hennepin County Public Health

An analysis of Hennepin Health member referrals to the FHV program was completed on a quarterly basis in 2024 (see Table 8). In summary, the pregnant population among Hennepin Health members increased from 373 in 2023 to 436 in 2024. Out of these totals, 68 (18%) and 159 (36%) were referred to the FHV program in 2023 and 2024 respectively. While data was not available to verify the number of people who enrolled into an FHV program after the referral in 2023, there were 114 out of the 159 referred members who were enrolled in the FHV programs 2024 (72% referred). Table 6 below displays referral and FHV program enrollment data for Hennepin Health members. Please note that some members enrolled in more than one program; therefore, the sum of enrollments on the graph may not equal the number of members enrolled.

Table 6. FHV Referrals and Program Enrollments by Race and Ethnicity 2024		
Race / Ethnicity	Referral	Enrollment
American Indian/Native American	3	2
Asian/Pacific Islander	4	4
Black/African American	50	36
Hispanic	82	73
White/Caucasian	10	4
Unknown	8	1

Data Source: Hennepin County Public Health

An IDU analysis was completed for members who were referred and those who enrolled into the FHV program. The disparity populations in this category were the Black/African American (IDU106.57%), the American Indian IDU 115.09%), and the White/Caucasian (IDU 191.82%).

Intervention Tracking Measures (ITMs)

DHS mandated MCOs to develop ITMs as a mechanism to assess implementation and effectiveness of interventions through regular tracking. While the ITM strategy is expected to evolve over the course of the PIP cycle, Hennepin Health piloted the strategy with three key measures for prenatal care, postpartum care and CIS Combo-10 immunizations. The purpose of the ITMs is to improve the performance rates through implementing small tests of change which are adjusted, adopted or abandoned for alternative tactics until improvement is achieved. The ITMs tracking was restricted to Hennepin Health members who receive care from Hennepin Healthcare and NorthPoint. The reported data is obtained from claims and Hennepin Healthcare’s EPIC® system.

Table 7 below provides an overview of the ITM rates whose tracking started in the 2nd quarter.

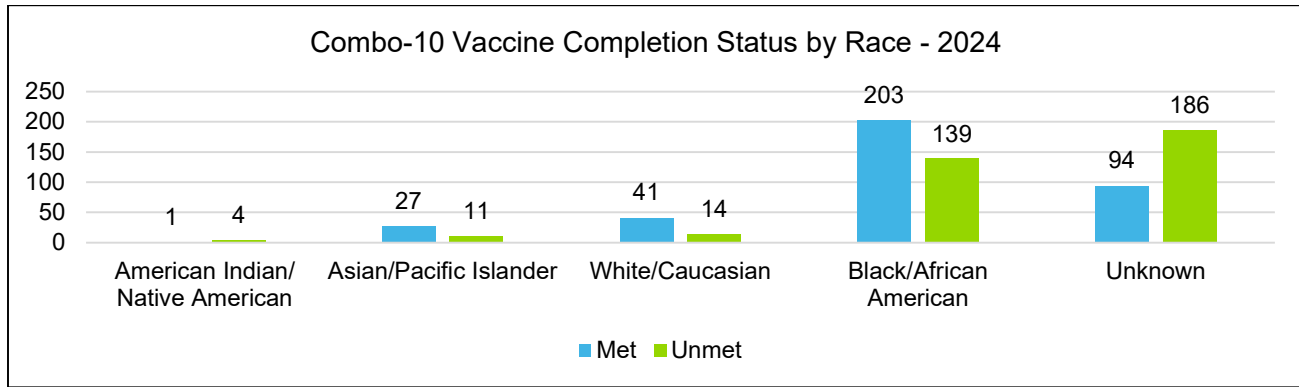
Table 7. Interim Tracking Measures - 2024					
Measure	Quarterly %				Cumulative %
Description	Q1	Q2	Q3	Q4	2024
Improving CIS Combo-10 Immunization Rates Measuring number of lagging Hennepin Health members (0-2 yrs old) who get caught up with Combo-10 vaccinations	NA	54%	69.4%	66%	63%
Improving Prenatal Care Visit Rates Measuring number of Hennepin Health pregnant members who receive at least one prenatal care visit in their first trimester, on or before the enrollment start date or within 42 days of enrollment	NA	48%	72%	70%	67%
Improving Postpartum Care Visit Rates Measuring the number Hennepin Health newborn parents who fulfilled their postpartum care visits on or between 7-and-84 days following delivery of baby.	NA	97%	100%	95%	97%

Data Source: Hennepin Health Data Warehouse

CIS Combo-10 ITMs

This ITM addresses the low rates of 0–2-year-olds who are on schedule with their recommended childhood vaccinations. Hennepin Health initiated a collaboration with Hennepin Healthcare’s Pediatric Mobile Clinic to implement a telephone outreach to their patients who are Hennepin Health members and not on schedule with their Combo-10 immunizations. This initiative was launched in April of 2024. Over the three quarters that this ITM was implemented, 1,236 member records were reviewed by the Mobile Clinic staff and outreach was conducted to set members up with in-clinic appointments or mobile clinic visits to ensure they are up to date with their vaccines. Sixty-three percent of members who were targeted for the outreach met their Combo-10 immunization goals. Thirty-eight mobile clinic runs, and 85 scheduled appointments were completed for Hennepin Health members in 2024. Figure 8 below illustrates vaccine completion status by race. The graph data on the graph excludes people who identified as “multiracial”. There were 90 ethnic Hispanic identifying people. The Black/African American and American Indian/Native American populations constituted IDUs of 106.32% and 315.53% respectively; therefore, found to be the disparity populations.

Figure 8. Combo-10 Vaccine Completion Status by Race 2024

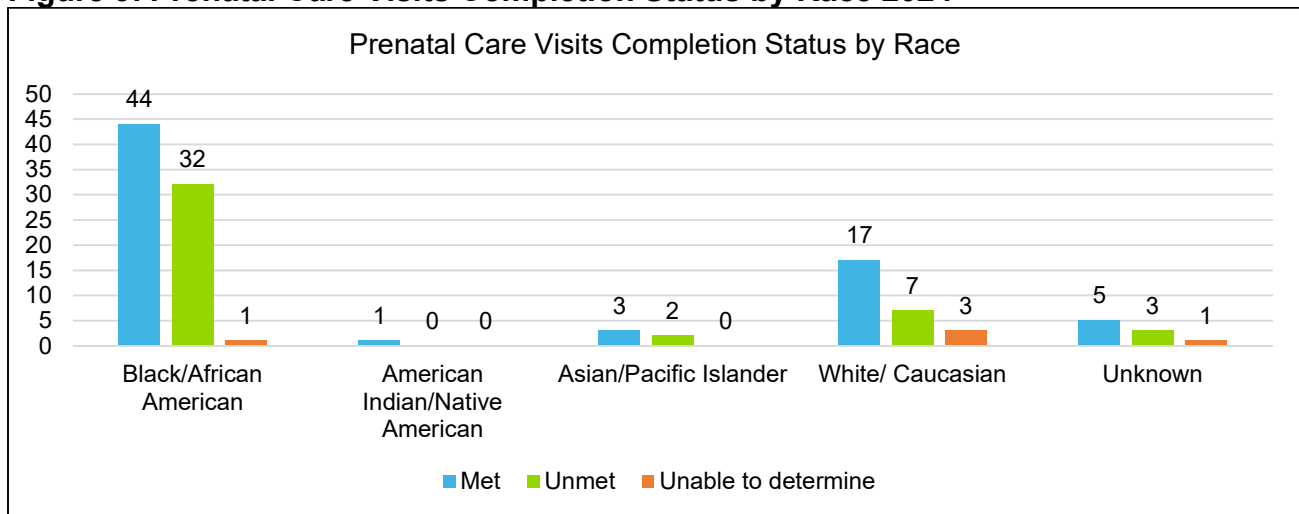


Data source: Hennepin Health Data Warehouse

Prenatal Care Visits ITM

The second ITM focused on improving prenatal care visit rates for Hennepin Health members. The measure tracks the number of Hennepin Health members who receive at least one prenatal care visit in their first trimester, on or before the enrollment start date or within 42 days of enrollment with Hennepin Health. Prenatal care codes were pulled on a claims report, and records of eligible members were reviewed in Epic® to determine compliance with this measure. In total, 217 eligible member records were reviewed, of which 67% met the requirement for their first trimester prenatal care visit. Figure 9 below illustrates Prenatal Care Visits completion status by race. The data on the graph excludes people who identified as “multiracial”. There were 91 ethnic Hispanic identifying people. The Black/African American, Asian/Pacific Islander and White/Caucasian populations constituted IDUs of 116.94%, 111.37% and 106.13% respectively, and therefore, were found to be the disparity populations.

Figure 9. Prenatal Care Visits Completion Status by Race 2024



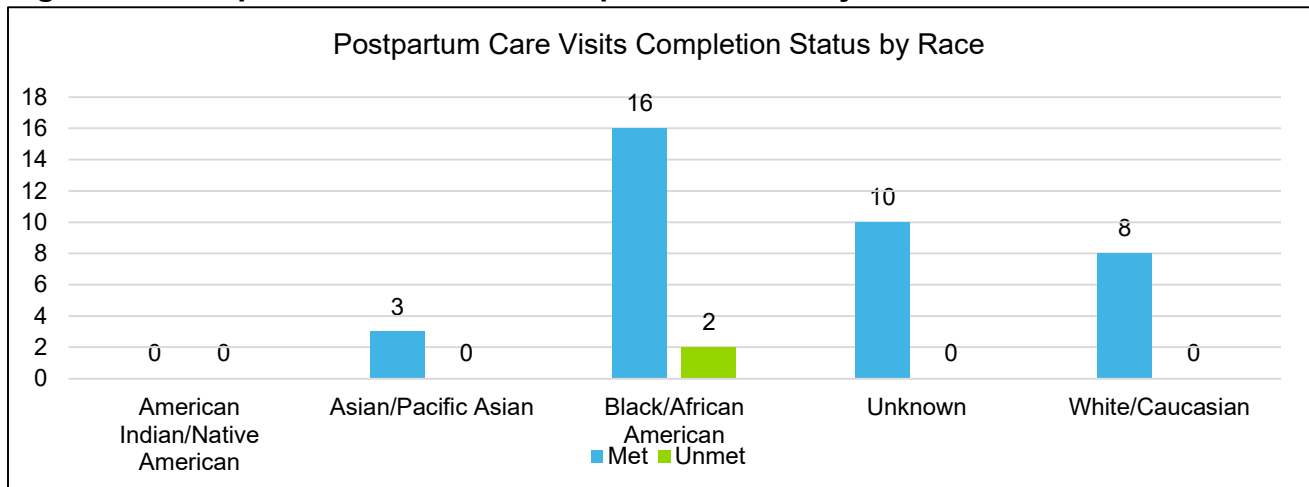
Data Source: Hennepin Health Data Warehouse

Postpartum Care Visits ITM

The third ITM aimed at improving postpartum care visit rates, measures the number of Hennepin Health newborn parents who completed their postpartum care visits on or between 7-and-84 days following delivery of their baby. Postpartum care codes were obtained per the claims report, and records of eligible members were reviewed in Epic® to determine compliance with this measure. A total of 68 unique records were reviewed, of which 97% had postpartum care visits. Figure 10 below illustrates Postpartum Care Visits completion status by race. The data on the graph excludes people who identified as “multiracial”. There were 27

ethnic Hispanic identifying people. The Black/African American population constituted an IDU of 109.19%; therefore, was found to be the disparity population.

Figure 10. Postpartum Care Visits Completion Status by Race 2024



Data Source: Hennepin Health Data Warehouse

Community Engagement

Maternal Health Screening

Hennepin Health continues to receive member feedback through the New Enrollee Screening (NES) which addresses a wide area of care topics including maternal and child health. The survey also assesses social drivers of health. As of the time of writing this report, a comprehensive maternal health assessment is being developed, using the NES document as the basis for this document. Plans are to have a member of the Social Services Navigation team reach out to pregnant members for additional assessment to see if more resources and support are needed for their prenatal, postpartum and child health care needs.

Member Newsletter

The bi-monthly member newsletter continued to be a vehicle for providing members with information and resources for prenatal care, postpartum care and childhood health care needs. The October 2024 edition of the newsletter featured the collaboration of Hennepin Health and Hennepin Healthcare’s Pediatric Mobile Clinic to take health care services to the doorsteps of our members. Other topics included rewards provided for preventive care such as cervical cancer screening, colorectal cancer screening and mammograms.

Hennepin Health Wellness Day

Hennepin Health organized its maiden Wellness Day event in October 2024 which provided the opportunity for members to access care and resources, discuss their health concerns with staff and providers, and learn about incentives for preventive health care services. The second edition of the event is scheduled for June 2025, and one is in the plans for the fall season. Hennepin health plans to make the Wellness Day an event where engagement is optimized and member feedback solicited for provision of better services meeting their needs.

Enrollee Advisory Council

The Enrollee Advisory Council (EAC) quarterly meetings continue to be used as a platform to engage our members. Through these meetings in 2024, public health information highlights and resources were brought to members, topics discussed, and feedback obtained from members to guide the next steps. For instance, the proposed Maternal Health Screening tool

was discussed at the EAC and members provided feedback which resulted in inclusion of member identified questions. Health incentives were also shared at the meetings.

Member Survey

Hennepin Health conducted a member survey in the fall of 2024 as a follow up to the previous member survey implemented in 2022. The survey is used as a tool to identify the needs of members and how best Hennepin Health can meet member needs. The 2024 survey centered on key issues identified in the previous survey and included an assessment of member satisfaction with transportation options provided by the plan, which is a crosscutting issue. Fifty percent of survey respondents reported that they were somewhat satisfied or extremely satisfied with transportation services. Hennepin Health will continue to address the members' needs identified in these surveys.

Collaborative Interventions and Measures of Success

The Collaborative 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. Additionally, the MCO-specific initiatives are developed with an MCO's specific resources and membership as focus.

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 webinars are recorded and are available for viewing on the [Stratis Health website](#).

Webinars presented in 2024 were:

- *Maternal Health and Inclusive Communication- 8/6/24*
Presented by Haley Brickner, Health Equity Coordinator of the Minnesota Medical Association.
This webinar addressed inclusive communication to ensure that all expecting and new parents receive respectful and comprehensive care. The webinar provided participants with valuable knowledge and tools to address health disparities and foster a supportive environment with enhanced communication skills.
- *Well Child Checks: Growth, Development, and Safety, Oh My! - 11/23/24*
Presented by Krishnan Subrahmanian, MD, MPhil, FAAP. This webinar provided an overview of screening and intervening in a child's developmental progress.

Tools and Resources

The Collaborative, in partnership with the Minnesota Council of Health Plans (MCHP), created an educational blog about the importance of well child visits and immunizations, [A Reminder from your Healthcare Provider: Come back to get caught up](#). This educational resource directed at families with young children was posted on the MCHP site in December 2022 in English with an accompanying voice recording to address concerns of health literacy.

Additionally, the content was translated into Spanish, Somali, and Hmong in 2023. Concerns over the quality of the initial translations caused a delay in the publication of this information for these communities. The Collaborative had the vendor translations reviewed for accuracy by native-speaking plan employees and worked with the vendor to make the needed changes. In the case of the Somali materials, internal medical interpreter staff re-translated the materials so it would be understandable to that community. Multiple dialects make it difficult to

universally translate some languages, but reviews by native speakers found the translations to be of high quality. The translated blog and voice recordings were posted as they became available in the spring of 2023.

This resource continues to be made available on MHCP’s webpage as an educational resource for families with young children. The Collaborative has also posted a link to the resource on the [Healthy Start PIP project page](#). Each plan publicized the blog through various channels including member newsletters and sharing with clinic partners, especially those serving a diverse patient population. This project with MCHP highlighted opportunities for continued efforts with partners across the state to support the dissemination of the resource.

Community Partnerships

Since the beginning of this PIP, the Collaborative has had discussions with several groups who were interested in collaborating 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 PIP and have proven vital to the PIP in identifying community needs and interventions. The partnerships have resulted in several webinars that have furthered relevant knowledge for our shared providers, as well as statewide policy changes that improved access to doula care. A list of the guests we have hosted for discussion on strengthening our PIP work is included in the table below and is followed by a description of some community-based partnerships the Collaborative has focused on.

The Collaborative hosted guests in 2024 to strengthen our PIP work. See Table 8 below.

Table 8. Guests Hosted at the Collaborative Platform - 2024		
Name	Organization	Date
Megan Warfield Kimball	DHS	2/1/24, 8/1/24
Shawn Holmes	MDH – Help Me Connect	3/7/24, 11/7/24
Savannah Riddle and Anne Walaszek	MDH – IMOMS	3/21/24
Juliana Milhofer	MMA (MN Medical Association)	4/18/24
Corenia Smith and Olivia Mastry	Birth Justice Collaborative	5/16/24
Louise Matson	MN Division of Indian Work	5/16/24
Ruth Buffalo	MN Indian Women’s Resource Center	5/16/24
Haley Brickner	MMA (MN Medical Association)	6/20/24
Alec Wagner	MDH Immunization – Community Action Duluth	9/19/24
Sheyanga Beecher	Hennepin Healthcare’s Pediatric Mobile Clinic	10/3/24
Karina Kelton	Raices Latina	10/17/24
Ellen Jirik	NorthPoint Health and Wellness Center	11/21/24
Ryan Davenport	MHCP	11/21/24, 12/5/24, 12/19/24
Amanda Axvig	612 Social	11/21/24, 12/5/24, 12/19/24

Data Source: Collaborative Healthy Start 2.0 PIP

Minnesota Department of Health- IMOMS and Help Me Connect are initiatives of the Minnesota Department of Health (MDH) focused on improving maternal and infant health outcomes. IMOMS works to align perinatal health initiatives, strengthen data infrastructure, and implement quality improvement strategies. The Collaborative has engaged with IMOMS to support community-driven efforts addressing disparities in Black, American Indian, immigrant, refugee, and rural communities. Help Me Connect is a free online navigation resource that connects expectant and parenting families with essential local services, including health care, housing, childcare, and mental health resources. Since its launch in 2021, the platform has provided access to over 14,500 programs statewide. The Collaborative continues to engage with Help Me Connect to ensure families and providers can efficiently access the support they need.

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. The services include birth education, lactation support, prenatal yoga, and birth doula support. The Collaborative 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 pregnant people. The Collaborative will maintain and continue to leverage this relationship to improve services for our members.

Birth Justice Collaborative (BJC) – The Birth Justice Collaborative (BJC) aims to advance maternal health and birth justice for African American and American/Native Indian communities through community engagement and systemic changes. BJC's strategies focus on addressing racism, investing in community resources, enforcing anti-bias systems, and advocating for policy reforms. The Collaborative has had ongoing conversations with BJC about how we can support and amplify their work, especially in improving maternal and infant health outcomes.

Minnesota Medical Association (MMA) – The MMA is Minnesota's oldest and largest professional association for physicians and physicians-in-training. The Collaborative and the MMA share the urgent goal of improving immunization rates for children, ideally to rates that surpass pre-COVID-19 pandemic numbers. The Collaborative has initiated discussions about a potential partnership with the MMA.

County Partnerships

Regional Child and Teen Check-up – (C&TC) groups- Each part of the state has a group that consist 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, as well as attending the relevant regional C&TC group meetings depending on their service area. In 2022, responsibility for some C&TC outreach shifted to participating in Integrated Health Partnership (IHP) clinics. IHPs have now established their outreach systems and several IHPs attend the C&TC meetings. The Collaborative works with all parties to facilitate C&TC outreach to our members and will continue to do so going forward.

Birth Equity Community Council (BECC) – BECC is a Ramsey County led initiative to support birth equity for communities of color in the metro area. BECC has three primary focus areas to support this goal - policy, training, and celebrations, and has subcommittees for each of the areas. Members of the collaborative have participated in these subcommittees. For example, BECC teams worked with community partners to offer training related to birth equity and the Collaborative members have shared the trainings with our provider networks and other partners. Collaborative members have worked with the BECC policy committee to problem-

solve issues for community-based and BIPOC doulas. The Celebrations committee has sponsored community baby showers and other events for the Club Mom and Club Dad participants and Collaborative members have supported these events. The Collaborative looks forward to continuing the partnership and considers it an element of our community engagement perspective going forward into the next PIP cycle. Although BECC is a Ramsey County initiative, it is directed by BIPOC leaders and birth workers and brings in laypeople from the community to be active participants and decision makers in the strategic planning process. BECC's effects in improving the birth experience of BIPOC birthing people in Minnesota cannot be overstated and the Collaborative is proud to be BECC's partner and supporter.

In addition to these partnerships for 2024, the Collaborative has continued to build on its work into 2025, furthering the goals of the Healthy Start PIP.

Community Informed Measurement

As directed by DHS, in May 2023, the Collaborative started incorporating *community-informed measures* into the PIP processes for both PMAP and MinnesotaCare members. Specifically, DHS tasked the MCOs with collecting member input on their interactions with the health care system and developing community informed measures for the PIP while recognizing that such work takes time and has not been previously attempted in the context of the PIPs.⁴ During the PIP planning process, the Collaborative researched different existing methodologies for community engagement and used the findings to develop a guiding philosophy on how to incorporate this new aspect into the work.

Overall, the idea of community-informed measurement is having groups of people most negatively impacted by structural inequities help identify, design, and validate a metric of quality that can be considered in implementing into the overall health care quality improvement cycle.

Each health plan understands that directly consulting with various marginalized member communities will help us understand what matters the most for their pregnancy care and for their children's healthy start in life. The Collaborative developed questions that can be used in many settings/methods with plans to aggregate the results as a Collaborative to identify patterns of barriers and/or successes that can be applied broadly.

By late 2023, the Collaborative started exploring community engagement opportunities through potential partner discussions at the platform level. Questions around community engagement were incorporated into discussions with all guests, offering insights into how they leveraged member inputs to define their work and meet community. The dialogue aimed to provide the Collaborative more guidance in streamlining community informed measurements in the PIP work.

In May 2024, the Collaborative held its first community listening session in partnership with Everyday Miracles during a Baby Shower event, where pregnant people and new parents shared their experiences and challenges regarding health care and health equity. Feedback from the 16 participants highlighted the main factors influencing the choice and access of prenatal care providers included:

- Insurance status.
- Provider stability.

⁴ Presentation by Dr. Mark Foresman at the May 23rd, 2023, Quarterly Workgroup Meeting.

- Understanding of the importance of prenatal care.
- Delay in confirmation of pregnancy.
- Provider communication.

Some barriers that prevented members from getting timely and quality care included:

- The complexity of health insurance.
- Outdated equipment at clinics, affecting timely confirmation of pregnancies.
- Use of technical terminologies.
- Lack of information.

Participants reported learning about doulas through their insurance, medical providers, and other programs, highlighting the role and benefits of doulas in pregnancy and delivery. They recognized doulas as vital for advocacy, education, and resource navigation. Participants felt more prepared, empowered, and heard with a doula at their side. The support extended beyond prenatal care and childbirth, providing access to community and health plan resources they would not have known about otherwise.

Participants also discussed the importance of postpartum care for their physical and mental health and appreciated the home visits and education classes they received. Some challenges they faced were fear of postpartum depression, lack of knowledge about what to expect or do, and difficulty accessing resources.

The following recommendations emerged from the session.

- Members reaching out to MNSure navigators for insurance help.
- MCOs coordinating communication between different insurance plans to minimize member confusion.
- MCOs providing more education and outreach about health plan benefits and incentives.
- Providers using MyChart to share resources.
- Providers respecting the individual choices and preferences of birthing people.

The Collaborative began exploring opportunities identified from the listening session to meet member needs. These included educational interventions such as a webinar on *Inclusive Communication* which focused on improving provider-community communication through a health equity lens. Through continued partnerships with leading institutions like Birth Equity Community Council (BECC) and Birth Justice Collaborative (BJC), the Collaborative championed respect for birthing people's choices by promoting doula services. Individual MCOs also enhanced outreach efforts, providing the members with additional information about health plan benefits and incentives.

In the summer of 2024, the Collaborative launched a community survey to better understand the experiences and barriers of pregnant people in accessing timely health care. The target group included professionals working within systems that serve birthing populations and young children aged 0-5. The plan was to analyze the responses to identify challenges and shape interventions aimed at improving health outcomes and reducing disparities for low-income Minnesotans.

In total, 81 respondents completed the survey, 75% of whom identified as Black/ African American, 44% Native American or Alaska Native, 49% Asian, 24% Native Hawaiian or Pacific

Islander, 90% White and the race of 25% respondents were not identified. While 88% of respondents served the pre- and post-partum population, approximately 79% of them served young children. Respondents came from different settings such as Counties (46%), Clinics (36%), Health Plans (6%), Community Non-Profits (9%), State agencies (2%), and independent contractors (1%).

The highest rated barriers to receiving prenatal care were as follows:

- Transportation issues (54%)
- Fear of getting care due to lack of insurance coverage (46%)
- Lack of childcare (45%)
- Lack of trust or culturally appropriate care (36%)
- Lack of comfort with the health care system or provider (29%)

The highest rated barriers to maintaining ongoing prenatal care beyond the first trimester were as follows:

- Transportation issues (51%)
- Lack of childcare (43%)
- Lack of trust or culturally appropriate care (34%)
- Lack of comfort with the health care system or provider (29%)
- Fear of getting care due to lack of insurance coverage (26%)
- Inability to get off work (17%)

The highest rated barriers to receiving post-partum care were as follows:

- Transportation issues (48%)
- Lack of childcare (44%)
- Fear of getting care due to lack of coverage (30%)
- Does not think care/ appointment are necessary (30%)
- Lack of comfort with the health care system or provider (24%)
- Lack of trust or culturally appropriate care (30%)
- Inability to get off work (17%)

The highest rated barriers for children receiving well-child visits in the first 30 months of life were as follows:

- Transportation issues (52%)
- Inability to get off work (34%)
- Lack of trust or culturally appropriate care (28%)
- Lack of comfort with the health care system or provider (23%)
- Fear of getting care due to lack of coverage (21%)

The highest rated barriers for children receiving immunizations by age two were as follows:

- Transportation issues (43%)
- Does not think vaccines are necessary (35%)
- Lack of comfort with the health care system or provider (35%)
- Lack of trust or culturally appropriate care (35%)
- Inability to get off work (28%)

- Fear of getting care due to lack of coverage (19%)

Transportation consistently emerged as the top barrier across all indicators. The perception that postpartum care and immunizations lack importance highlights a need for better education on these topics. The difficulty in taking time off work and finding childcare impedes access to prenatal and postpartum care. The need for culturally appropriate care is emphasized, aligning with the appreciation expressed during the listening sessions for doula support.

Survey feedback showed that key strategies and resources helping clients overcome care barriers included education, reassurance, listening, personal contact, reminders, incentives, trust building, and flexibility. Offering care in alternative settings, providing rides, addressing vaccine hesitancy, navigating public transportation, finding resources, accommodating late arrivals at appointments, and utilizing community health workers were also impactful. Equally important were strategies like patient-clinician bonding, identifying social drivers of health (SDOH) barriers, insurance navigation, having providers and interpreters of color, and offering evening or weekend appointments.

For other benefits and resources that health plans could offer to help individuals/families overcome perceived barriers, respondents highlighted the following:

- Quicker and easier insurance approval and coverage, especially for dental care and postpartum care.
- Transportation, such as same-day rides, Uber or Lyft vouchers, or mobile vaccine units.
- Financial incentives, such as gift cards, stipends, or vouchers, for attending preventive care appointments.
- Culturally appropriate and bilingual providers, staff, interpreters, and community health workers who can build trust, understand values, and provide education.
- Flexible and convenient appointment times, such as evening or weekend slots, and alternative care settings, such as home visits or telehealth.
- More public health education and outreach on the importance and safety of vaccinations, pregnancy and postpartum care, and other preventive care services.

Survey feedback also highlighted challenges with insurance coverage, application processing, and affordability of care; limitations of self-reported data from health care workers rather than patients; the differences and complexities of various Medicaid Assistance plans and providers; and barriers of transportation, fear of Child Protective Services, and lack of social support. Respondents emphasized the importance of public health education and outreach on various topics related to maternal and child health, and benefits of incentives, home visits, telehealth, and doula services.

During meetings with the Metro Action Group (MAG), county Child and Teen Check-up (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 the geographic area. This barrier greatly impacts the expanding immigrant communities in rural areas.

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Next Steps

As we move forward in 2025, we continue to focus on maintaining and expanding the community partnerships. These partnerships contribute to the development and delivery of educational webinars and tools, and support increasing member utilization of community resources such as doula services, immunizations and childhood development. In addition, we will continue community engagement that could inform a shared measurement and associated activities. Below are examples of how these partnerships have already taken shape:

- The Collaborative has engaged with key partners to support efforts in community engagement and outreach. We have continued our work with Shawn Holmes, who conducted a webinar on *Help Me Connect*, providing valuable insights and resources for families.
- We are actively working with Ryan Davenport and Amanda Axvig from the Minnesota Council of Health Plans on an immunization campaign, aiming to improve vaccination rates and awareness through strategic outreach and education.
- Additionally, we have partnered with Ellen Jirik from NorthPoint Health and Wellness Human Services to facilitate community listening sessions. These sessions are designed to ensure the voices and needs of the community are reflected in the initiatives, strengthening our ability to create meaningful and effective programs.

The Collaborative will continue to:

- Engage key stakeholders and community/organization partnerships.
- Develop plans for collaborative interventions, training, and community-led initiatives.
- Identify and implement input mechanisms and measures for community engagement activities.
- Schedule and host webinars as appropriate.

Hennepin Health will continue to:

- Improve its processes for understanding the circumstances that lead to NICU births and develop/implement potential interventions to improve birth outcomes.
- Collaborate with AHM partners to improve maternal and child health
- Solicit ways of reaching out and engaging the members to identify barriers to care and determine what is important for their health. Strategies for enhanced engagement with the members will continue to be solidified as we continue to develop in the community engagement space.
- Collect and analyze the interventions tracking measures (ITMs) and outcomes data
- Incentivizing prenatal and postpartum care visits through gift card rewards program.
- Incentivizing well-child visits and childhood immunizations through gift card rewards program.
- Provide members with essential maternal and child health resources through outreach mechanisms such as mailing prenatal and postpartum packets.
- Promote health equity through education, providing access to car seats, and exploring safe sleep initiatives.
- Draft and submit Year 1 Interim Report for the “Healthy Start” PIP 2.0.



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