Hennepin Health
your community health plan

Population Health Strategy

2025

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Program Purpose

To identify the strategy Hennepin Health utilizes as an organization to assess, segment, and act to meet the needs of its member population within the context of the communities where Hennepin Health members live.

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 members and to improve care coordination for members with high risk and complex conditions. In 2012, Hennepin Health established an Accountable Health Model (AHM) with three county-based provider organizations: Hennepin County Health and Human Services, Hennepin Healthcare, and NorthPoint Health and Wellness. The model is based on principles of population health management. Some key principles of the Accountable Health Model 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 drivers of health are addressed as part of a member's health care.

Based on these principles the Accountable Health Model 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 providers.
2. A collaborative decision-making process for providers and the payer.
3. Collaboration with Hennepin County Public Health and Human Services 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 service navigators and care guides to address social determinates of health.
7. Multiple clinical sites that provide integrated behavioral, substance use treatment, and physical health services

Program Direction and Strategy

Efforts to improve and manage the health of populations require a combination of member, health care system, and community level approaches. Hennepin Health is dedicated to increasing the quality and value of its members' health care by improving preventive care, chronic disease care, and care coordination for people with the most 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 large subpopulation of our membership is low-income adults without children. Unstable housing, which is pervasive in this population, often leads to higher utilization of emergency room services, hospital readmissions, injuries, and illness caused by exposure to the environment. Often there is a coexisting substance use disorder, mental illness, and criminal history. The combination of all those factors increases health care costs and utilization and reduces the use of primary care and preventive services.

Hennepin Health recognizes the importance of leveraging primary care clinics to promote and educate members about routine care. To reduce gaps in care in a member-centric socially focused manner, our work has focused on engaging people in their own space. Hennepin Health implements an annual comprehensive strategy for our population health management program based on the National Committee for Quality Assurance (NCQA) *Population Health Management* standards. Through our programs, we work to accomplish the following:

- Keep members healthy
- Manage at-risk (emergent) populations
- Manage outcomes across settings
- Manage chronic disease and multiple chronic conditions

To accomplish these goals, Hennepin Health utilizes a data-driven process to select programs and services that aim to improve the health of our members.

Organizational Support for Population Health Management

As an organization, Hennepin Health is engaged in promoting the health and wellbeing of members, so much that in late 2023, Hennepin Health hired the organization's first Population Health Manager and created a department for the endeavor. This commitment grew the company's existing population health work and expanded it into new areas and will continue to do so for the foreseeable future. Population health work has always been embedded in all that Hennepin Health does, and different departments address specific segments of the population. Now that work happens with guidance, integration, and support from the Population Health Department. For example, the Member Services, Population Health, and Quality Management departments all provide proactive outreach to members with no identified risks to promote "*Preventive exams and associated screenings*" thereby keeping members healthy in the population we serve. The Quality Management department identifies and supports "*Members with Emerging Risk*". The Medical Administration Care Management department is particularly focused on assisting members with *"Outcomes Across Settings"* and *"Managing Multiple Chronic Illnesses*", though there are also care coordination programs that provide member-specific interventions for the lower risk segments of the population (see table that follows). Members may move along the acuity continuum as their needs change, and services will be matched to the member's level of need. In other words, while a member may have few identified risks, they may have difficulty navigating the health care system and require an intensive level of intervention.

Conversely, a member with multiple chronic conditions may have well-established support systems and not require the assistance of the care coordination team to access care.

Segment	**Focus Area**	**Organizational Support**
No Risk: Members with minimal 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). Free YMCA gym memberships for SNBC members and a 40% discount for PMAP and MinnesotaCare members *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 routine immunizations (focus on children's Combo-10 and adolescents Combo-2). *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:* Adult Preventive Visit campaign launching by end of 2025 to include outreach, provider partnerships, value-based payment methodologies, care coordinator support, member scheduling assistance, and more.
Low to Moderate Risk: Members with diabetes mellitus with risk of disease exacerbation, or a newly diagnosed	*Emerging Risk*	Member Needs: Access to specialty care and/or behavioral health providers to manage emerging, changing, or co-occurring chronic conditions; resources/education supporting lifestyle management to maximize health and

Segment	Focus Area	Organizational Support
chronic illness (Diabetes).		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:* Collaborative outreach campaign with the SNBC care coordinators/care navigators to members living with diabetes to encourage preventative care and follow through on diabetic monitoring tests. Monitoring of and support for co-occurring mental health issues. *Care Coordination Interventions:* Coordination of services; referrals to community support groups/disease prevention programs; motivational interviewing; resource identification, appointment scheduling, review health education materials; teach-back. *Population Health Interventions:* In Lieu of Services (ILOS) Teaching Kitchen program called *Flavors of Health* to teach members how to prepare food to optimize their condition management. Class is followed by 8 weeks of healthy food delivery. Collaborative campaign outreach, including a focus on SNBC care coordination, to increase diabetic eye exams.

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. *Population Health Interventions:* In Lieu of Services (ILOS) Teaching Kitchen program called *Flavors of Health* to teach members how to prepare food to optimize their health during pregnancy and beyond. Class is followed by 8 weeks of healthy food delivery.
Moderate Risk: Members experiencing homelessness, and/or substance use disorder going through transitions across settings.	*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. *Care Coordination Interventions:* Targeted assessments with individualized care plans; coordination of services; implementing discharge or 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 – Cancer Screening

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. Assess the member experience with the PHM program.	Adults with screening gap.	Phone calls, texts, Facebook posts, newsletters, and emails to inform and remind members when due for colorectal cancer screening. Appointment scheduling assistance and/or interpreter services and answer any questions or concerns. Use of Healthwise Knowledgebase®. Inform members of financial incentive for completing colorectal cancer screening. Fecal immunochemical test (FIT) home CRC screening campaign. Collaborative activities with Hennepin Health Accountable Health Model

Goals	Target Population	Programs or Services
		partners, such as coordinated organizational outreach and data sharing to improve accuracy in identification of care gaps.

Focus Area: Managing 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 over CY2022. Reduce racial and ethnic disparity gap for Black population when compared to the Non-Hispanic White population in 2024. 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 financial incentives for completing eye exams. Increased training for SNBC Care Guides of members with diabetes to facilitate member eye exams. Expand number of contracts with eye care providers to ensure member access to exams.

Focus Area: Managing Members with Emerging Risk – Pregnancy Care

Goals	Target Population	Programs or Services
Improve HEDIS® PPC first prenatal care visit by 2.5%[1] points over CY 2019 data for eligible members.	Pregnant people with delivery of live births on or between November 6 of the year prior to the	Phone calls, texts, Facebook posts, and emails to pregnant members to inform them of benefits, offer to set up

[1] This goal is adjusted from the original 5% goal based on historical data as well as an acknowledgement that Hennepin Health's prenatal visit rates are already higher than the most recent national Medicaid HMO PPC-prenatal rate reported by NCQA of 83.1% in 2023.

Goals	Target Population	Programs or Services
Improve HEDIS® PPC postpartum visit by 6%[2] points over CY 2019 data for eligible members. Reduce racial and ethnic disparity gaps	measurement year and November 5 of the measurement year.	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. Prenatal and New Mom mailers with resources for healthy pregnancy and healthy infants. *Flavors of Health* teaching kitchen and food delivery program.

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 40% 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

[2] In 2024, Hennepin Health surpassed the existing goal of a 5%-point improvement over the 2019 baseline data with a 5.7%-point improvement. The new goal is to improve further to a 6%-point improvement.

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

Informing Members about Available PHM Programs

Members are informed about our programs through various communications. The information provided pertains to eligibility for programs and services, how to use the services and when appropriate, how to opt out.

Written information about programs is provided to members in new member packets, member website, member newsletters printed, emailed and posted on the Hennepin Health website, and Facebook. The 2022 Fall Member Survey results revealed the members preferred communication method about Hennepin Health benefits, services, and rewards program through email (41%) with text messaging (22%) the second most preferred method. The communication preference for members is unchanged when compared to the 2020 Fall Member Survey which identified that members preferred communication method was email (50%) with text messaging (37%) the second most preferred method[3]. Since 2024, members are notified of available PHM programs via text messages sent by Agent511, Hennepin County's texting vendor. Information is also provided via the telephone when members call customer service, both while they wait for a representative through a pre-recorded hold message and when they are speaking to our representatives. Members also are informed of programs and services when they visit our Member Service Center either through information displays, written materials, and discussions with Hennepin Health staff. The Member Service Center reopened in May 2022 and relocated to the Hennepin County Health Services Building at 525 Portland Avenue. This location allows our members to access Hennepin Health's Member Service Center while they make use of other services in

[3] The 2024 Hennepin Health member survey was conducted but did not include questions around preferred communications. The 2025 member survey will again ask regarding preferred communications.

the building such as the Public Health Clinic, Red Door Clinic, Adult Representation Services, and more.

Members who are eligible to receive a FIT kit as part of the colorectal cancer screening campaign are informed via a prenotification letter 1-2 weeks prior to receiving the kit that explains why they have been selected, why it is an important screening, and information on how to opt-out of the program. They receive opt-out information again when they receive the FIT kit along with a printout of the colorectal cancer screening incentive voucher to send to Hennepin Health upon completion of the test to receive a gift card. Members who qualify for the *Flavors of Health* ILOS program receive information about their eligibility to participate in a variety of ways including MyChart messaging from our AHM partners and direct emails from Hennepin Health. *Flavors of Health* is an opt-in program with condition-specific eligibility criteria.

Coordination of PHM Programs

As an organization, Hennepin Health has many different member programs/initiatives concurrently planned and executed. Until mid-2024, Hennepin Health utilized the Essette® case management software system to plan and/or execute the programs impacting our members and prevents duplication of effort. Hennepin Health transferred this work to a new system called GuidingCare® which allows for the same planning capabilities with several user enhancements.

To further coordinate programs throughout Hennepin Health, the Population Health Manager meets regularly with the Chief Medical Officer, Medical Administration department (Care Coordination, Pharmacy, Utilization Management, and Social Service Navigation), Quality Management department, and the Marketing, Outreach, and Communications team. Additionally, the PHM manager meets regularly with the Hennepin Healthcare Population Health Director to provide updates on new initiatives and to coordinate efforts across memberships and strategize about data sharing across the AHM. Through these mechanisms, Hennepin Health actively coordinates activities that involve contacting members to minimize disruption for members, increase the likelihood of a productive interaction, and improve the overall effectiveness of population health programs.

In addition, there are Hennepin Health Executive and Management Committee meetings that convene to review programs and initiatives to leverage activities to maximum effect and ensure teams are collaborating. Hennepin Health Care Management and Social Service Navigation and Quality Management staff work collaboratively with providers, multidisciplinary health agencies, community resources, and community collaboratives/workgroups. The goal of Hennepin Health's collaboration is to assist in the identification, planning and support of healthy initiatives in the community, and to identify specific members that can benefit from community programs and resources.

Informing Members on Interactive Content

Interactive discussions occur between members and Hennepin Health staff, including care coordinators and social service navigators. Member events also are used to provide

information about services and answer member questions. Additionally, Hennepin Health collaborates with providers to design the programs and service identified in the Hennepin Health Population Health Strategy to fully inform members about options available. The interactive discussion described in this section routinely includes information about how members become eligible to participate, how to use program services, and how to opt in or out of the program. Many Hennepin Health's programs and services are designed to be interactive, allowing members to select the extent to which they wish to engage in these opportunities. In all instances, members can opt out of the program. Should the member express this wish – in writing, in a telephonic conversation, or through a face-to-face interaction, this preference is documented for the campaigns.

How Member is Identified/Eligibility	**How Member is Notified/Services Described**	**How Member can Opt Out**
Members without risk of disease; focus on supporting wellness. (Colorectal Cancer Screening) Members are identified via data from our AHM partners at NorthPoint and Hennepin Healthcare and via internal Hennepin Health claims data. Members are indicated as due for CRC screening and removed from the sample if there are clinical exclusions.	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 also 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 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 is 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.

How Member is Identified/Eligibility	How Member is Notified/Services Described	How Member can Opt Out
Pregnant members have risk of disease or 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, Facebook postings, member newsletters, member website, prenatal mailed packets, New Mom mailed packets, and/or if newly enrolled, through the new enrollee screening.	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 report and are flagged as homeless and/or having substance use disorder.	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 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.	The member is visited in-person in their hospital room, staff explain the purpose of Care Coordination and offer an opportunity for engagement Participation in Care Coordination is voluntary and all interactions with members are noted in Epic® (EHR).
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 complex case management (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	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/if the member is reached, staff explain the purpose of CCM and offer an	Members voluntarily participate in CCM and their consent to participate is documented in the medical record (Epic®).

How Member is Identified/Eligibility	How Member is Notified/Services Described	How Member can Opt Out
requiring the support of an individualized care plan. For SNBC members, CCM is provided upon request when care coordination needs exceed SNBC care management requirements.	opportunity for engagement.	

Promote Health Equity

Promoting health equity is at the center of the Hennepin Health vision to change how we build healthy, equitable communities and at the heart of the vast majority of Hennepin Health's work over the past several years. Hennepin County has implemented a sustained, long-term effort to enhance its work to reduce disparities in Hennepin County across seven intersecting domains: health, housing, income, justice, education, employment, and transportation. Because Hennepin Health has expertise primarily in the health domain, most Hennepin Health disparities reduction work is focused on reducing health disparities while other Hennepin County departments with deeper expertise focus more in-depth on the remaining six domains. Hennepin Health does, however, continue active initiatives in all seven domains and actively collaborates with other Hennepin Health departments working within the other domains.

Under the leadership of the Hennepin County Board of Commissioners and in alignment with the broad and sustained work to reduce disparities across Hennepin County, Hennepin Health has deepened its enduring commitment to closing racial disparities. As a department of Hennepin County, Hennepin Health has actively participated in countywide efforts to promote inclusion and reduce disparities across sectors and communities. As an organization serving a significant population of members with disabilities, Hennepin Health has also intentionally expanded its disparities reduction conversations to include both disparities rooted in race, as well as disparities faced by members with disabilities.

Through the Diversity, Equity, and Inclusion division of Hennepin County, which is a part of the Disparities Reduction line of business, Hennepin Health requires training that helps staff attain skills and understanding to be more effective in the workplace, be more supportive of colleagues, and help government advance equity and meet the needs of all residents and Hennepin Health members.

All Hennepin Health team members, including new staff upon hire, are required to attend a half-day training on Advancing Racial Equity. This training brings participants to a deeper understanding of the roots of racial disparities in societal outcomes. Through this training,

Hennepin Health staff gain awareness of the history of race; implicit and explicit bias; and individual, institutional, and structural racism and how it affects our lives. The training emphasizes that each staff member has an important role in reducing disparities at Hennepin County and helps participants understand government's role in reducing disparities and creating a more equitable society.

All Hennepin Health staff with supervisory and project management responsibilities are required to attend the Racial Equity Impact Tool (REIT) training. The REIT is designed to integrate explicit consideration of racial equity into decision-making. The REIT is a set of questions structured to elicit examination of how different racial and ethnic groups will likely be affected by a proposed action or decision, and to assist in uncovering where our choices may have a disparate, adverse impact on some groups. Use of the REIT provides a systematic way to engage the voices of those affected by decisions, surface unintended biases and consequences of decisions before they are made and reveal a wider range of options for policy choices.

Below are some activities Hennepin Health is involved in that promote equity in the management of member care through our PHM strategy.

Performance Improvement Projects (PIPs)

Hennepin Health works with other Minnesota managed care organizations (MCOs) and stakeholders in the implementation of PIPs that 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. Hennepin Health is a participant in the MCO PIP Collaborative (known as the Collaborative) which in 2025 includes BluePlus, HealthPartners, IM Care, Medica, PrimeWest, South Country Health Alliance, and UCare.

As part of the 2024-2026 PMAP/MinnesotaCare and SNBC PIPs, the 2022 Hennepin Healthcare Community Health Needs Assessment goals were incorporated into the PIP proposal. Also, incorporated into each PIP are *community informed measures* based on member input on their interactions with the healthcare systems. To accomplish this, the PIPs are focused on community engagement which includes *obtaining public feedback on analysis, alternative, and/or decisions*. The corresponding promise to the public is to keep *you informed, listened to, and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.*

- The PMAP/MinnesotaCare "Healthy Start" PIP, which began in 2021 and continues through 2026, promotes a healthy start for PMAP/MinnesotaCare children by focusing on and improving services provided to pregnant members, infants, and children, ages 1-3, particularly in populations experiencing racial and ethnic disparities in health care and outcomes. Hennepin Health supports joint collaborative interventions in addition to plan-specific strategies. The Collaborative hosts webinars on topics such as implicit bias. Other activities that Hennepin Health is currently involved in include promoting doula care and working with our Accountable Health

Model partners on promoting established culturally congruent prenatal groups for Black and Native American pregnant people. The Collaborative continues to forge partnership with organizations whose work revolves around promoting health equity in maternal and child health such as Birth Justice Collaborative (BJC), Minnesota Department of Health (MDH) and Minnesota Medical Association (MMA).

- The SNBC 2024-2026 "The Impact of Depression on the Management of Diabetes Care" focus is to improve the health and wellness of SNBC members with co-occurring diabetes and depression. As the focus is on reducing the disparities in diabetes care, the plan refers to existing evidence-based programs to address the many factors that influence health. A collaborative approach between both health care and non-health care factors to improve diabetes and addresses the social, environmental, and mental health factors that affect vulnerable populations are considered. Examples include access to nutritious foods and options for physical activity.

Health Equity Stakeholder/Community Engagement

Hennepin Health has implemented a process for engaging and obtaining input to advance health equity from communities in the enrolled populations groups who experience disparate outcomes. Hennepin Health participates in several community-led initiatives that capture and address stakeholder feedback around health inequities in access to the quality and access to care. Based on the community stakeholder feedback, Hennepin Health develops and executes plans to use the information to respond to issues raised. Some community group meetings Hennepin Health is working with in 2025 are listed below.

- Birth Equity Community Council (BECC) of Ramsey County
- Hennepin Health American Indian Community Outreach Workgroup
- American Indian Community Meeting
- Hennepin Health Accountable Health Model Maternal/Perinatal Workgroup
- Unsheltered Needs Meeting
- High Rise Health Alliance Meeting

Reinvestment Opportunities

Hennepin Health has a strong collaborative relationship with our Accountable Health Model partners. Hennepin Health has funded several reinvestment projects designed to improve care and racial disparities. Some projects still running in 2025 which promote health equity include the following:

- SUD continuity of care model, supported by Licensed Alcohol and Drug Counselors and peer support specialists.
- Culturally responsive model of psychiatric care for Somali, East African, and other Muslim patients.
- Hennepin Healthcare Cerebrovascular Ultrasound Lab – SAVE BRAIN Initiative.
- Mobile Post Partum Healthcare Delivery

- Improving Inpatient to Outpatient Care Coordination for Medication for Opioid Use Disorder (MOUD).
- Improving Transitions of Care from Hospital Discharge to Primary Care Follow-Up
- Centralized PAP Smear Results Management and Follow-Up (PAP Core).
- Healthy for Life: Skills and Education Through Group Medical Visits.

Unfortunately, due to budget constraints affecting Hennepin Health and all MCOs, there will be no additional reinvestment opportunities in 2025 and possibly 2026. Hennepin Health has, however, supported our AHM partners in other ways when possible. For example, Hennepin Health's value-based funding agreement with NorthPoint Health and Wellness provided the financial support for the Child Wellness Center in the 2024 NorthPoint campus expansion. The Child Wellness Center is a beautifully designed space for children to rest, relax, and play while their parents receive care at NorthPoint.

Promoting equity in the management of member care

In addition to the existing equity work of the organization, the Population Health 2025 plan incorporates the continuation of a new equity effort and related initiative for members. In 2024, Hennepin Health launched a home Fecal Immunochemical Test (FIT) campaign pilot to screen members for colorectal cancer. Hennepin Health's colorectal cancer screening (COL) HEDIS® rate for 2023 was 22.6%, far lower than the 2023 MNCM reported overall MCO statewide rate of 54.8%[4]. The pilot FIT campaign increased our HEDIS rate for COL by 3.48 percentage points to 26.4% in the first year without having yet included the entire eligible population. The 2025 plan is to expand screening to the remaining eligible population with a few updates to the sampling methodology and improved data sharing partnerships with our AHM partners. Upon completion of year 2 of the pilot program, Hennepin Health will assess the results, further streamline the processes, and implement an annual campaign to include all eligible members for whom we have an attributed healthcare system to ensure follow up. At the time of the 2024 campaign launch, there were not notable inequities between race groups among members that are getting screened. Hennepin Health seeks to avoid inadvertently creating any inequities with our campaign and the analysis of the pilot showed no marked change in inequities amongst those who participated in the pilot Round 2 of the pilot will also monitor for inequity creation and adjust the processes and outreach techniques if any are inadvertently created.

Hennepin Health undertook a thoughtful and thorough process to decide on home FIT kits as the preferred way to increase COL screening rates. There are multiple testing options for people to be screened for colorectal cancer. The Hennepin Health members who are current on their CRC screening have most often had a colonoscopy (57.6% of those screened in 2023), which is a time demanding experience that requires intense, difficult, unpleasant preparation, made even more challenging for someone who is housing insecure

[4]Minnesota Department of Health. Healthcare Disparities in Minnesota by Insurance Type [PDF]. Retrieved from https://mncmsecure.org/website/Reports/Community%20Reports/Disparities%20by%20Insurance%20Type/Disparities%20by%20Insurance%20Type_2023%20MY%20-%20FINAL.pdf

and therefore without reliable access to a toilet. After considering this and speaking with our AHM partner clinicians about the different testing options, Hennepin Health decided to send our members FIT kits to meet their screening needs. FIT tests require minimal preparation, have easily returnable samples, and work around the schedules of our members.

Throughout the launch of the campaign, Hennepin Health closely monitored the metrics of who is completed the tests and worked to avoid the creation of inequities. Hennepin Health does not only monitor the data by race but also uses GIS mapping to understand whether certain communities or locales are struggling more with completing or returning their FIT kits. The 2024 pilot GIS data mapping also did not uncover any inequities. If inequities begin to surface, Hennepin Health will focus more resources on the groups or locales falling behind.

Population Identification

Data integration

Hennepin Health integrates the following data to use for population health management functions:

Medical and behavioral claims or encounters and pharmacy claims.
Medical, dental, and behavioral health claims data are loaded weekly into our data repository to integrate with other types of information. The repository includes enrollment data, medical claims data, behavioral claims data, pharmacy claims data, dental claims data, and data from the care management system. The data is used to analyze the need for specific initiatives, to analyze the impact of these initiatives, and to guide health plan operations.

Laboratory results.
Laboratory results are available through the electronic medical record (EMR) system we share with our providers.

Health appraisal results.
Health appraisal results are stored and accessed in GuidingCare®, our care management system.

Electronic health records.
Hennepin Health has access to Hennepin Healthcare's EMR system. The medical management teams use the EMR to guide care management activities. EMR data is combined with claims data for health plan analysis. An example of this integration is our use of the Hennepin Healthcare's housing insecurity flag in population health analyses. Another example is the identification of pregnant members for outreach,

Health services programs within the organization.
Hennepin Health uses HealthEdge GuidingCare®, a care management software system, to track the services we offer and evaluate their effectiveness. For example, we have assessed the impact of a utilization management (UM) program to support the care of members with schizophrenia and used the care management data to document and assess the impact of this work. We also flag members with certain pharmacy prescriptions, members in waiver programs, members in our restricted recipient program, and those eligible for well-child visits. In 2024, Hennepin Health moved from Essette® to GuidingCare® which has the core capabilities of Essette® and several enhancements.

Advanced data sources.

Minnesota Immunization Information Connection (MIIC) data is available to Hennepin Health. The data is used to supplement our claims data with immunization and COVID-19 vaccinations data that may have not been billed.

Population assessment

The organization annually:

Assesses the characteristics and needs, including social drivers of health, of its member population.
Hennepin Health uses the various sources listed above to identify the characteristics and needs of our member population and subpopulations. Information related to medical costs is evaluated along with other member data that may identify age groups, genders, ethnic or racial characteristics, languages, members residing in the high-risk SVI (social vulnerability index) zip codes or other social determinants of health that may point to specific needs. We often analyze Hennepin Healthcare's housing insecurity flags. Data from the county to analyze participation in county programs and case management services is also used. Monthly, Hennepin Health analyzes medical spending by category, including inpatient, outpatient, mental health, professional, and pharmacy. This reporting is supplemented with reports on hospital admissions, readmissions, emergency department use, utilization of specific drugs, and rates of dental utilization. More specialized analyses look at specific utilization targets such as the use of opioid medications.

In 2024, the Hennepin Health Medical Administration team, including the Population Health Manager, began a weekly data huddle to monitor our member population's needs. The team reviews performance and utilization metrics that are updated weekly to identify important trends and opportunities for further alignment and collaboration on behalf of members in the timeliest manner possible.

Social determinants of health have long been a focus of Hennepin Health programs and assessments. Because of our position as a part of Hennepin County's government structure and unique relationships with provider and community partners, the organization has both the need for and access to data to assess social determinants of health. A study published in 2018 by Hennepin Health examined the use of a variety of County services most utilized by Hennepin Health members and contrasted high utilizers of medical services with other

members. The study showed that high utilizers of medical services also had high needs for a variety of housing services, food support, financial support, and case management. These high utilizers also had more contact with the criminal justice system.

Identifies and assesses the needs of relevant member subpopulations.
Hennepin Health routinely assesses the characteristics and needs of subpopulations among members. Our utilization reports break out information about the members in our three products: PMAP, MinnesotaCare and SNBC. The PMAP population is further broken into information about PMAP children, PMAP parents, and PMAP adults without children (Medicaid Expansion) members. The PMAP adults without children comprises about 70% of our PMAP membership. Demographic analyses provide information by gender, age, race, and social determinants of health. Disease specific breakouts include members with substance use disorder and mental health diagnoses.

We conduct assessments of members attributed to certain health systems, new members, members experiencing housing insecurity, and members in certain products.

Finally, as a health plan member in the Center for Community Health (CCH) collaborative, we utilize information the Community Health Needs Assessments (CHNA) completed by the metro area local health systems, and completed by local public health systems, such as Hennepin County Public Health and the City of Minneapolis as a source of reliable data about our population and the community to understand issues pertinent to the residents we serve. The Population Health Manager at Hennepin Health served on the planning committee for the county's CHNA in 2024 which will be released in 2025.

Assesses the needs of child and adolescent members.
Hennepin Health conducts population analyses to assess the needs of our child and adolescent population. Hennepin Health sometimes also includes parents/guardians or pregnant members. The organization typically coordinates with provider systems to focus on the children and adolescents utilizing the services there. The provider system and Hennepin Health meet to interpret results and brainstorm initiatives to impact those members. Analyses focus on demographics, mental health diagnoses, substance use disorder diagnoses, attribution, and risk scores. Analyses also include housing insecurity, county human service program utilization, diagnosis code categories, primary care utilization, ED utilization, inpatient service utilization, professional services utilization, and pharmacy utilization. These ongoing assessments informed the development of one of Hennepin Health's 2023 reinvestment projects, which was a collaborative care model for integrated behavioral health/primary care in the Hennepin Healthcare Adolescent and Young Adult Clinic.

Assesses the needs of members with disabilities.
Hennepin Health members with disabilities are in our SNBC population. As described above, analyses of member demographics, health care service utilization, and disease burden are done for all three product populations and are typically segmented by product. In addition to these analyses, SNBC members are asked to complete a Health Risk Assessment upon enrollment and annually thereafter. These assessments identify members

who have targeted case management, members without primary care clinic relationships, and members in waiver programs. These assessments guide our decisions about appropriate support for these members.

Assesses the needs of members with serious and persistent mental illness (SPMI).
Hennepin Health routinely conducts analyses of members with mental health diagnoses to understand the types of diseases affecting our members, the locations where they receive their care for these conditions and their use of targeted case management or assertive community treatment. As suggested in the previous paragraph, analyses of the SNBC population with mental health conditions are particularly important since so many of our members in this population have a disability related to their mental health diagnosis and therefore are considered to have serious and persistent mental illness. For the SNBC population, the most common mental health diagnoses are depression, anxiety, post-traumatic stress disorder, schizophrenia and related diagnoses, and bipolar disorder. In 2025, Hennepin Health will undertake a process in partnership with leadership from all areas of Hennepin County to ascertain how we can best meet the needs of citizens and members, often with SPMI, who have serious mental health-related sentinel events including emergency room visits, readmissions, and jail stays. Hennepin Health will then develop a double pronged strategy to both identify and support members at risk for a sentinel event, and support those who have experienced one to prevent further harm and implement this strategy by early 2026.

Assess the needs of members of racial or ethnic groups.
As stated above, Hennepin Health incorporates racial or ethnic groups data from the Department of Human Services (DHS) enrollment data and Hennepin Healthcare's EMR data when assessing the needs of the members. The information is used routinely to identify and address the specific barriers of groups that lag furthest behind on any topic during the planning of interventions, assess the effectiveness of initiatives to reduce racial disparities, and ensure that interventions do not inadvertently create new disparities. All Population Health interventions and campaigns assess inequities during the planning process, during the campaign itself, and at the conclusion (for those with a finite end). This is true across departments at Hennepin Health. For example, the Quality Management Dashboard includes a tab that tracks each metric by race and ethnicity and displays current disparities by metric and group. This dashboard is in the process of being updated in 2025 to be more expansive in topic and to provide more immediate data from our systems.

Assesses the needs of members with Limited English proficiency.
Hennepin Health complies with the recommendations of the revised Policy Guidelines published on August 4, 2003, by the Office for Civil Rights of the Department of Health and Human Services, titled "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient (LEP) Persons". Hennepin Health requires our providers and subcontractors to apply the four factors described in the above document to the various kinds of contacts they have with the public to assess language needs, and decide what reasonable steps, if any, they should take to ensure meaningful access for LEP persons.

Hennepin Health routinely analyzes the language spoken by our members. Currently, 91% of our members speak English, 5% speak Spanish, and 4% speak other languages. Hennepin Health utilizes its LEP plan and the Hennepin County LEP plan to ensure that members have meaningful access to our health plan programs and services. Hennepin Health provides qualified interpreters or information in accessible formats to our members. As an example, based on needs assessment and member feedback, Hennepin Health translated the wellness rewards incentive vouchers to Spanish and Somali languages. In 2024, Hennepin Health began sending Spanish versions of its all-member mailings to members who listed Spanish as their primary language. Based on the needs assessment, Hennepin Health will translate documents and provide information in alternative formats for members with visual impairment of LEP. Additionally, Hennepin Health staff assesses member LEP needs in our ongoing personal conversations with members. Hennepin Health team members have a higher level of interaction with individual members than do those at other health plans because of our general accessibility as a small MCO, particularly as one with a walk-in customer service center. For example, a Hennepin Health employee recently learned that a member with vision impairment needed an accessible member ID card. Hennepin Health staff found a resource to produce a member ID card in braille for that member, who was extremely grateful to have their needs addressed, and now has better access to Hennepin Health services because they can more easily locate contact information in a language that they can read.

Activities and resources

The organization annually uses the population assessment to:

Review and update its PHM resources to address member needs.
Historically, the Hennepin Health Population Health Management Committee oversaw the implementation our PHM program. The committee was comprised of senior leaders from Hennepin Health's Medical Administration, Quality Management, Analytics and Finance departments, Hennepin Health's Chief Medical Officer, Hennepin Health's Accountable Health Model program manager (embedded at Hennepin Healthcare) and a senior leader in Hennepin Healthcare's population health program. With the creation of a formal Population Health department with a manager, specialist, and analyst, this process has changed somewhat. The Population Health team, under the guidance of Hennepin Health's Chief Medical Officer, developed a data-informed strategic plan. The strategies within have been presented to Hennepin Health leadership and stakeholders as listed above on a quarterly basis for feedback and approval. The Population Health department continues to utilize the population health assessment and continually discusses new data analyses, review current PHM activities, and assesses the need for changes to our resource allocations in response to changing member needs.

Review community resources for integration into program offerings to address member needs.

Hennepin Health staff use a wide variety of community resources and programs to help members meet their health and social service needs. Our social service navigation team in particular has extensive experience with community organizations that address housing insecurity, food insecurity, employment, financial support, transportation, and other needs. Hennepin Health staff do not just refer members to these organizations; they follow through with members to be sure the community resources are meeting their needs. Hennepin Health staff has developed a strong understanding of the abilities and assets of the community organizations that our members use for support. This expertise is invaluable as navigators make decisions about the referrals that best support our members. Hennepin Health contracts with Unite Us as a community directory for additional services to offer to members. In addition, Hennepin Health works with the Hennepin County Office of Multi-Cultural Services to help LEP residents become independent by connecting them to resources and services offered by Hennepin County and the community partners in their preferred language. Hennepin Health also refers members to the Office of Broadband and Digital Inclusion which provides members and Hennepin County members with the tools, knowledge, and skills needed to participate in a digital world, from lifelong education to employment and training, and access to essential services such as telehealth.

Segmentation

At least annually, the organization segments or stratifies its entire population into subsets. Hennepin Health segments its entire population by age and gender to understand relative sizes of these groups and the specific characteristics and needs of these groups. The analysis tracks the race, ethnicity, and language of the members in the segments. In addition, it tracks the following by segmented population.

- Prevalence of serious mental health diagnoses.
- Prevalence of substance use disorder diagnoses.
- Cases of multiple emergency room visits.
- Cases of multiple hospitalizations.

Hennepin Health maps our key clinical and social programs to specific segments to understand relative sizes of these groups. The PHM department reviews the size of the segments along with the race/ethnicity makeup of each segment.

Segment	Size	Description
Dental Gaps for Outreach	17,866 Members	Hennepin Health uses data to identify members without a dental visit to encourage them to schedule a visit.
SNBC External Care Coordination Coordinators	417 Members	SNBC members who need more higher intensity services are assigned to an outside care coordinator which have more capacity for long term attention because they have lower guide-to-member ratios.
Healthcare for the Homeless	308 Members	Healthcare for the Homeless helps meet the medical, preventive, and behavioral health needs of members experiencing housing insecurity.
PMAP/MinnesotaCare Social Service Navigators (Community Referral)	140 Members	Members with social needs are referred to our social service navigators with provide individualized care plans along with assistance accessing social and community supports.
RISE Vocational Engagement	36 Members	Members with vocational needs are referred to the organization RISE.
PMAP/MinnesotaCare Social Service Navigators (Hospital Referrals)	1152 Members	Members experiencing housing insecurity and Substance Use or Mental Health disorders that are hospitalized at Hennepin Healthcare are automatically flagged for consideration for a referral to our social service navigators with provide individualized care plans along with assistance accessing social and community supports.

Delivery System Supports

Practitioner or provider support

The organization supports practitioners or providers in its network to achieve population health management goals in the following ways

Sharing data

Hennepin Health routinely shares data analyses related to utilization, health care costs, and other issues with provider organizations. This is done through collaborative committees that review our progress and through other meetings to discuss our programs and their impacts. Hennepin Health and collaborating provider organizations share data and medical records through a common EMR, which makes real-time communication possible and improves care decisions for members. Hennepin County Public Health clinics, NorthPoint Health and

Wellness Center, Hennepin Healthcare, and Hennepin Health all share Epic® medical records which allows for communication with the member care teams.

As Hennepin Health has expanded their population health work, the data sharing processes with our AHM partners have grown, as well. Data sharing with Hennepin Healthcare has been particularly beneficial as pertains to our colorectal cancer screening campaign. The Population Health Department there collaborates with Hennepin Health's by clinically vetting the eligible FIT kit recipient list. This greatly reduces the possibility of members getting kits when they are clinically indicated to use other kinds of screenings thereby providing better care and saving on costs.

Offering evidence-based or certified decision-making aids

Shared Decision Making (SDM) aids are particularly useful for diagnoses that have more than one treatment option as they can be used to improve patient knowledge of their condition, explain the treatment options and the potential outcome probabilities. Decision aids also facilitate dialogue to engage the member and improve agreement between patient preference and subsequent treatment decisions.

Hennepin Health contracts with Healthwise, Inc. for the Healthwise Knowledgebase® to provide online health information and shared decision-making tools. Healthwise, Inc. delivers consistently high standard to these tools and makes them more accessible to members. Healthwise includes shared decision-making tools for providers and members to use alone or together. Healthwise is a licensed online resource whose SDM tools meet International Patient Decision Aids Standards (IPDAS) and are certified by NCQA. Members may be provided aids such as print material, or they may use the interactive tools, quizzes, and videos by accessing Healthwise through the Hennepin Health website. As of 2024, Healthwise© Knowledgebase and WebMD© are integrated resulting in more information and availability for members.

Providing practice transformation support to primary care practitioners

The Hennepin Health care model is anchored by interdisciplinary teams located in primary care clinics. The teams consist of physicians, behavioral health professionals, registered nurse care coordinators, clinical social workers, and community health workers. Hennepin Health has an annual process to select and provide financial support for new methods to improve care for our members. Each year our partner providers propose new innovations to transform care, and the best ideas receive funding. Examples of projects that have been supported are listed below.

- Culturally Responsive Model of Psychiatric Care for Somali, East African, and Other Muslim Patients
- Hennepin HealthCare Cerebrovascular Ultrasound Lab – SAVE BRAIN Initiative
- Mobile Post Partum Healthcare Delivery
- Improving Inpatient to Outpatient Care Coordination for Medication for Opioid Use Disorder (MOUD)
- Improving Transitions of Care from Hospital Discharge to Primary Care Follow-Up

- Centralized PAP Smear Results Management and Follow-Up (PAP Core)
- Hennepin Healthcare Systems Car Seat Safety Program
- Healthy for Life: Skills and Education Through Group Medical Visits

Providing comparative quality information on selected specialties

Hennepin Health utilizes Minnesota Community Measurement (MNCM) data for comparative quality of care information, such as the Annual Report and Minnesota Health Care Quality report. The MNCM Minnesota Health Care Disparities by Insurance Type report is also utilized as it presents statewide and medical group rates of performance on quality measures for patients in Minnesota Health Care Programs (MHCP). This report includes differences in rates of care provided by medical groups between patients insured through MHCP and those insured through other forms of health care insurance. Data for Hennepin Health's members is aggregated with data from others across the state of Minnesota. Quality of care data is analyzed using member demographics. Performance ratings for all clinics, which include primary care or multi-specialty medical groups, are identified for each measure. Hennepin Health also utilizes the MNCM Minnesota Health Care Disparities report which presented information by race, ethnicity, language, and county of origin (RELC) for quality measures. The report collects patient-level data on RELC to enable comparison for the measures included in the report.

Hennepin Health is a founding member of Minnesota Community Measurement and continues to collaborate with other payers and providers in the development and improvement of healthcare measures through Community Measurement committees. Healthcare providers and any individual can use the website, mnhealthscores.org, to compare provider costs and quality with other providers on a procedure-by-procedure basis.

Providing comparative pricing information for selected services

Hennepin Health also utilizes MNCM for comparative pricing information. Data for our members is aggregated with data from health care providers and other health plans across the state of Minnesota.

Value-based payment arrangements

Hennepin Health has a strong collaborative relationship with Hennepin County Health and Human Services, Hennepin Healthcare, and NorthPoint Health & Wellness Center. All four organizations participate in an Accountable Health Model with full financial risk- and gain-sharing agreements. Value based payments are distributed annually from gains or losses relative to per member per month capitation payments. Additionally, Hennepin Health has put reinvestment funds into projects designed to improve care (described above in practice transformation). Hennepin Health is actively working to expand value-based payment model relationships with other healthcare providers, as well. At the time of this report writing, Hennepin Health is drafting a value-based payment model proposal to approach one of the health systems outside of our current AHM. More information to follow in the 2026 Strategy Report.

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