Hennepin Health
your community health plan

Population Health Management Impact Analysis Report

2024

07/31/2025

Vanessa Bembridge, MPH, Population Health Manager
Jessica Cook, MSc, Population Health Specialist
Tim Walter, MPH, Population Health Analyst

525 Portland Ave S, Minneapolis, MN 55415

612-596-0719

https://www.hennepinhealth.org/

Table of Contents

Introduction

Population Health Management (PHM) has been an integral part of Hennepin Health since its inception as an early Medicaid expansion demonstration project. Our central strategy for population health is to tailor proactive and preventive health outreach for all and improve care coordination for members with high risk and complex conditions. An Accountable Health Model (AHM) was established in 2012 by Hennepin Health and three county-based provider organizations: Hennepin County Human Services and Public Health, Hennepin Healthcare, and NorthPoint Health and Wellness. The AHM is based on principles of population health management. Some key principles of the AHM are listed below.

1. All members have a primary care provider.
2. Primary care providers coordinate patients' care.
3. Behavioral health and physical health are integrated.
4. Social determinates of health are managed as part of a member's health care.

Based on these principles, the AHM partners have established structures, tools, and processes to support the care of members as listed below.

1. A shared-risk and shared-savings financial arrangement between payer and provider.
2. A collaborative decision-making process for providers and the payer.
3. Collaboration with Hennepin County Human Services and Public Health programs and community organizations that serve our members.
4. A shared electronic medical record system.
5. A common understanding and implementation of care coordination.
6. Integrated teams of social workers to address social determinates of health.
7. Multiple clinical sites that provide integrated behavioral, substance use treatment, and physical health services.

This report, the 2024 Hennepin Health Population Health Management Impact Analysis, is a comprehensive analysis of our 2024 PHM strategy goals, interventions, and outcomes.

2024 PHM Strategy Description

Efforts to improve and manage the health of populations require a combination of member, health system, and community level approaches. Hennepin Health is dedicated to increasing the quality and value of its members' health care by improving preventative care, chronic disease care, and care coordination for people with complex medical and social needs. This allows us to meet members "where they are at" to keep healthy people healthy and support those with higher needs. As described later in the strategy, a significant subpopulation of our members are low-income adults without children. Unstable housing in this population often leads to higher utilization of emergency room services, hospital readmissions, injuries and illness caused by exposure to the environment as well as interruptions in healthcare coverage and access. A coexisting substance use disorder, mental illness and/or justice system involvement is often present. The combination of all

those factors increases health care costs and utilization and reduces the use of primary care and preventative services. Hennepin Health recognizes the importance of leveraging primary care clinics to promote and educate members about preventative and chronic disease care. In order to reduce gaps in care in a member-centric socially focused manner, our work has focused on engaging people in their own space. Through our programs, we work to accomplish the following:

- Keep members healthy through wellness and prevention initiatives.
- Increase colorectal cancer screening rates and reduce racial disparities.
- Manage at-risk (emergent) populations.
- Increase eye exams for Special Needs BasicCare (SNBC) members living with diabetes while addressing racial disparities and social drivers of health.
- Increase prenatal and postpartum visits for pregnant people while addressing racial disparities and social drivers of health.
- Manage outcomes across settings.
- Inpatient care coordination for members experiencing homelessness and substance use disorder.
- Manage chronic disease and multiple chronic conditions.
- Complex case management for Prepaid Medical Assistance (PMAP) and MinnesotaCare members.
- Care coordination for SNBC members.

To accomplish these goals, Hennepin conducted a data-driven process to select programs and services that improve the health of our members. The goals, target populations, and programs and services addressed in 2024 are listed below. A detailed description of the PHM strategy, goals, population, and interventions are listed in Appendix A: Project Descriptions.

Members' feedback about the PHM programs was obtained and acted on, as appropriate. Hennepin Health monitored member complaint data about the PHM program throughout 2024. For this report, members' feedback about 1) the diabetes program for SNBC members living with diabetes and 2) care coordination for members diagnosed with a substance use disorder are reported on the following components.

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

2024 Hennepin Health Membership Demographics

A PHM program is supported by data related to the demographics of the health plan's membership. As of December 2024, Hennepin Health had 26,454 MHCP members compared to a December 2023 membership of 35,108. The notable drop in membership

size is attributable to the end of the Public Health Emergency during which reenrollment by members was not required.

The 2024 breakdown by program was:

- Hennepin Health PMAP – 22,224 (84%)
- Hennepin Health MinnesotaCare – 2,296 (9%)
- Hennepin Health SNBC – 1,934 (7%)

In 2024, total enrollment decreased by 16% points as compared to the 2023 total. Between December 2023 and December 2024, enrollment decreased in each specific program by 8,134 (PMAP), 252 (MinnesotaCare), and 268 (SNBC). The PMAP program represented about 84% of the total membership in 2024, slightly lower than in 2022 and 2023 at 87%.

Hennepin Health serves a diverse membership. The membership race and ethnicity composition are significantly different from that of Hennepin County residents overall as demonstrated in Table 1 below. Approximately 70.6% (16,808 members; excluding unknown population) of Hennepin Health's total membership is non-white.

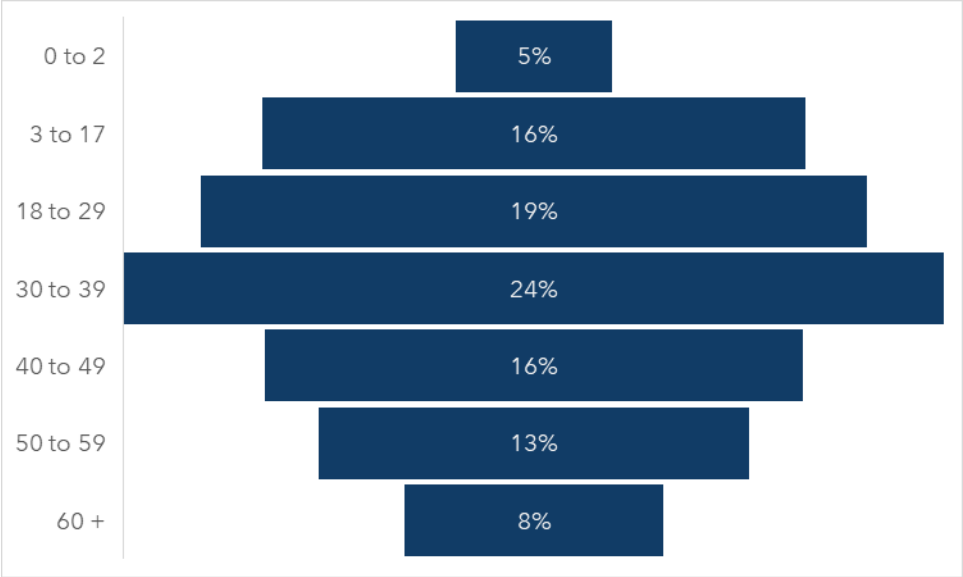
Table 1. Race and Ethnicity Composition of Hennepin County and Hennepin Health Membership

	Hennepin County 2020	**Hennepin Health 2021**	**Hennepin Health 2022**	**Hennepin Health 2023**	**Hennepin Health 2024**
Non-Hispanic White	**73.2%**	25%	24%	29%	**27%**
Black	**14.5%**	30%	28%	38%	**39%**
Hispanic	**7.2%**	9%	9%	5%	**12%**
Native American	**1.1%**	3%	3%	4%	**4%**
Asian/Pacific Islander	**7.8%**	3%	3%	4%	**4%**
Multi-Race	**3.5%**	Data not available	2%	5%	**5%**
Unknown	**N/A**	30%	30%	9%	**10%**

Data Source: Hennepin County 2020 Census Data/2021, 2022,2023, and 2024 Hennepin Health Data Warehouse

Reported gender of the member population reveals 59% identify as male and 41% as female. As visible in Figure 1 below, the largest concentration by age of Hennepin Health members is those age 30 to 39 years old (24%), with members aged 18 through 29 comprising 19% of the total membership. Children and adolescents ages 0 through 17 comprise 21% of the total membership.

Figure 1. Age Categories, All Membership, 2024



Data source: Hennepin Health Data Warehouse

Hennepin Health has approximately 21,072 (80%) members living in high social vulnerability index (SVI) zip codes. Communities with high SVI rates generally have higher rates of poverty, crowded housing, concentration of racial/ethnic minorities and lack of access to transportation compared to low SVI communities. High SVI communities also tend to have lower vaccination and immunization rates.

Reducing health inequities for members is a key priority of Hennepin Health. As such, the Population Health 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 of our populations, as well as the high population of members whose race is unknown to the MCO. It should also be noted that individuals of Hispanic ethnicity can be of any race; therefore, some individuals may be counted in both the Hispanic and a race category, which may lead to the sum of a measure being a larger number than is presented as the total. The data should be interpreted with caution.

To uncover and monitor inequities, Hennepin Health's Population Health Impact Analysis Report now calculates 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. (This is a change from previous Impact Analysis reports in which disparities for each year were calculated and then compared to the disparities that existed in 2019, the baseline year for several measures.) The IDU is calculated by dividing the subpopulation's percent of the total denominator by the subpopulation's percent of the total numerator. Results over 100% indicate a disparity subpopulation. Using the IDU is more meaningful for Hennepin Health's small population sizes and has the added advantage of not setting the rates for white populations as being the goal and comparison point for all measures. It allows inequities to be considered in the context of each individual year as population self-identifications change. Finally, the use of the IDU facilitates more robust discussion of findings, including for the measures in which

the white population does not have the "best" rate and therefore should not be set as the goal.

Impact Analysis

Keeping Member Healthy

Cancer Screening

Goal 1: Improve HEDIS® Colorectal Cancer screening rate (COL) by 5% points over CY2022 data, or to a minimum of the 50th percentile, whichever is higher, for eligible members, ages 45 – 49 and 50-74.

Quantitative results for relevant clinical, cost/utilization and experience measures

All HEDIS® clinical measures have a minimum sample size of 411. The sample size of 411 specified by National Committee for Quality Assurance (NCQA) is based on a statistical estimation of providing an 85% chance of identifying a five-percentage point difference between plans. HEDIS® COL measures the percentage of members of the measurement year 45–75 years of age who had appropriate screening for colorectal cancer. Table 2 displays the proportion and percentage of the Hennepin Health eligible members who had a colorectal cancer screening completed. The 2023 colorectal cancer screening rate was 22.96% for Hennepin Health members. The 2024 rate of 26.44% registers a 3.48 percentage point increase relative to the previous year. This increase is a success that reflects the efforts Hennepin Health has put into improving colorectal cancer screenings.

Table 2. Colorectal Cancer screening Rates, 2022, 2023, and 2024

Year	Numerator	Denominator	Rate	Rate change compared to 2022
2022	1373	6208	22.1%	N/A
2023	1404	6114	22.9%	0.8%
2024	1097	4149	26.4%	4.3%

Data Source: Hennepin Health HEDIS® CYs 2022, 2023, 2024

Comparison of results with a benchmark or goal

The Hennepin Health 2024 colorectal cancer screening rate has increased by 4.3% points when compared to the 2023 Colorectal Cancer Screening rate.

The most recent national Medicaid Health Maintenance Organization (HMO) COL-E[1] rate reported by NCQA was 38.6% in 2023[2], which is 12.2% higher than the Hennepin Health 2024 rate. The colorectal cancer screening measure was updated in HEDIS Measurement Year 2022 to align with new screening guidelines set by the U.S. Preventive Services Task

[1] In 2024, the COL measure became an ECDS measure and therefore the acronym was updated to include an "E" going forward. https://www.ncqa.org/blog/improving-quality-measurement-for-colorectal-cancer-screening/

[2] https://www.ncqa.org/blog/ncqa-developing-hedis-measure-for-colorectal-cancer-screening-follow-up/

Force for adults ages 45-75, therefore comparison to historical HEDIS COL measures is not applicable.

Interpretation of results

The COL-E HEDIS® rate has increased from 2023 to 2024 by 4.32 percentage points overall and therefore does not yet meet the set goal of increasing the rate by 5 percentage points or to a minimum of the 50th percentile but it is a notable improvement, especially in only one year's time.

The Hennepin Health COL-E sample size is much smaller than that of the other Minnesota MCOs, so drawing conclusions across MCOs is challenging and statistical testing for significance is even more so. Small sample sizes also lead to high variability, making it difficult to draw conclusions.

Goal 2: Reduce racial and ethnic disparity gaps for COL-E while improving screening rates for all groups

Quantitative results for relevant clinical, cost/utilization and experience measures

In 2024, observable racial health inequities were present amongst members screened. The highest screening rate was in the Asian/Pacific Islander membership at 31.0%, and the lowest rate was in the Native American membership at nearly 21%. As outlined in Table 3 below, the sample sizes for the various racial and ethnic groups are small, making analysis difficult.

Table 3. COL-E Rates by Race and Ethnicity, 2024

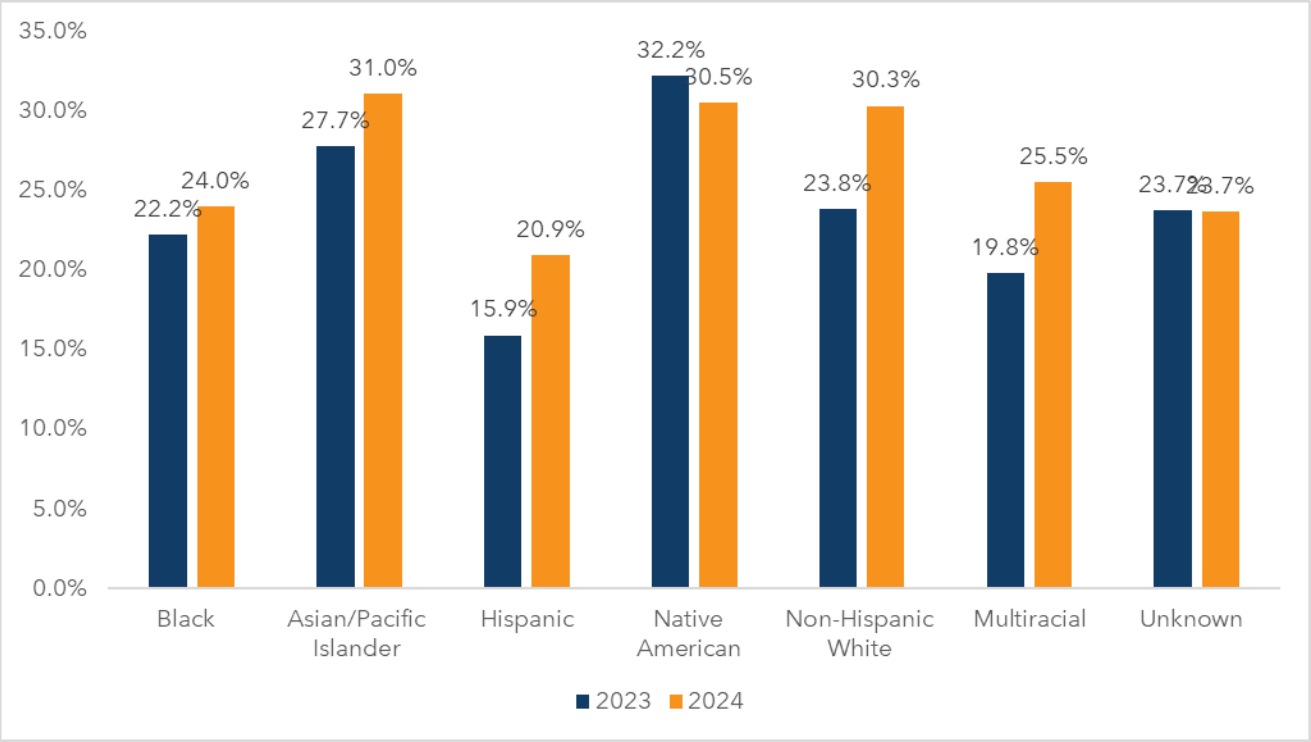
Race	Numerator	Denominator	Rate
Black	446	1859	24.0%
Asian/Pacific Islander	36	116	31.0%
Native American	52	249	20.9%
Hispanic*	83	272	30.5%
Non-Hispanic White	483	1595	30.3%
Multiracial	27	106	25.5%
Unknown	53	224	23.7%
Total	1097	4149	26.44%

Data Source: Hennepin Health HEDIS® CY2024

*Hispanic members may also fall into other racial categories and therefore be counted in multiple groups but are counted individually in the total rate.

Figure 2 below displays the COL rates by race for 2023 and 2024. All racial and ethnic groups saw an increase in the COL rates from 2023 to 2024, except for the Native American population which dropped slightly by 1.7% and the unknown population which remained the same. Due to the small denominators, no conclusions can be drawn.

*Figure 2. COL Rates by Race 2023 and 2024**



Data Source: Hennepin Health HEDIS® CY2023, CY2024
*Race and ethnicity breakdown is not available for CY2022

Comparison of results with a benchmark or goal

The COL rates by race and ethnicity for the benchmark year, 2022, are not available. In 2024, all groups, except Native American and the Unknown population, saw an increase in the COL rate compared to 2023. The Native American population saw the only decrease in the COL rate of 1.7% points between 2023 and 2024 while the Unknown population remained the same at 23.7%. Compared to 2023, the Non-Hispanic White population saw the largest increase from 23.8% in 2023 to 30.3% in 2024. The Black, Multiracial and Unknown groups were found to be disproportionately underrepresented amongst the screened population with IDU:110.21%, IDU:103.8% and IDU: 111.75% respectively.

Next Steps

Hennepin Health has made notable strides in enhancing access to colorectal cancer screening among its members. Phone calls, texts, Facebook posts, newsletters, and emails were utilized to inform and remind members when they were due for colorectal cancer screening. Members were also given assistance for scheduling appointments and/or interpreter services. In 2024, Hennepin Health launched the inaugural colorectal cancer screening outreach campaign that distributed at-home fecal immunochemical test (FIT) kits to a targeted segment of the eligible population.

2,393 members were marked as eligible for a colorectal cancer screening. A subset of members was removed because they had no attributable health care system to send results to, an important element of the campaign. The remaining 1,957 members were included in the first round of the campaign. Prior to receiving the kits, selected members received a pre-

notification letter to increase awareness and engagement and explain opt-out options. Included was a printout of the Hennepin Health colorectal cancer screening $50 voucher. In the weeks that followed, eligible members received the at-home FIT kits accompanied by clear, detailed instructions on sample preparation and submission. The instructions were available in both English and Spanish and in written and video formats. The contracted laboratory partner processed the samples and communicated the results to both the individual members and their primary care providers, thereby supporting continuity of care.

The initiative demonstrated promising results, with just over 12.9% of recipients submitting samples for analysis (253 members). As of May 2025, 23 members (9.2%) had abnormal results and were contacted for follow-up. Of those 23 members, 14 members have had follow-up consultations with their providers regarding their FIT results, and 13 members have either completed or scheduled a colonoscopy for further evaluation. Hennepin Health will continue to follow members who have a positive FIT screening. Building on this success, Hennepin Health will relaunch the FIT kit campaign in July 2025, targeting an eligible population of approximately 1,000 members. Upon analysis of the second FIT pilot, Hennepin Health will consider the impact of the FIT campaign on our overall COL-E rates and how our organizational efforts could be modified to address the high IDU of 110.21% for our Black members.

Managing Members with Emerging Risk

Diabetes Care

All HEDIS® clinical measures have a minimum sample size of 411. The sample size of 411 specified by NCQA is based on a statistical estimation of providing an 85% chance of identifying a five-percentage point difference between plans. Hennepin Health measures often do not meet the minimum sample size requirement, as is true of the EED rate.

Goal 1: Improve the HEDIS EED rate by 5% points in CY2024 over the CY2019 rate for eligible SNBC members.

Quantitative results for relevant clinical, cost/utilization and experience measures.

Table 4 displays the proportion and percentage of members who completed an eye exam in 2019, and 2021-2024. The 2024 EED rate was down slightly from 2023 to 54.7%.

Table 4. HEDIS® EED 2019, 2021- 2024 for SNBC members

Year	Numerator	Denominator	Rate	Rate change compared to 2019
2019	128	199	64.3%	N/A
2021	109	203	53.0%	-11.3%
2022	117	227	51.5%	-12.8%
2023	132	232	56.9%	-7.4%
2024	117	214	54.7%	-9.6%

Data Source: Hennepin Health HEDIS® data 2019, 2021, 2022, 2023, and 2024.

Comparison of results with a benchmark or goal.

The 2024 EED rate of 54.7% is 9.6% points lower than the 2019 rate of 64.3%. The most recent national Medicaid HMO EED rate reported by NCQA was 52.8% in 2023[3]. NCQA has not yet published its 2024 rates. Hennepin Health's rate exceeds the most recent NCQA rate by 1.9%.

Interpretation of Results

The PHM goal to improve the HEDIS® EED rate by 5% points over CY2019 data for eligible SNBC members has not yet been reached. The eye exam rate decreased by 9.6% points relative to the 2019 rate. However, the sample size is significantly below the NCQA HEDIS® required sample size of 411. Therefore, caution should be taken when interpreting the results.

Hennepin Health members with diabetes face significant challenges in accessing diabetic eye exams, primarily due to a lack of awareness and education. Many members may not understand the importance of these exams or are unaware of the locations where they can receive them. This is compounded by confusion about what services are covered by Hennepin Health leading to missed opportunities for preventive care. Additionally, members often prefer not to travel downtown for eye exams, but there is a lack of awareness about local providers who can offer these services. This geographical barrier further complicates access to necessary eye care.

Another challenge is the referral and scheduling process. After receiving a referral from their primary care provider, many members do not follow through with scheduling the eye exam. This issue is exacerbated by the lack of systematic follow-up and tracking of these referrals. For SNBC members, care navigators can schedule eye exam appointments, but there is a need for better coordination to ensure that members complete these important exams. Addressing these challenges requires a multifaceted approach, including educational outreach, better tracking and follow-up systems, and improved coordination among care providers.

[3] https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/

Population Health work in 2025 will include both member and provider education, SNBC Care Coordinator outreach, and expansion of the contracted network of eye clinic providers.

Goal 2: Reduce the EED disparity gaps between racial and ethnic groups while improving rates for all groups

Quantitative results for relevant clinical, cost/utilization and experience measures

As displayed in Table 5, the Hispanic and Unknown populations had the highest rate of EED at 66.7% for both groups. The multiracial population had the lowest rate of 40%.

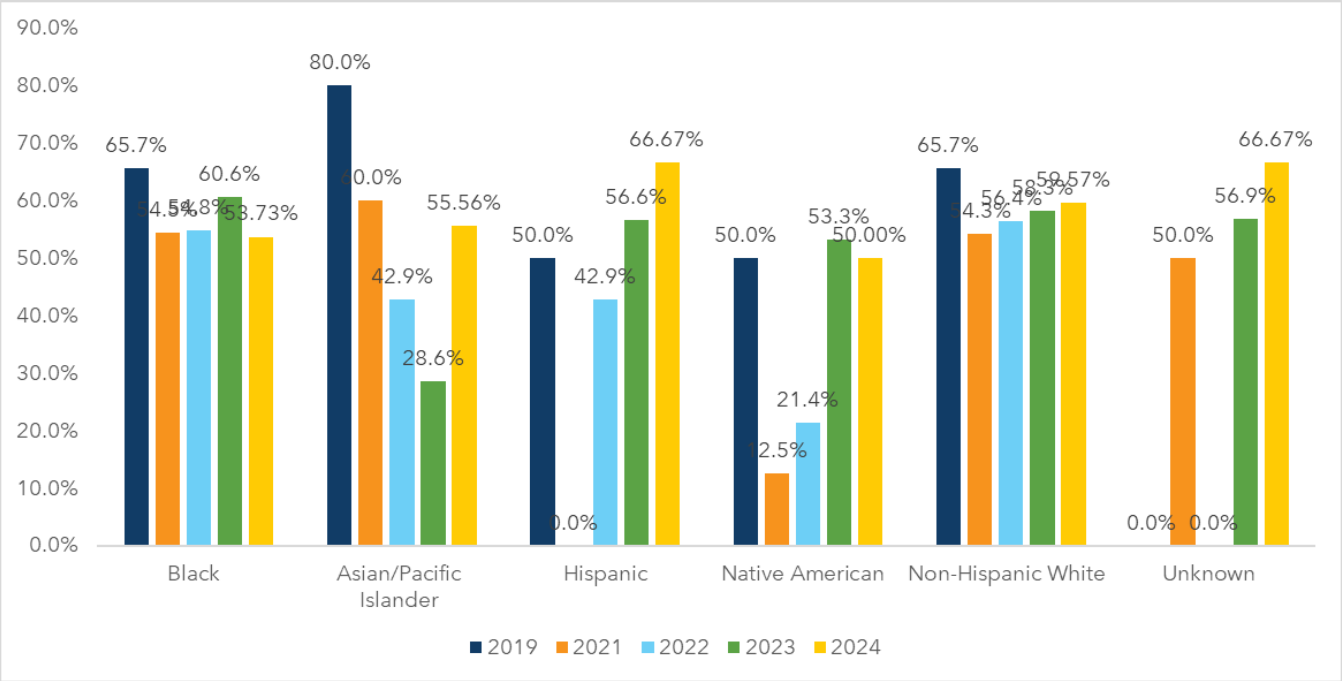
Table 5. EED Rates by Race (SNBC), 2024

Race	**Numerator**	**Denominator**	**Rate**
Black	72	134	53.7%
Asian/Pacific Islander	5	9	55.6%
Native American	8	16	50.0%
Hispanic*	4	6	66.7%
Non-Hispanic White	28	47	59.6%
Unknown	2	3	66.7%
Multiracial	2	5	40.0%
Total	117	214	54.7%

Data Source: Hennepin Health HEDIS® CY2024

*Hispanic members may also fall into other racial categories and therefore be counted in multiple groups but are counted individually in the total rate.

Figure 3. EED rates by Race and Ethnicity (SNBC), 2019, 2021-2023



Data Source: Hennepin Health HEDIS® CY 2019, CY 2021, CY2022, CY 2023, CY 2024
*Multiracial data not available for 2019 or 2021

Comparison of results with a benchmark or goal.

As displayed in Figure 3 above, in 2024, all groups except Hispanic, Unknown, and Native American saw decreases in the EED rate compared to 2019. The Hispanic and Unknown rate increased 16.7% and 66.7% since 2019, respectively, while the Native American rate in 2024 matched the 2019 rate (50%). The Unknown population saw the largest increase in the EED rate since 2019 with an increase of 66.7%[4]. The Asian/Pacific Islander group saw the largest decrease with 80% in 2019 to 55.6% in 2024. In 2024, The Black/African American, Native American, and Multiracial groups were found to be disproportionately underrepresented with IDU: 101.75%, IDU:123.38% and IDU: 136.68% respectively.

Interpretation of Results

For the EED, inequities continue to be seen with disparities developing for the Asian/Pacific Islander and Black population and narrowing for the Native American population when comparing the 2019 rates with the 2023 rates for the Non-Hispanic White population (Figure 3). The EED rates did, however, increase for most races and ethnicities from 2023 to 2024, excluding the Black and Native American populations. Sample sizes remain very small so this is subject to random variation and no definitive conclusions can be identified.

[4] Since DHS began supplementing race and ethnicity data, the percentage of "unknown" racial identification in the data has fallen considerably from approximately 30% in 2019 to around 10% in 2024, depending on the measure in discussion. In this case, only 3 people were in the denominator as "unknown", so while we report the increase, very little can be derived or learned from it.

Member Experience

In late 2021, an assessment tool addressing social drivers of health and health care delivery for SNBC members living with diabetes was developed and implemented. The purpose of the assessment tool is to gather member feedback to better understand how well members are managing their diabetes to better assist members, to understand each member's unique situation and identify additional resources that may help them improve their diabetes health care outcomes. While the Population Health focus is the EED measure of diabetic care, that measure and corresponding interventions require a holistic understanding of the barriers faced and care received by members with diabetes. The Hennepin Health assessment provides feedback about population health efforts and is used to inform interventions.

Both the internal and external SNBC care coordinators conducted in-person/telephonic outreach to complete the assessment tool with members living with diabetes. The 2024 assessment results were shared with the Chief Medical Officer, Director of Clinical Services, Behavioral Health and SNBC Care Coordination Manager, and the Manager of the Quality Management department. In December of 2024, MVA contacted 256 members for an engagement rate of 98% and Touchstone contacted 161 members for an engagement rate of 47%. Of the 417 members who were actively engaged in care coordination services, 30 members completed the assessment for a rate of 7.2% in 2024. Of the members surveyed, 43% of the members expressed an interest in in receiving information and resources to improve their understanding of their condition and to better self-manage it. Seventy percent (70%) of the members wanted to learn more about eye exams, foot exams, blood glucose (A1c) values and blood pressure values and to understand the connection to diabetes. While 80% of the members noted that they felt that they ate a healthy diet, 53% of members indicated they would be interested to learn more about the best foods to eat to better manage their diabetes. Nine of the 30 members indicated that either food or clothing were items they were unable to get when it was really needed. Only one member indicated they were having difficulties with equipment such as a blood pressure monitoring equipment. Most members (90%) stated that they take their diabetic medications every day.

The assessment is also used as an information tool. During the assessment, care coordinators inform members of the wellness reward incentive programs for completing an annual HbA1c test and having an eye exam. Members are excited about the gift card incentive programs and appreciative of receiving this information. Care coordinators provide information on how to obtain the rewards and worked with the members to obtain eye exam appointments and/or appointments with their health care providers to discuss diabetes management. An increase of gift card incentive reward requests for eye exams and HbA1c testing have been processed since the assessment launched in 2022.

Next Steps

Increasing eye exam rates for individuals living with diabetes while focusing on eliminating racial disparities is an area of opportunity for Hennepin Health in 2025. Hennepin Health will continue to focus on this PHM program. Hennepin Health is partnering with other Minnesota MCOs in the SNBC 2024 - 2026 "Impact of Depression on the Management of Diabetes"

PIP. The PIP focuses on decreasing the health disparity gap in HEDIS® and/or process measures chosen year-over-year from 2024 through 2026 by improving the member's health while experiencing co-occurring diabetes and depression. To reduce the disparities in diabetes, evidence-based programs already available will be used to address the many factors that influence both physical and mental health, such as access to nutritious foods, options for physical activity through a collaborative approach between both health care and non-health care providers to improve diabetes management and address the social and environmental factors that affect vulnerable populations.

Hennepin Health has SNBC internal and external care coordinators who are trusted, knowledgeable, frontline personnel. They bridge cultural and linguistic barriers and expand access to coverage and care. They work closely with members who have behavioral/chemical dependency and/or medical conditions to assist members in improving their quality of life. They encourage members to schedule visits with the health care provider and receive necessary tests such as HbA1c test and eye exams.

Hennepin Health will continue to engage SNBC care coordinators to develop processes to better identify if and what social drivers are impacting members ability receive timely health care services. Due to small racial groups' numbers and based on the recommendations from the Department of Human Services, only the racial disparity gap between Non-Hispanic White and Black members will be monitored for impact. Hennepin Health will focus on decreasing other disparities and addressing social drivers of health to lift the population measures. In addition, in 2025 this initiative will be expanded to include the PMAP/MinnesotaCare populations and will only focus on the eye exams. (SNBC care guides, Quality Management initiatives and the PIP will continue to address other areas of diabetes care.) The upcoming campaign will also include provider, care coordinator, and member education about the importance of eye exams and their availability and accessibility.

Pregnancy Care

Goal 1: Improve HEDIS® Prenatal and Postpartum Care (PPC) first prenatal care visit by 5% points over CY 2019 data for eligible members.

Quantitative results for relevant clinical, cost/utilization and experience measures

The HEDIS® PPC-prenatal rate is the percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in Hennepin Health. The PPC-prenatal and postpartum measures at Hennepin Health have never met the minimum sample size of 411.

Table 6 displays the proportion and percentage of members meeting the criteria in 2019, and 2021-2024. The PPC-prenatal rate was 85.4% in 2019. In 2024, the PPC-prenatal rate was 85.3%.

Table 6. HEDIS PPC – Prenatal Rate, 2019, 2021 - 2024

Year	Numerator	Denominator	Rate	Rate change compared to 2019
2019	234	274	85.4%	N/A
2021	281	329	85.4%	0.0%
2022	322	372	86.5%	1%
2023	297	357	83.2%	-2.3%
2024	284	333	85.3%	-0.1%

Data Source: Hennepin Health HEDIS® data 2019, 2021, 2022, 2023, 2024

Comparison of results with a benchmark or goal

The 2024 rate is nearly constant to the 2019 rate, and an improvement of nearly 2.1% over 2023. The most recent national Medicaid HMO PPC-prenatal rate reported by NCQA was 83.1% in 2023, which is notably 2.2% lower than the Hennepin Health 2024 rate of 85.3%. Hennepin Health has struggled to raise its PPC measures by five percentage points in part because the Hennepin Health rate is already high, leaving little room for improvement, and is already higher than the national rate. Hennepin Health will consider changing this goal in coming years, either removing it as a measure or changing it to a more reasonable percentage improvement.

Interpretation of results

The goal for this PHM program was to improve HEDIS® PPC first prenatal care visit by 5% points over the 2019 data for eligible members. As mentioned above, when reviewing the results, caution is advised when interpreting the results as the sample size is below the NCQA HEDIS® required sample size of 411. The 2024 PPC-prenatal rate was nearly the same as baseline at 0.1% lower than the 2019 PPC-prenatal rate, though the rate does show improvement from 2023. Despite that improvement, the goal was not reached in 2024.

Hennepin Health will continue to focus on this PHM program. Hennepin Health is partnering with other Minnesota MCOs in the "Healthy Start" PIP. 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 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 reducing disparities, relevant to the individual MCO population.

Goal 2: Improve HEDIS® PPC postpartum visit by 5% over 2019 data for eligible members.

Quantitative results for relevant clinical, cost/utilization and experience measures

To be included in the HEDIS® PPC-postpartum rate, a member must have a postpartum visit on or between 7 and 84 days after delivery. The PPC-postpartum rate for Hennepin Health

was 83.8% in 2024 which is an increase by 3.1% compared to 2023. The HEDIS PPC-postpartum rate improved by 5.7% points from 2019 when compared to 2024 (Table 7).

Table 7. HEDIS PPC – Postpartum Rate, 2019, 2021- 2024

Year	Numerator	Denominator	Rate	Rate change compared to 2019
2019	214	274	78.1%	N/A
2021	263	329	79.9%	1.8%
2022	306	372	82.3%	4.2%
2023	288	357	80.7%	2.6%
2024	279	333	83.8%	5.7%

Data Source: Hennepin Health HEDIS® data 2019, 2021, 2022, 2023, 2024

Comparison of results with a benchmark or goal

The 2024 PPC-postpartum rate increased by 5.7% points compared to the 2019 PPC-postpartum rate. The most recent national Medicaid HMO PPC-postpartum rate reported by NCQA was 78.6% in 2023, which is lower than the Hennepin Health 2024 rate of 83.8%. NCQA has not yet published its 2024 rates.

Interpretation of results

The goal for this PHM program was to improve PPC-postpartum visit by 5% points over the 2019 data for eligible members. The 2024 HEDIS® PPC-postpartum rate increased by 5.7% from the 2019 PPC-postpartum rate. Therefore, the target has been reached. When reviewing the results, caution is advised as the sample size is below the NCQA HEDIS® required sample size of 411.

Goal 3: Reduce racial disparity gaps by improving rates for all groups.

Quantitative results for relevant clinical, cost/utilization and experience measures

For both prenatal and postpartum HEDIS® PPC rates, the highest rates are observed for Hispanic members (excluding the "unknown" members from the prenatal rate). For the prenatal measure, Native Americans have the lowest rate of prenatal care at 64% with a denominator of 25 people. For the postpartum measure, the lowest rate is amongst Asian/Pacific Islanders with a denominator of only 8 people. Native American and Asian/Pacific Islanders have the clearest opportunity for an improvement in rates for both prenatal and postpartum care.

Table 8 below provides an analysis of PPC-Prenatal rates by Race. The Native American population PPC-prenatal rate significantly decreased from 83.3% in 2023 to 64% in 2024 The Black population prenatal rate remains close to the rate in 2023, increasing slightly from 82.4% to 83.5% in 2024. The Asian/Pacific Islander population saw a decrease in the PPC-prenatal rate from 2023 to 2024 of 5%. The Hispanic and unknown populations had the highest prenatal visit rate of all members at 94.4% and 97.1%, respectively. As depicted in Figure 4, all racial and ethnic groups, excluding the Native American and Asian/Pacific

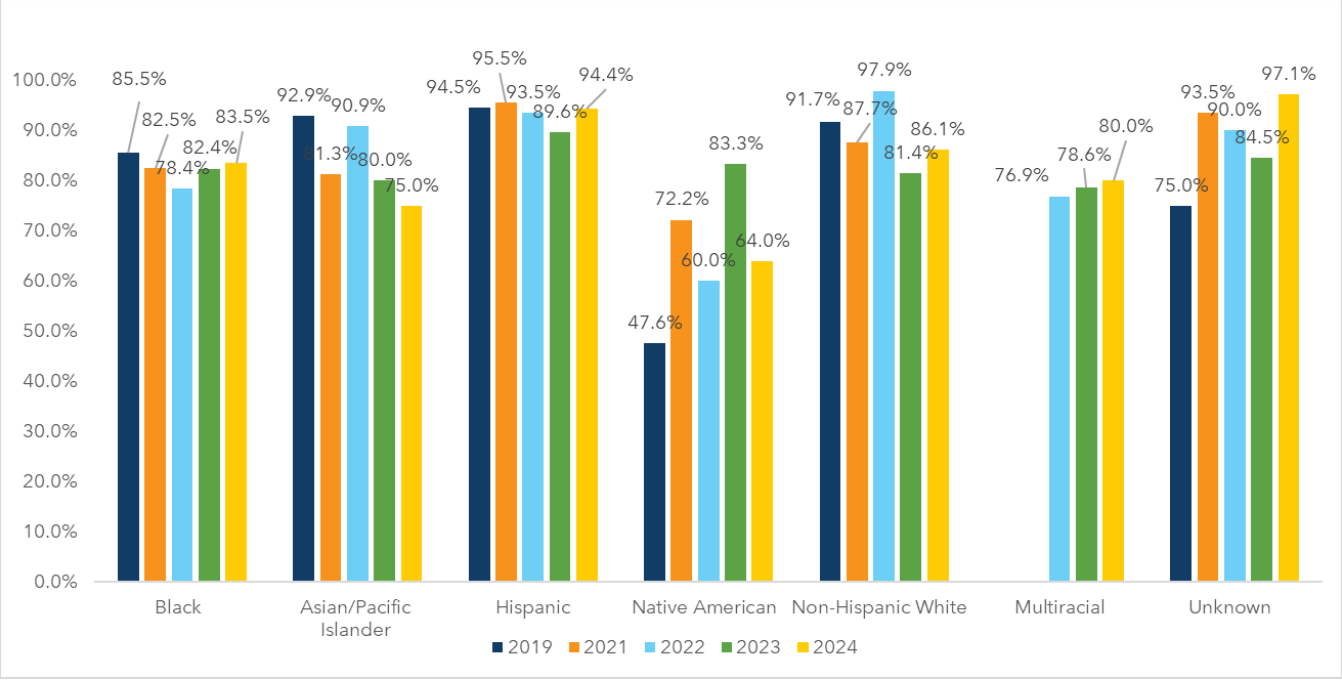
Islander populations, saw an increase in the PPC-Prenatal rates compared to 2023. The sample size of each race/ethnic group is small and therefore no definitive conclusions can be drawn.

Table 8. HEDIS PPC- Prenatal Rates by Race, 2024

Race	Numerator	Denominator	Rate
Black	96	115	83.5%
Asian/Pacific Islander	6	8	75.0%
Native American	16	25	64.0%
Hispanic*	84	89	94.4%
Non-Hispanic White	87	101	86.1%
Multiracial	12	15	80.0%
Unknown	67	69	97.1%
Total	284	333	85.3%

Data Source: Hennepin Health HEDIS® data 2024
*Hispanic members may also fall into other racial categories and therefore be counted in multiple groups but are counted individually in the total rate.

Figure 4. PPC-Prenatal Rates by Race, 2019, 2021-2024



Data Source: Hennepin Health HEDIS® data 2019, 2021, 2022, 2023, 2024
*Multiracial data not available for 2019 and 2021

As depicted in Table 9 below, all racial and ethnic groups except the Black, Native American, and Multiracial populations saw increases in the PPC-postpartum rate compared to 2023. Compared to 2019, all groups except the Asian/Pacific Islander population, saw increases in the PPC-postpartum rates. The Native American population PPC-postpartum rate decreased from 77.8% in 2023 to a rate of 72% in 2024, representing a drop of 5.8 percentage points. The white population postpartum rates dropped below the 2019 baseline for the first time in 2023, but increased dramatically in 2024 to 90.1%, increasing 13.4% from 2023, respectively. The Asian/Pacific Islander population experienced the most remarkable inequities amongst all racial groups for postpartum care. Hispanic members, followed by the unknown racial population have the overall highest postpartum exam rate at 93.3% and 92.8%, respectively. However, the sample size of each race/ethnic group sample size is small, so no conclusions can be drawn.

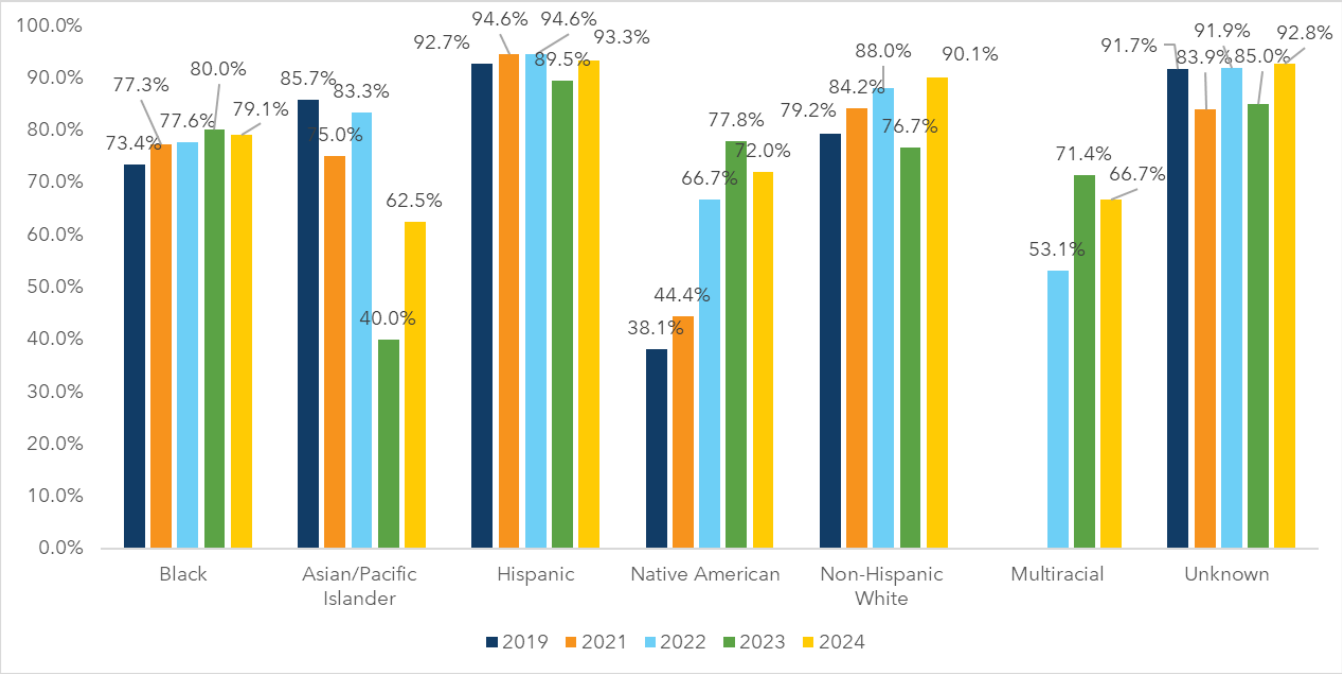
Table 9. HEDIS PPC- Postpartum Rates by Race, 2024

Race	**Numerator**	**Denominator**	**Rate**
Black	91	115	79.1%
Asian/Pacific Islander	5	8	62.5%
Native American	18	25	72.0%
Hispanic*	83	89	93.3%
Non-Hispanic White	91	101	90.1%
Multiracial	10	15	66.7%
Unknown	64	69	92.8%
Total	279	333	83.8%

Data Source: Hennepin Health HEDIS® 2024

*Hispanic members may also fall into other racial categories and therefore be counted in multiple groups but are counted individually in the total rate.

Figure 5. PPC-Postpartum Rates by Race, 2019, 2021-2024



Data Source: Hennepin Health Data Warehouse, Hennepin Health HEDIS CY 2019, CY 2021, CY 2022, CY 2023, CY 2024

*Multiracial data not available for 2019 and 2021

Comparison of results with a benchmark or goal

For the PPC-Prenatal rate, all groups, excluding Native American and the Unknown populations, saw decreases in the rate compared to 2019. The population Unknown saw the largest increase in rate from 75% in 2019 to 97.1% in 2024. The Asian/Pacific Islander population saw the largest decrease in rate from 85.7% in 2019 to 75% in 2024. 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.

For the PPC-Postpartum rate, compared to 2019, all groups except the Asian/Pacific Islander population saw increases. The Native American population saw the largest increase in rate from 38.1% in 2019 to 72% in 2024. The Asian/Pacific Islander saw the largest decrease in rate from 85.7% in 2019 to 62.5% in 2024. 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.

Interpretation of results

Sample sizes for all race/ethnic groups are small so caution should be taken when interpreting the results. The PPC-prenatal and postpartum disparity gaps remain for the Black, Native American, and Asian/Pacific Islander groups. However, improvement in the disparity gap can be seen for the Native American population in both the PPC- prenatal and postpartum which Hennepin Health considers to be a notable improvement for our Indigenous members.

Hennepin Health will continue to focus on this PHM program. Hennepin Health is one of seven MCOs implementing the "Healthy Start" Performance Improvement Project (PIP). The PIP is intended to promote a "Healthy Start" for Minnesota children in the Prepaid Medical Assistance Program (PMAP) and MinnesotaCare populations by focusing on and improving services provided to pregnant people and infants, particularly in areas exhibiting significant racial and ethnic disparities. Each participating MCO has established goals aimed at improving prenatal care and postpartum care rates, well-child visits and/or Combo-10 immunizations rates with the focus on closing health care disparity gaps.

Managing Outcomes Across Settings

Inpatient Care Coordination for members experiencing homelessness and substance use disorder

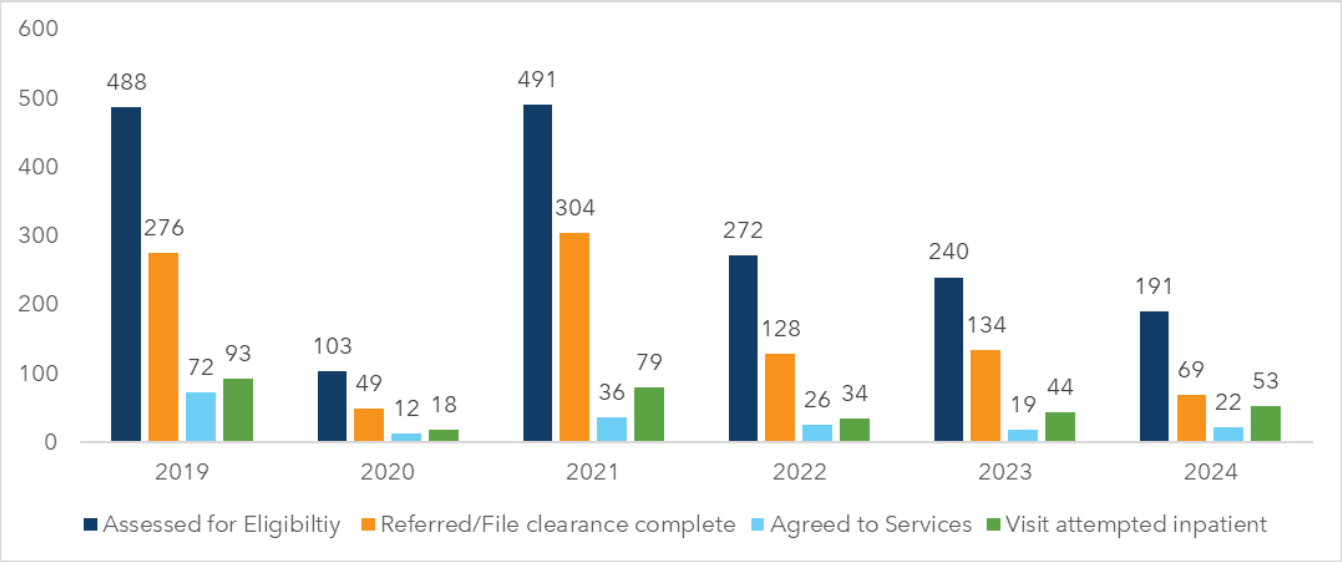
Goal 1: Hennepin Health care coordination team will engage 50% of all targeted members while inpatient.

Quantitative results for relevant clinical, cost/utilization and experience measures

The Hennepin Health case management programs receive referrals through the Epic® dashboard jointly created with Hennepin Healthcare. This dashboard provides information in real time and identifies Hennepin Health members who are hospitalized at Hennepin Healthcare and who may be experiencing housing or substance use barriers to manage their health and/or accessing care. The case management staff reach out to these members directly in person while the member is in the hospital. A focus on outreach for inpatient members with housing instability began in 2019 with a baseline of 16.7% for all cause readmissions among the PMAP population. This work was paused starting in March 2020 due to the COVID-19 pandemic. It resumed in February 2021 on a remote basis due to visitor and other restrictions for entering the Hennepin Healthcare hospital. The in-person work for this program resumed in April 2021. In 2021, an additional SUD-specific outreach intervention for inpatient members was launched which is discussed in more detail in the next section.

As displayed in Figure 6 below, 69 Hennepin Health inpatient members who were experiencing homelessness were referred in 2024. Of the 53 members where visits were attempted while the members were inpatient, 22 members (41.5%) agreed to services with the Hennepin Health case management staff which is lower than the targeted goal of 50%.

*Figure 6. Housing Instability Readmission Referrals, 2019, 2021-2024**



2020 data only reflect a few months as the program was paused due to COVID-19 pandemic.
Data Source: Epic®, MS SharePoint

Comparison of results with a benchmark or goal

Program staff are available Monday- Friday, excluding holidays, therefore there were times when care management staff were unable to directly connect with discharging members. In 2024, 69 patients were referred to the case management team during Monday through Friday. The goal is to engage 50% of eligible members in this service. A total of 69 members met the criteria for the program, of which 53 were visited while in the inpatient setting. Twenty-two members (41.5%) agreed to work with the case management staff (Figure 6).

Interpretation of results

The case management staff successfully engaged 41.5% of members who were eligible for this program. There was a slight decrease of 1.6% from 2023. The goal for 2025 will be re-evaluated and revised, as appropriate. Setting meaningful goals for this type of work is particularly challenging as environmental factors such as weather, housing availability, and potency of substances can change quickly and without notice, while the number of available staff to engage affected members is not as nimble.

Goal 2: Readmissions among the targeted and engaged population will be under the Hennepin Healthcare commercial 30-day readmission rate of 14%.

Quantitative results for relevant clinical, cost/utilization and experience measures

In 2021, the intervention expanded when the Hennepin Health Case Management team developed and operationalized a dedicated Peer Recovery Support Specialist (PRSS) position whose focus has been to assist members experiencing substance use disorders identified during acute medical encounters to obtain access to treatment. Initially, the role was developed as a pilot and was categorized as limited duration position. Since this work began in June 2021, many members have successfully been referred by Hennepin Health to treatment options of their choice thereby reducing the 30-day readmission rate (see Figure 7 below). This work was expanded in 2024 to include an additional PRSS and two Licensed

Alcohol and Drug Counselors (LADCs). As of 2025, this intervention is only implemented at our AHM partner facility, Hennepin Healthcare.

Readmissions specifically due to SUD were not proactively identified or tracked prior to implementation of the intervention workflow. Therefore, data for the first complete month of this intervention was used as the baseline. In June 2021, readmissions in the SUD intervention group were over 30%. The all-cause readmission rate (including SUD and other causes) was 12% from July 2021 through December 2022. The difference between those rates demonstrates the need for a SUD-specific intervention.

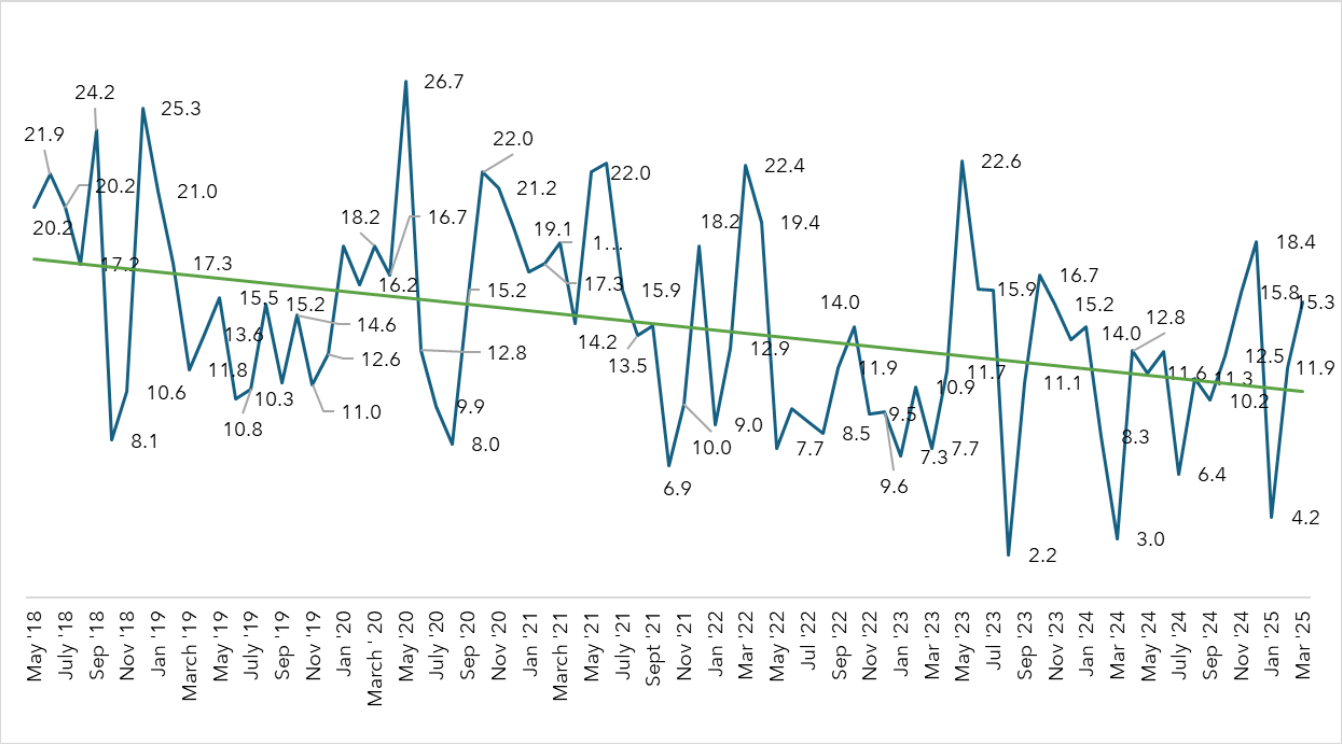
In 2024, the SUD-related readmission rate was 16.3%. Between January 1, 2024, and December 31, 2024, 1152 members were screened for eligibility and 161 agreed to intervention. Members screened were primarily English speaking. Forty four percent were Black, 31% White, and 10% American Indian.

For PMAP members, the all-cause (not SUD specific) readmission rate for 2024 was 12.03%, an improvement by 7% points from 2023 (19.3%) but not a notable change from the baseline all-cause rate of 12% (Figure 7). Although the trend is showing a favorable decline and the 2024 SUD readmissions rate is also lower than the baseline, there is still room for improvement. Please note that many factors that influence SUD admissions and readmissions are far out of the control of Hennepin Health, for example the increase in fentanyl use and changes in the potency of substances. Every instance of harm reduction for our members is worthy of celebration and reflects a person who is safer, regardless of rates.

Internal Hennepin Healthcare[5] data demonstrates a steady decline in SUD related readmissions within the Hennepin Health population at Hennepin Healthcare, as they are the only facility where this intervention is in place because the AHM relationship between the respective organizations readily allows for the collaboration (Figure 8). However, this improvement in rates is then by default exclusive to one hospital. Despite this success, Hennepin Health claims data showed SUD admission rates across all hospitals to be on the rise overall (See Appendix B, Figure 14). This rise is in stark contrast with Hennepin Health claims at Hennepin Healthcare, where member SUD admission rates have more than halved (See Appendix B, Figure 15), and SUD ED visit rates have decreased by over a third since this work began (See Appendix B, Figure 16, Figure 17). The contrast between reduced SUD admission rates of Hennepin Health members at Hennepin Healthcare and increased SUD admission rates of members at other healthcare systems demonstrates the success of the intervention.

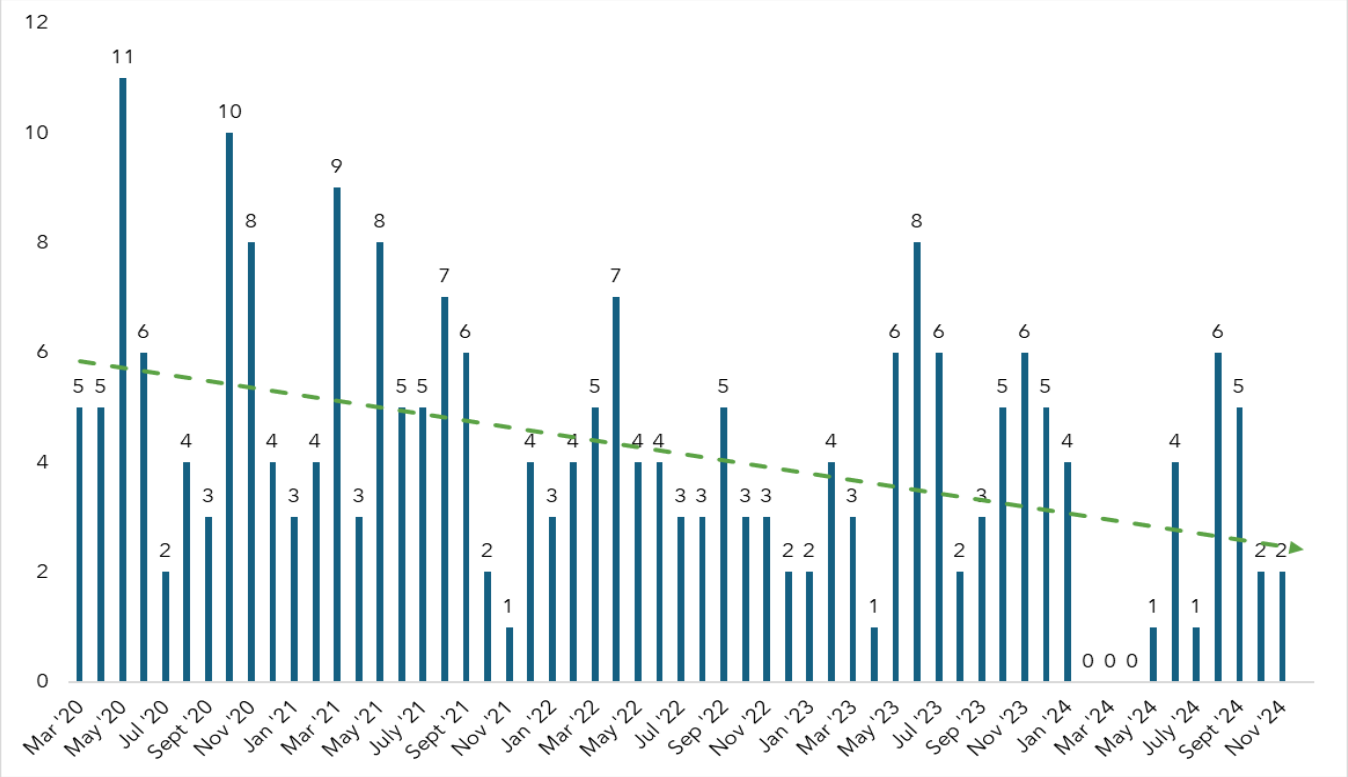
[5] The MCO Hennepin Health is often confused with the health system of Hennepin Healthcare because of our similar names and close relationship. When reading this conversation and others that rely heavily on our AHM cooperation, please pay careful attention to which organization is being referenced.

Figure 7. 30 Day Readmission Percentage, Hennepin Health ACO PMAP, 2018-2024



Data Source: Hennepin Healthcare Data Warehouse

Figure 8. Hennepin Health SUD Readmissions at Hennepin Healthcare, 2020-2024



Data Source: Hennepin Healthcare Data Warehouse

Comparison results with benchmark or goal

As described above, there was not a benchmark for this type of intervention and therefore the rate calculated during the first month of the intervention is considered baseline, which was 30%. The 2024 readmission rate in the intervention group that accepted support (vs the overall Hennepin Health admitted population) was 7.7% at Hennepin Healthcare and 11.8% when including outside hospitals. However, it is acknowledged that the true baseline, in absence of any intervention, was likely even greater. In the readmitted cohort, 40% of encounters were medical, a third medical and SUD-related, and a quarter were solely SUD-related. Ten percent of patients were discharged to a treatment or detoxification facility.

Interpretation of results

Since this work began in June 2021, the intervention efforts have successfully connected many members to treatment options of their choice and reduced the 30-day SUD readmission rate at Hennepin Healthcare. There is an encouraging trend in decreasing readmissions over the program period. The success of this program is why this initiative will continue. Hennepin Health will also explore the possibility of expanding this program to other health systems.

Managing Multiple Chronic Conditions

Goal: Ninety percent (90%) of members identified with multiple chronic conditions, co-occurring behavioral health disorders, substance use disorders (SUD), and chronic medical conditions will be evaluated for complex care management (CCM) and managed as appropriate.

Quantitative results for relevant clinical, cost/utilization and experience measures

Hennepin Health accepts and receives referrals for members from primary care clinics, community organizations, Hennepin County Public Health and Human Services and internal staff. Members are identified by direct care relationships and referred for assessments and services for social service navigation, assistance with housing support service, and CCM for members with multiple chronic conditions. Referrals are received through Epic®, the Hennepin Health website, phone, fax, email, or the Hennepin Health Member Service Center. Referrals are screened for social service and care management needs.

There were 352 adult screenings completed for special health care needs in 2021, and 269 referrals made to the CCM team. By contrast, in 2024, there were 3,942 adult screenings completed with 2,404 referrals made to CCM. Table 10below presents the breakdown of the referrals.

Table 10. 2024 Special Health Care Needs Screening Assessment Completed

Special Health Care Needs Category	Adults Screened	Referrals to CCM
AHRQ Admissions (PQI reports)	140	33
Admissions/Readmission – Housing Instability	191	69
Admissions/Readmissions – Substance Use Disorder	1,021	1,021
High Dollar Claims - $100,000+	532	79
High Emergency Department Utilizers	2,058	1,202

Data Source: Hennepin Health Data Warehouse

Comparison with benchmark or goal

The goal was to screen members identified as potential candidates for complex case management services. Members identified were screened and referred as appropriate. All members identified were screened; however, 2,404 met criteria. Reasons for not meeting complex case management criteria were members already being engaged in case management, duplicate referrals, members no longer eligible (on plan) at the time of the referral, or previous refusal of services.

Interpretation of results

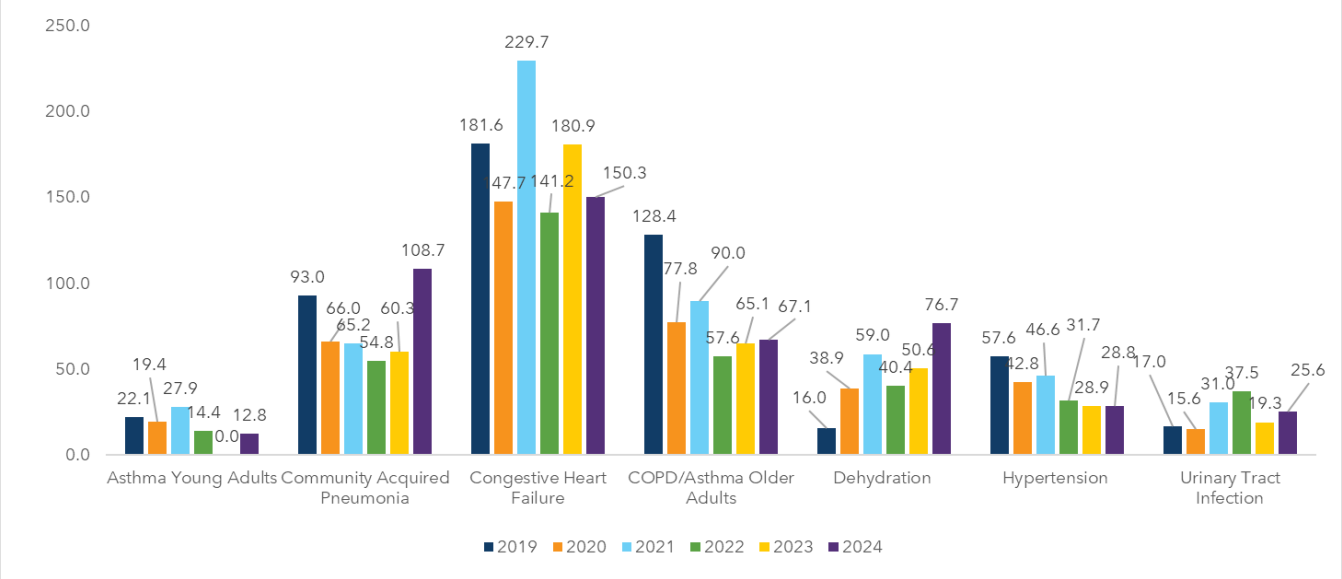
The goal of evaluating 90% of members identified with multiple chronic conditions, co-occurring behavioral health disorders, substance use disorders (SUD), and chronic medical conditions for complex care management and managed as appropriate was met. The admission rates are calculated per 100,000 admissions. For most ambulatory conditions, the rates were low for the past several years (see Figure 9). There were 140 total admissions for ambulatory sensitive conditions in 2024, down from 166 in 2023. A notable increase can be seen in admissions for community-acquired pneumonia and dehydration in 2024, both surpassing the 2019 rates. While it is challenging to attribute these increases to a single cause, climate change may be a contributing factor. With more extreme seasonal temperatures—hotter summers and colder winters, there are known public health implications, including elevated risks associated with dehydration, respiratory illness, and infectious disease transmission. These environmental stressors may correlate with the observed uptick in certain ambulatory–sensitive conditions. It is important to note that direct comparisons between 2023 and 2024 data should be made cautiously, given substantial changes in the member population and the effects of enrollment churn during this period.

There was a slight decrease in admissions for hypertension and a more sizeable decrease for CHF admissions. Hospital admissions increased for community-acquired pneumonia, dehydration, asthma in young adults, COPD, and urinary tract Infections. Dehydration, UTIs, and community-acquired pneumonia were the conditions for which the admission rates were higher in 2024 than the 2019 baseline. Notably, there were zero admissions for asthma in young adults in 2023. In 2024, there were 12.79 per 100,000 young adults. Although there is an increase in the asthma rate in 2024, it remains lower than any of the previous

years, excluding 2023. Hennepin Health has a disproportionately lower child population than other MCOs and therefore not a high number of children with asthma in the membership. Recognizing that this allows for greater impact of efforts, in 2024 Hennepin Health began sponsoring attendance for child members with diabetes to attend Camp Superkids[6], a weeklong medically supervised camp that teaches kids how to best manage their condition while they have fun with their peers.

Once again, the highest admission rates were for CHF. Year over year this diagnosis continues to be the most common ambulatory sensitive condition reason for admission. This is not wholly surprising given that it is one of the most severe of the group and the hardest to control overall. Additionally, younger members are increasingly diagnosed with CHF and other heart related conditions. This may be due to a rise in opioid drug use and other substances of abuse, including xylazine, which have recently entered the market. Hennepin Health recognizes the severity of CHF as a driver of admissions. Not yet reflected in this 2024 report is a 2025-launched Population Health initiative called *Flavors of Health* that is a teaching kitchen and food delivery intervention that targets members with CHF as well members with diabetes and those who are pregnant.

Figure 9. Admissions for Ambulatory Sensitive Conditions PMAP/MinnesotaCare 2019 - 2024



Data Source: Hennepin Health Data Warehouse

Readmissions

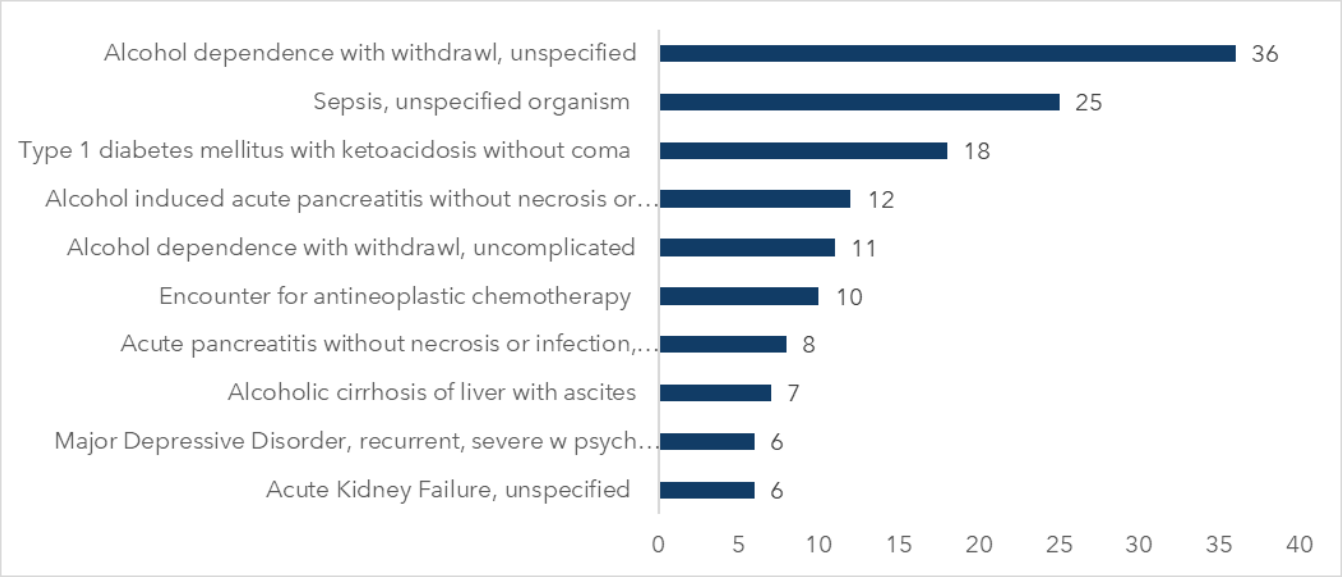
For members who met the screening criteria, the RN case managers and social workers met with the members in their inpatient hospital room. The readmission programs, as described in the previous section, were restarted in March 2021 after a one year pause due to the COVID-19 pandemic, and the SUD readmissions program was launched that year as well.

Figure 10 represents the top ten readmission diagnosis in 2024. Alcohol related disorders account for 47.5% of the top 10 readmission diagnoses, representing a notable decrease

[6] https://www.ymcanorth.org/adventure/posts/camp-superkids-camp-kids-asthma

from 68.4% in 2023. This could be due to older members dying or aging out of the plan into Medicare, random outcomes from enrollment churn, or the increase in use of fentanyl over alcohol in younger populations.

Figure 10. Top 10 Primary Readmission Diagnosis, PMAP/MinnesotaCare, 2024



Data Source: Hennepin Health Data Warehouse

Emergency Department Utilization

Figure 11 depicts the rate of ED visits for all causes in 2024. For ED visits, medical and behavioral health diagnosis are tracked together and separately. The data shows that unlike hospital readmissions, the rate for ED visits among members is more influenced by medical diagnoses (Figure 12) than mental health and SUD/chemical health diagnoses (Figure 13). There may also be a high rate of overlap in the medical, behavioral and/or substance use disorder populations, however, the medical diagnosis is often the presenting diagnosis when dealing with co-morbidities. Of note, ED visits were slightly higher in 2024 than in 2023. Behavioral health visits increased, while medical visits decreased.

Figure 11. Emergency Department Visits Rates-All Causes, PMAP/MinnesotaCare, 2024

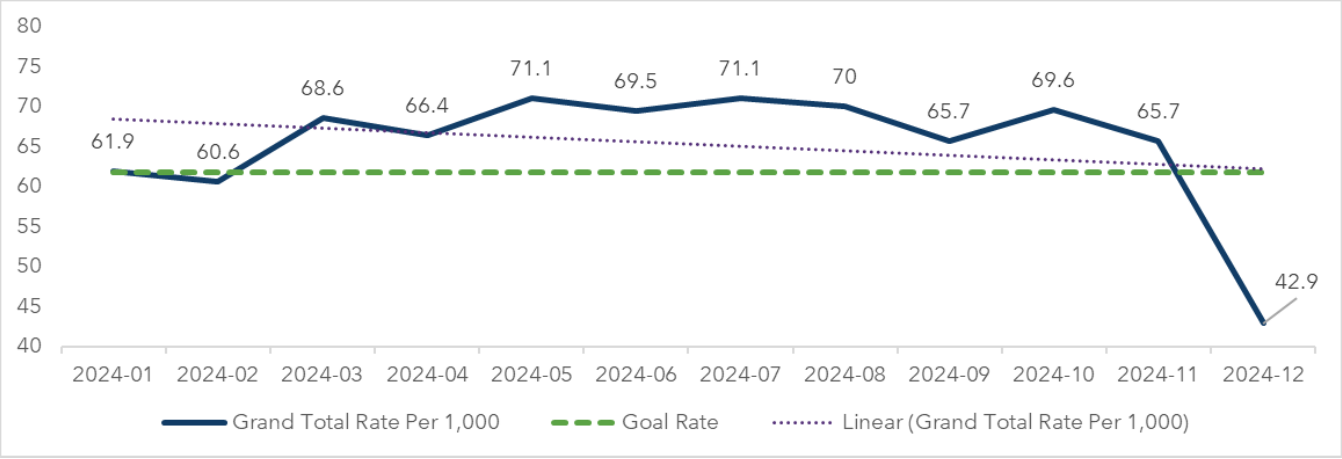
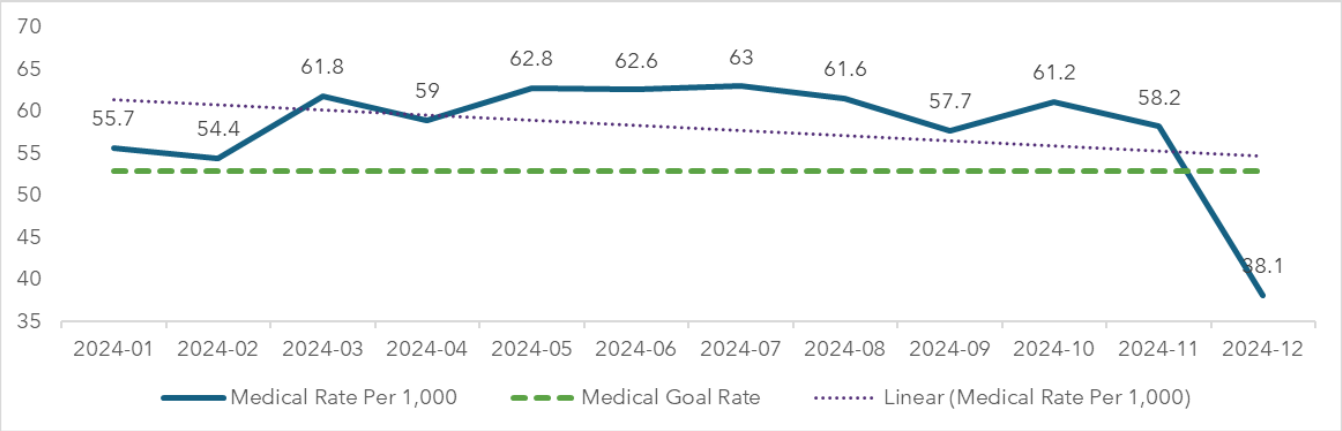
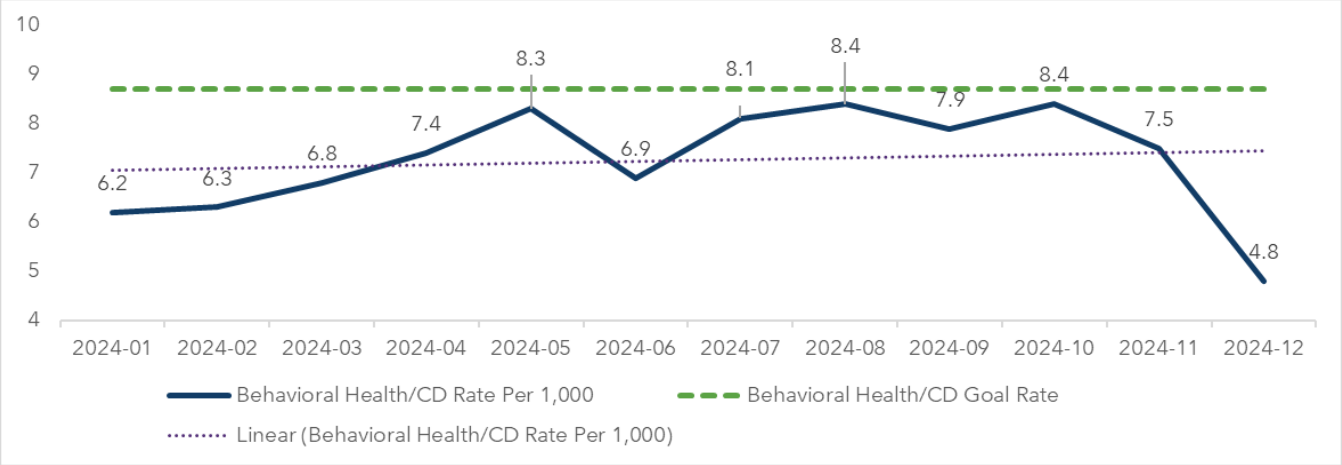


Figure 12. Emergency Department Visit Rates – Medical, PMAP/MinnesotaCare, 2024



Data Source: Hennepin Health Data Warehouse

Figure 13. Emergency Department Visits Rates, Behavioral Health/SUD, PMAP/ MinnesotaCare, 2024



Data Source: Hennepin Health Data Warehouse

High Dollar Claims

The high dollar claims report captures claims above $50,000 and identifies members with claims greater than $100,000. In 2024, 532 members' claims triggered CCM review and outreach (when appropriate) (Table 10). This is higher than the 128 from 2023 and higher than all previous reported years at 223, 25, and 31 from 2022, 2021, and 2020, respectively. These claims were reviewed by a RN who made appropriate referrals to CCM.

The notable increase in high dollar claims from 2023 to 2024 can be attributed to multiple factors. In 2024, Hennepin Health launched a process improvement to monitor high dollar claims more closely to be more predictive and proactive in identifying cases for outreach. The 2024 data then included cases with the potential for very high claims for outreach rather than being only reflective of the filed claims data. As such, the number reflected in 2025 is more inclusive than previous reporting. Additionally, 2024 was a year with some very long NICU stays for newborns which also impacts the high dollar claims.

Referrals for Social Service and Case Management

Hennepin Health accepts and receives referrals from primary care clinics, community organizations, Hennepin County Public Health and Human Services and internal staff. Members are identified by direct care relationships and referred for assessments and services for social service navigation, assistance with housing support service, and CCM for members with multiple chronic conditions. Referrals are received through Epic®, the Hennepin Health website, phone, fax, email, or the Hennepin Health Member Service Center. Referrals are screened for social service and care management needs. See Table 10 above for more information.

Member Experience with Population Health Programs

Hennepin Health regularly seeks input from members on all aspects of the services provided, including regarding Population Health programs. Feedback is sought in a variety of ways including direct surveying, partner surveys, and in person direct feedback during member interactions and events.

The SUD readmissions intervention is one that members are surveyed about directly by Hennepin Health. In 2024, after visiting with the peer support specialists, members were surveyed and asked, "Have you gotten the information you need about SUD Treatment? Yes or no?" There were 490 members who responded to the survey, answering "yes" to the question. There were zero "no" responses.

The report section on the diabetic eye exam campaign describes the diabetic member assessment that Hennepin Health developed and employs. The results inform the type of interventions we develop, and that specific feedback is how Hennepin Health knows that members with diabetes are looking for more information on how to manage their condition through nutrition. In 2025's analysis, Hennepin Health will also discuss how this information informed the creation of the *Flavors of Health* in lieu of services (ILOS) teaching kitchen program and food delivery and provide member feedback from that program, as well.

Hennepin Health's clinical partner for the FIT colorectal cancer screening program conducted a survey of members who completed the FIT screening and found that of the 23 people who responded 100% found the screening test easy to use and understandable. They included comments such as "great experience, nothing to improve on" and "a bit awkward to take but overall easy."

No complaints or grievances were received in 2024 regarding the Hennepin Health Population Health programs.

Appendix A: Project Descriptions

Tables below are the segments and goals of the 2024 Population Health Strategy document and provided as reference.

Segment	Focus Area	Organizational Support
No Risk: Members without risk of disease; focus on supporting wellness.	*Keeping Members Healthy*	**Member Needs:** Understanding benefits and how to access them; identifying and accessing providers for primary care; help with prescriptions or durable medical equipment (DME). *Member Services Interventions:* Bi-monthly member newsletters, website, Healthwise Knowledgebase® and Facebook posts; explain benefits, raise awareness on health education resources, highlight current events and topics. *Quality Management Interventions:* Outreach campaigns to members aimed at improving preventive care, such as *Care Coordination Interventions*: Coordination of Services (appointments, equipment, prescriptions, etc.); education for resources available in the member's community (housing, transportation, support groups, etc.); establish care with providers. *Population Health Interventions:* Fecal Immunochemical Test sent to members for Colon Cancer Screening.
Low Risk: SNBC Members with diabetes mellitus with risk of disease exacerbation, or a newly diagnosed chronic illness (Diabetes).	*Emerging Risk*	**Member Needs:** Access to specialty care and/or behavioral health providers to manage emerging or changing chronic conditions; resources/education supporting lifestyle management to maximize health and wellness, and to mitigate effects of chronic disease; learn ways to manage new diagnoses. *Member Services Interventions:* Explain benefits and how they may be accessed; connect members to providers. Bi-monthly member newsletters, website, Healthwise Knowledgebase® and Facebook posts. *Quality Management Interventions:*

Segment	Focus Area	Organizational Support
		Outreach campaigns to members identified with diabetes to encourage members to follow through on diabetes monitoring tests; support providers in building capacity for seeing and tracking members with these needs. *Care Coordination Interventions:* Coordination of services; referrals to community support groups/disease prevention programs; motivational interviewing; review health education materials; teach-back.
Low to Moderate Risk: Pregnant members have risk of disease/complications.	*Emerging Risk*	**Member Needs:** Access to specialty care and/or behavioral health providers to manage emerging or changing conditions related to pregnancy and other medical and/or mental health illness; resources/education supporting lifestyle management to maximize health and wellness, and to mitigate effects of disease/complications; learn ways to manage new diagnosis. *Member Services Interventions:* Explain benefits and how they may be accessed; connect members to providers. Bi-monthly member newsletters, website, Healthwise Knowledgebase® and Facebook posts. *Quality Management Interventions:* Outreach campaigns to pregnant members to encourage members to follow through on recommended interventions and strategies; support providers in building capacity for seeing and tracking members with these needs. *Care Coordination Interventions:* Coordination of services; referrals to community support groups/prevention programs; motivational interviewing; review health education materials; teach-back.
Moderate Risk: Members experiencing homelessness, and/or substance use disorder going	*Outcomes Across Settings*	**Member Needs:** Assistance with transitions between setting (inpatient to community); making connections to county/community agencies, care management programs, and social support networks; an individualized care plan to promote member's wellness.

Segment	Focus Area	Organizational Support
through transitions across settings.		*Care Coordination Interventions:* Targeted assessments with individualized care plans; coordination of services; implementing discharge/transitional plan; motivational interviewing; assistance accessing social and community supports; interagency coordination to reduce duplication of efforts.
High Risk: Members with multiple chronic diseases, medically complex, frequent visits to emergency department and/or inpatient admissions; may also have poor social supports or other psychosocial issues.	*Managing Members with Multiple Chronic Conditions*	**Member Needs:** Coordination of medically complex care needs; an individualized care plan to optimize member's wellness and function. Member may have multiple chronic conditions or may be complex due to other factors: disorganized care delivery, cognitive or developmental impairment, or other communication difficulties. *Care Coordination Interventions:* Personalized assessments; motivational interviewing; medication reconciliation; education/support for disease(s); coordination of services; assistance accessing social and community supports; interagency coordination to reduce duplication of efforts; may include face-to-face interactions.

Programs and Services for Focus Areas

Focus Area: Keeping Members Healthy - Immunizations and Vaccines

Goals	Target Population	Programs or Services
Improve HEDIS® Colorectal Cancer screening rate (COL) by 5% points over CY2022 data, or to a minimum of the 50th percentile, whichever is higher, for eligible members, ages 45 – 49 and 50-74.	Adults with screening gap.	Phone calls, texts, Facebook posts, newsletters, and emails to inform and remind members when due for colorectal cancer screening. Scheduling appointments assistance and/or interpreter services and answer any questions or concerns. Use of Healthwise Knowledgebase®. Inform members of incentives for completing colorectal cancer screening. Inaugural fecal immunochemical

Goals	Target Population	Programs or Services
		test (FIT) pilot campaign. FIT tests are at-home, annual colorectal cancer screening tests. Collaborative activities with Hennepin Health Accountable Health Model partners, such coordinated organizational outreach.

Focus Area: Managing SNBC Members with Emerging Risk- Diabetes Care

Goals	Target Population	Programs or Services
Improve HEDIS® eye exam for patients with diabetes (EED) by 5% points for eligible members. Reduce racial and ethnic disparity gaps Assess the member experience with the PHM program.	Members living with diabetes	Phone calls, texts, Facebook posts and emails to members living with diabetes to inform them of benefits, offer to set up appointments, transportation and/or interpreter services and answer any questions or concerns. Use of Healthwise Knowledgebase®. Inform members living with diabetes of incentives for completing eye exams.

Focus Area: Managing members with emerging risk – Pregnancy Care

Goals	Target Population	Programs or Services
Improve HEDIS® PPC first prenatal care visit by 5% points over CY 2019 data for eligible members. Improve HEDIS® PPC postpartum visit by 5% points over CY 2019 data for eligible members. Reduce racial and ethnic disparity gap for all groups	Pregnant people with delivery of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year.	Phone calls, texts, Facebook posts, and emails to pregnant members to inform them of benefits, offer to set up appointments, transportation and/or interpreter services and answer any questions or concerns. Use of Healthwise Knowledgebase®. Inform pregnant members of incentives for completing prenatal and/or postpartum visits.

Goals	Target Population	Programs or Services
		Prenatal and New Mom mailers with resources for healthy pregnancy and healthy infants.

Focus Area: Managing Outcomes Across Setting – Inpatient Care Coordination for Members Experiencing Homelessness and Substance Use Disorder

Goals	Target Population	Programs or Services
Hennepin Health navigation team will engage greater than 50% of all targeted members while inpatient. Readmissions among the targeted and engaged population will be under the Hennepin Healthcare commercial 30-day readmission rate of 14%. Assess the member experience with the PHM program.	Hennepin Health PMAP and MinnesotaCare members admitted to target/select inpatient units at Hennepin Healthcare (HCMC) either experiencing homelessness and/or have substance use disorder.	Housing navigation Complex care management Social service navigation Peer Recovery Support Targeted Outreach

Focus Area: Managing Multiple Chronic Conditions

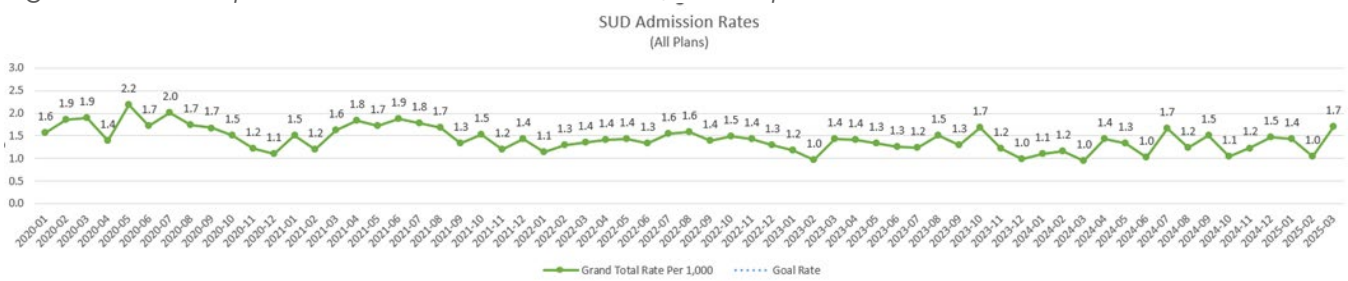
Goals	Target Population	Programs or Services
Ninety percent (90%) of referred members identified with multiple chronic conditions, co-occurring behavioral health disorders, substance use disorders (SUD), and chronic medical conditions will be evaluated for complex care management and managed as appropriate.	Members identified via the New Enrollee Screening, Annual Health Risk Assessment (MnCHOICES), Special Health Care Needs reporting, inpatient patient care coordination, social service navigation, or provider referrals with multiple chronic conditions such as SUD, behavioral health disorder, diabetes, and heart disease.	Complex care management SNBC care coordination

	How Member is Notified/Services Described	How Member can Opt Out
Members without risk of disease; focus on supporting wellness.	Members are notified of their eligibility and the FIT kit screening process via a prenotification letter prior to receiving home screening kits. SNBC members will also be notified by their case managers.	Information on opting out is included in the prenotification letter and includes a phone number and email address by which they can contact Hennepin Health to remove themselves from the program. SNBC members may opt out via their case manager.
Members living with Diabetes with risk of disease exacerbation, or a newly diagnosed chronic illness (Diabetes). Members are identified via Epic® and claims identifying members who are living with diabetes, outreach calls/postcards/routine health visits (primary care)/health risk assessment/complex case management/readmissions program.	Members are notified of their qualification when reached by phone, Facebook postings, member newsletters, member website and/or when member is contacted through programs, such as complex case management, readmissions program and conducting SNBC health risk assessments.	Information on opting out provided through call script and/or at the time when member is contacted through programs, such as complex case management, readmissions program and conducting SNBC health risk assessments.
Pregnant members have risk of disease/complications. Members are identified via Epic® and claims identifying members who are pregnant, outreach calls/postcards/routine health visits (primary care)/new enrollee screening survey.	Members are notified of their qualification when reached by phone, member newsletters, member website and/or if newly enrolled, through the new enrollee screening survey.	Information on opting out provided through call script.
Inpatient Care Coordination for members experiencing homelessness and/or substance use disorder. Members are identified via the daily real-time Epic® inpatient	This service is a support for members who at the time of admission to select inpatient hospital units at Hennepin Healthcare are experiencing homelessness and/or have substance use disorder.	When the member is visited in-person in their hospital room, staff explain the purpose of the service and offer an opportunity for

	How Member is Notified/Services Described	How Member can Opt Out
dashboard and are flagged as homeless and/or having substance use disorder.	Members are informed of available PHM programs and services when a Hennepin Health community care coordinator meets with a member in the hospital.	engagement in the interactive program. Member may decline participation (opt out) in the program and this choice is documented in the medical record system (Epic®) and in Essette® (care management system).
Complex Case Management Members of any age who meet one of the following criteria for enrollment: Members who have barriers to managing their care without the support of CCM, (e.g., poor support systems, fragmented care, health literacy barriers), or two (2) or more chronic medical conditions (e.g., CKD, COPD, CHF, DM, HTN, hyperlipidemia), and requiring the support of an individualized care plan.	This service is a support for members who have multiple/ unstable chronic conditions and/or have difficulty navigating the healthcare system without the intensive support of a care coordinator. When the member is identified, at least three efforts either in-person, or telephonic contact are made, When the member is reached, staff explain the purpose of Complex Case Management and offer an opportunity for engagement in the interactive program.	Members have the option of declining services (opt out), and this is documented in the medical record (Epic®) and Essette® (care management system).

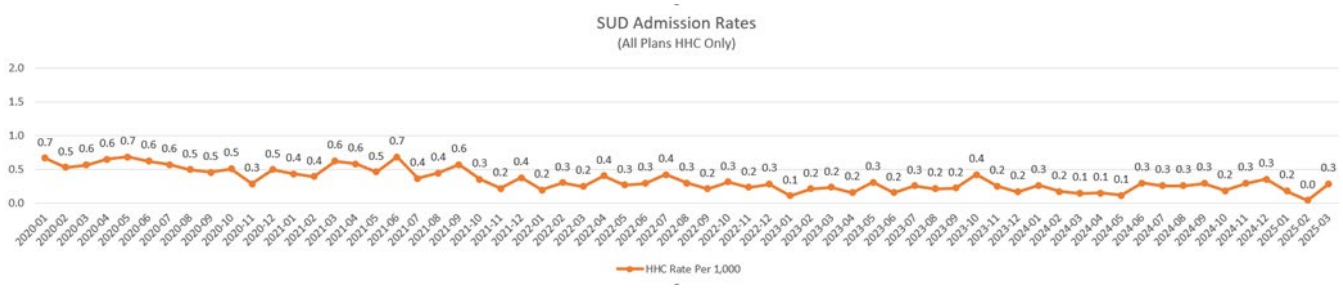
Appendix B: Additional Figures

Figure 14. Hennepin Health SUD Admission Rates, All Hospitals



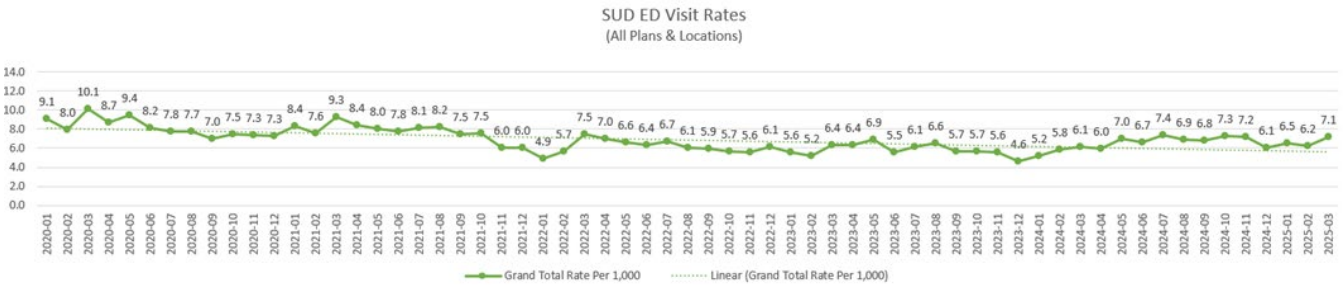
Data Source: Hennepin Health Data Warehouse

Figure 15. Hennepin Health SUD Admission Rates, Hennepin Healthcare



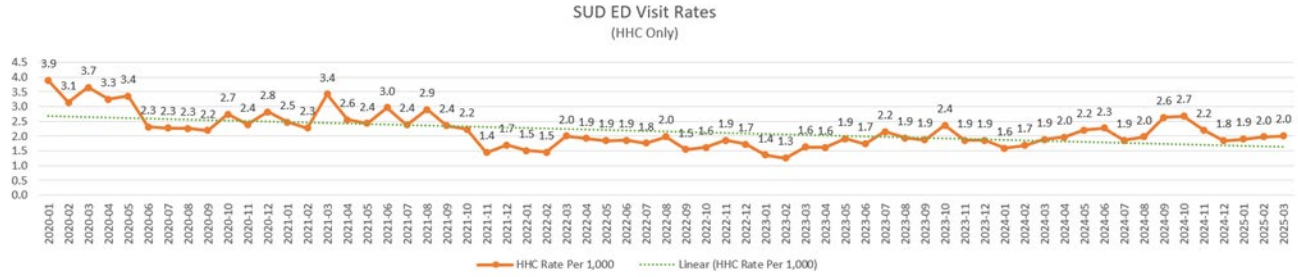
Data Source: Hennepin Health Data Warehouse

Figure 16. Hennepin Health SUD ED Visit Rates, All Locations



Data Source: Hennepin Health Data Warehouse

Figure 17. Hennepin Health SUD ED Visit Rates, Hennepin Healthcare



Contact information

Vanessa Bembridge, MPH, Population Health Manager
vanessa.bembridge@hennepin.us
612-596-0719
https://www.hennepinhealth.org/
300 South Sixth Street MC 604
Minneapolis, MN 55487-0604

Hennepin Health
your community health plan