Hennepin Health

Population Health Management Strategy - 2020 Impact Analysis

July 30, 2021

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

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. A collaboration was established in 2012 by Hennepin Health and three county-based provider organizations based on principles of population health management. Some of the key principles of the collaborative are listed below:

- All members have a primary care provider.
- Primary care providers coordinate patients' care.
- Behavioral health and physical health are integrated.
- Social determinants of health are managed as part of a member's health care.

Based on these principles the collaborative has established structures, tools, and processes to support the care of members. Among these are the following:

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 Social Service 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 and physical health services

This report is a comprehensive analysis of our 2019 Population Health Management strategy goals, interventions, and outcomes, that remained in effect throughout calendar year 2020.

2019 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 members' most complex medical and social needs. 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. Through our programs we work to accomplish the following:

- Keep members healthy through wellness and prevention initiatives
- Manage at-risk (emergent) populations
- Focus on patient safety
- Manage outcomes across settings
- Manage chronic disease and multiple chronic conditions.

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 2020 are listed below.

Keeping Members Healthy

Goals	Target population	Programs or services
At least 50% of children and adolescents will receive at least one dental visit per year.	Children and adolescents aged 1-20 years old	Telephone and mail reminder outreach Community sponsored “Give a Kid a Smile” children’s dental weekend $25 gift card incentive program
At least 50% of adults will receive at least one dental visit per year.	Adults aged 21-64, Special Needs BasicCare Plan (SNBC)	Telephone and mail reminder outreach services Community adult dental services Care Guide Agency outreach coordination $25 gift card incentive program

Managing enrollees with emerging risk: American Indian and African American women high risk pregnancy support

Goals	Target population	Programs or services
Improve American Indian and African American women's reported experiences with prenatal care, birth and postpartum care. Increase participation and engagement in prenatal care and postpartum care.	African American pregnant women American Indian pregnant women	Community-based, culturally responsible group prenatal programs

Focusing on patient safety: Decreasing opioid dependence

Goals	Target population	Programs or services
Reduce the number of opioid naïve members who receive more than a 7-day supply of opioid pain medication.	Opioid naïve members who receive a new prescription for opioids	Educational information on opioid use Prior authorization requirements for new prescriptions exceeding 7 days
Reduce the total number of opioid prescriptions filled by members.	Members using opioids	Educational campaign on opioid use for members and providers Open network of substance use disorder providers Prior authorization requirements for opioid prescriptions exceeding maximum daily dose

Managing outcomes across settings: Inpatient care coordination services for members experiencing homelessness

Goals	Target population	Programs or services
Hennepin Health care coordination team will engage 100% of all targeted members while inpatient. Readmissions among the targeted population will be reduced by 10% if first goal is achieved.	Homeless Hennepin Health PMAP and MinnesotaCare members admitted to Hennepin Healthcare inpatient units (excluding select units)	Housing navigation Complex care management Social service navigation

Managing multiple chronic conditions

Goals	Target population	Programs or services
Members identified with multiple chronic conditions, co-occurring behavioral health disorders, substance use and chronic medical conditions will be evaluated for complex care management and managed as appropriate.	Members identified via new enrollee screening and special health care needs with multiple diagnoses such as SUD, behavioral health disorder, diabetes, heart disease, ESRD.	Complex care management

IMPACT ANALYSIS

I. Keeping Member Healthy: Hennepin Health Dental Program

Goal 1: Increase the percentage of PMAP/MinnesotaCare children and adolescents, aged 1 – 20 years, who had at least one dental visit in 2020 to 50%.

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

The following table displays the proportion and percentage of members, aged 1-20, who had one dental visit in 2016, 2018, 2019, and 2020 as reported by the Department of Human Services (DHS). Calendar year 2016 was used as the baseline year for this measure.

Table 1. PMAP/MinnesotaCare annual dental visit

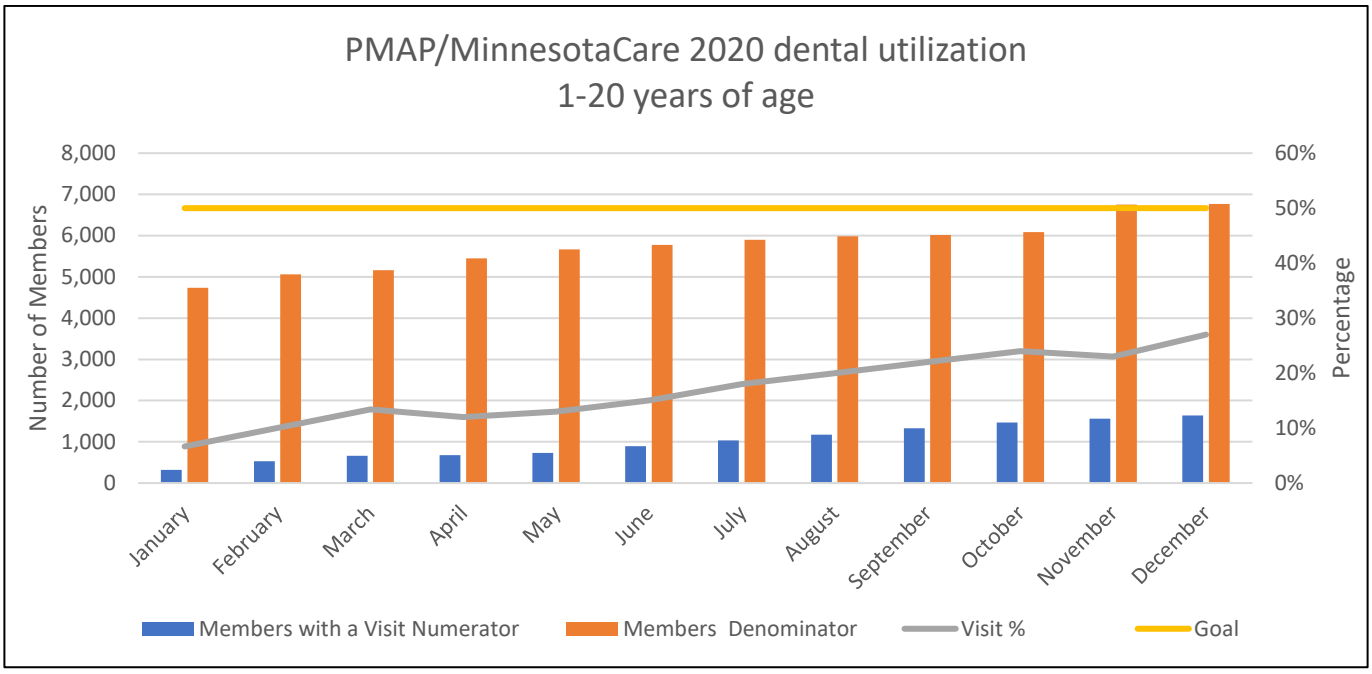
Year	Age range	Numerator	Denominator	Rate
2016	1-20 years of age	505	176	34.85%
2018	1-20 years of age	2,804	6,755	41.51%
2019	1-20 years of age	2,811	6,557	42.87%
2020	1-20 years of age	2,020	6,381	31.66%

DHS Withhold Performance Report, July 2019, July 2020 and July 2021

The graph below (Figure 1) displays the monthly and cumulative utilization rates of PMAP/MinnesotaCare children and adolescents, ages 1-20, in 2020. Hennepin Health used the DHS PMAP/MinnesotaCare dental utilization withhold technical specifications to calculate the monthly utilization rate. There is a difference in the final overall 2020 rates between Table 1 and Figure 1 as the DHS rate (Table 1) includes members who had a dental visit at a Federally

Qualified Health Centers (FQHC). The Delta Dental report does not include these members as FQHC claims are sent to DHS for processing.

Figure 1. PMAP/MinnesotaCare 2020 dental utilization – 1-20 years of age



Data source: Delta Dental of Minnesota, January 2021

The dental utilization rate for PMAP/MinnesotaCare children and adolescents, ages 1-20, increased by 6.66% from 2016 (baseline rate) to 2018. In 2019, the dental utilization rate increased by 1.36% when compared to 2018. The dental utilization rate decreased by 11.21% in 2020 when compared to the 2019 utilization rate (Table 1).

Comparison of results with a benchmark or goal

The comparison group is the children and adolescents, ages 1-20, who participate in the Hennepin Health PMAP/MinnesotaCare program. DHS used the same methodology to calculate the utilization rate for 2016, 2018 - 2020. The dental utilization rates were reviewed at the quarterly meetings with Delta Dental. The quarterly results were compared to the DHS withhold dental reports received throughout the year. In 2020, the denominator is 176 members lower

when compared to 2019. 791 fewer members had a dental visit in 2020 than in 2019 resulting in a significant rate decrease of 11.21%.

Interpretation of results

Hennepin Health had seen an increase in dental utilization for children and adolescents, ages 1-20, from 2016 through 2019. This is an important step in assisting children and adolescents to develop healthy behaviors. Ensuring a strong and healthy start for children and adolescents requires a focus on promoting oral health care and preventing and treating early childhood caries to arrest the development of long-term complications. Among all Minnesota MCOs, Hennepin Health has realized a higher dental utilization rate increase from 2016-2019 when compared to all Minnesota MCOs with a PMAP/MinnesotaCare program.

The COVID-19 pandemic had a significant impact on the dental interventions in 2020. Many dental clinics closed in March 2020 except for emergency care. Due to the dental office closures, Hennepin Health's Dental Outreach Program was suspended because of the lack of available providers and care. Dental clinics did not reopen until the fall of 2020 for preventative care services with many dental clinics not being fully functional until late 2020. With the additional COVID-19 cleaning protocols, dental clinics were not able to see as many patients per day as in pre-COVID-19 times. When clinics did reopen, many providers had virtual visits only and would only see a member on an emergency basis (i.e., to relieve pain). Even with the dental clinics re-opening, many members were reluctant to seek care because of the possibility of contracting COVID-19.

Goal 2: Increase the percentage of Special Needs BasicCare (SNBC) members who had at least one dental visit in 2020 to 50 percent.

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

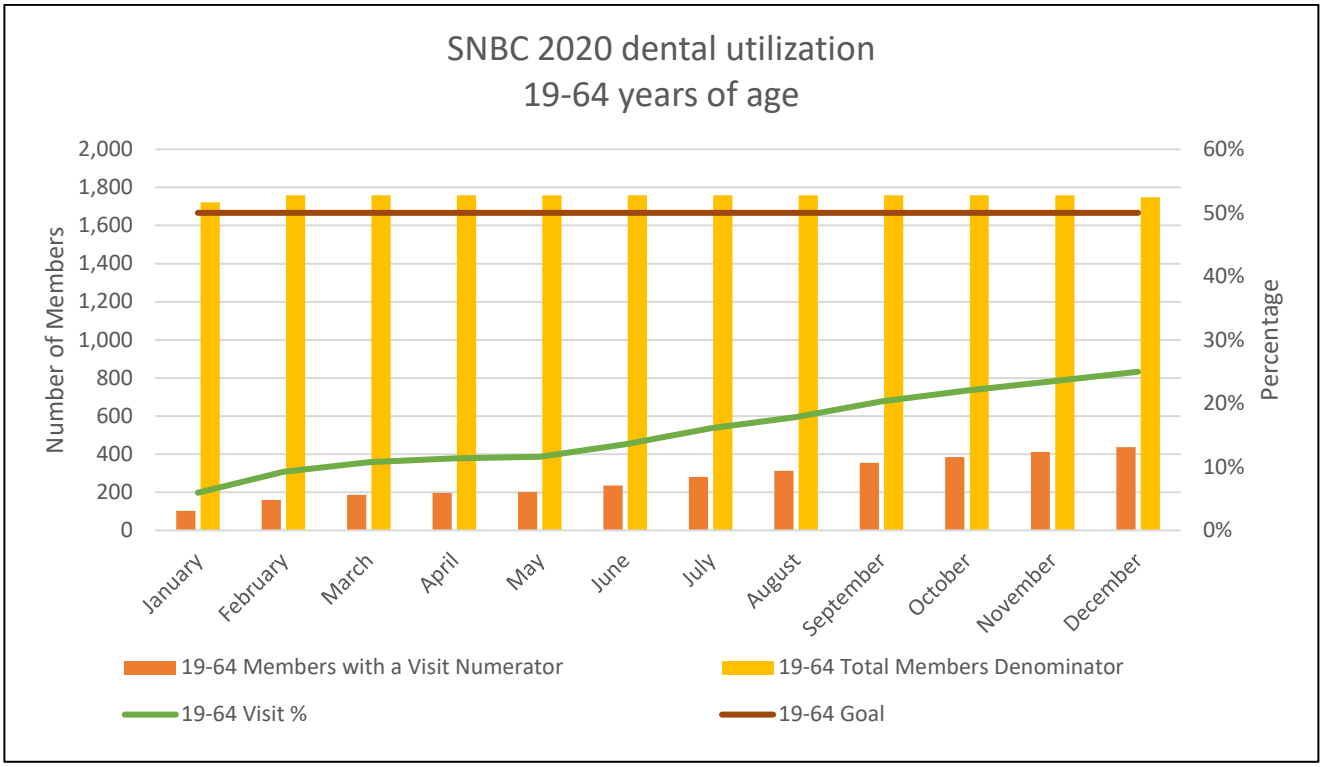
The following table displays the proportion and percentage of SNBC members who had one dental visit in 2018, 2019, and 2020 as reported by the Department of Human Services (DHS).

Table 2. SNBC annual dental visit				
Year	Age range	Numerator	Denominator	Rate
2018	19-64 years of age	714	1, 726	41.37%
2019	19-64 years of age	692	1, 726	40.09%
2020	19-64 years of age	566	1,837	30.81%

DHS Withhold Performance Report, July 2019. July 2020 and July 2021

The graph below displays the monthly and cumulative utilization rates of SNBC members in 2020. Hennepin Health used the DHS SNBC dental utilization withhold technical specifications to calculate the monthly utilization rate. There is a difference in the final overall 2020 rates between Table 2 and Figure 2 as the DHS rate (Table 2) includes members who had a dental visit at a FQHC. The Delta Dental report does not include these members as FQHC claims are sent to DHS for processing.

Figure 2. SNBC 2020 dental utilization – 19-64 years of age



Data source: Delta Dental of Minnesota, January 2021

The dental utilization rate for the SNBC members decreased by 9.28% in 2020 from 2020 (Table 2).

Comparison of results with a benchmark or goal

The comparison group is the SNBC member ages 19 - 64 who participate in the Hennepin Health SNBC program. DHS used the same methodology to calculate the utilization rate for 2018 - 2020. The dental utilization rates were reviewed at the quarterly meetings with Delta Dental. The quarterly results were compared to the DHS withhold dental reports received throughout the year.

The Hennepin Health SNBC enrollment was stable from 2018 - 2020 with a slight increase in enrollment noted in 2020. In 2020, 126 fewer members had a dental visit in 2020 than in 2019; resulting in a rate decrease of 9.28%.

Interpretation of results

Hennepin Health saw a significant decrease in dental utilization for the SNBC members, ages 19-64, in 2019 when compared to 2019. The rates may not be reflective of the actual number of members receiving dental services due to the limited dental benefit set for adults in the Minnesota Health Care Programs. Claims are only submitted for processing for covered dental services. In 2017 – 2019, Hennepin Health collaborated with the other MCOs and DHS on the SNBC Dental Access Improvement and Evaluation Project. The purpose of the project was to improve access to dental services for all SNBC members, with a primary goal of improving the annual dental visit rate from 45.6% to 60% or more over the next three to five years. DHS decided to end this project after three years as there were multiple factors impacting the utilization rates that were outside of the health plans' control. The project ended December 31, 2019.

In 2020, Hennepin Health continued to call members, welcoming them to the health plan and asking if they had a dentist or needed help finding a dentist. If a member replied yes, they were referred to Delta Dental for an appointment or they were given help from the care guide to make an appointment or an appointment was made for the member by the care guide. The COVID-19 pandemic had a significant impact on the dental utilization in 2020. Many dental clinics closed in March 2020 except for emergency care. With the start of the COVID-19 pandemic in March 2020, formal initiatives to encourage dental utilization stopped as many dental clinics closed for a few months and care guides were not able to see members face-to-face. Once the dental clinics started re-opening, care guides took the time to address dental care with each member when the Health Risk Assessment (HRA) was completed.

Dental clinics did not reopen until the fall of 2020 for preventive care services with many dental clinics not being fully functional until late 2020. With the additional COVID-19 cleaning protocols, dental clinics were not able to see as many patients per day as in pre-COVID-19 times. When clinics did reopen, many providers had virtual visits only and would only see a member on an emergency basis (i.e., to relieve pain). Even with the dental clinics re-opening, many members were reluctant to seek care because of the possibility of contracting COVID-19.

Encouraging adults to receive regular dental services is important, not just for health of the teeth, but the member's overall health and wellbeing. Poor oral health can increase the risk for heart disease, respiratory illnesses, stroke and more. Hennepin Health will continue to monitor and encourage members to seek dental care.

II. Managing enrollees with emerging risk: American Indian and African American women high risk pregnancy support

Goal: Improve American Indian and African American women's reported experiences with prenatal care, birth and postpartum care and increase participation and engagement in prenatal care and postpartum care.

During 2019, Hennepin Healthcare developed all aspects of the two group prenatal care models (African American and American Indian). The development process included:

Developing content and format including writing culturally specific curriculum for each group and designing the group format to incorporate standard prenatal care, prenatal education, and culturally relevant teachings and practices.

Figuring out and determining logistics such as location, recruitment, scheduling, billing, food, transportation and childcare.

Developing the evaluation plan including process measures (attendance), qualitative measures (extent to which participants felt heard, respected, and engaged), and quantitative measures (birth weight, gestational age, need for NICU care, fetal/newborn deaths, maternal complications, breastfeeding initiation, etc.).

The two pilot teams were fully ready and set to implement group care the third and fourth weeks of March. Following a half-day training on March 12, 2020 for all team members and others from Hennepin Healthcare Women's Health Center, it was decided it was not safe to move forward due to COVID-19. Once it safe to hold group care, the teams will implement the pilot.

Interpretation of Results

Community engagement has been an important component driving the development of this project. During the development phase, each team reached out to pregnant women in their respective communities to provide input on curriculum topics and approaches and to test run the program in the form of mock sessions. Women also weighed in on things like location,

transportation, food, and other logistics. Feedback and input from the engagement help shape the final pilot model.

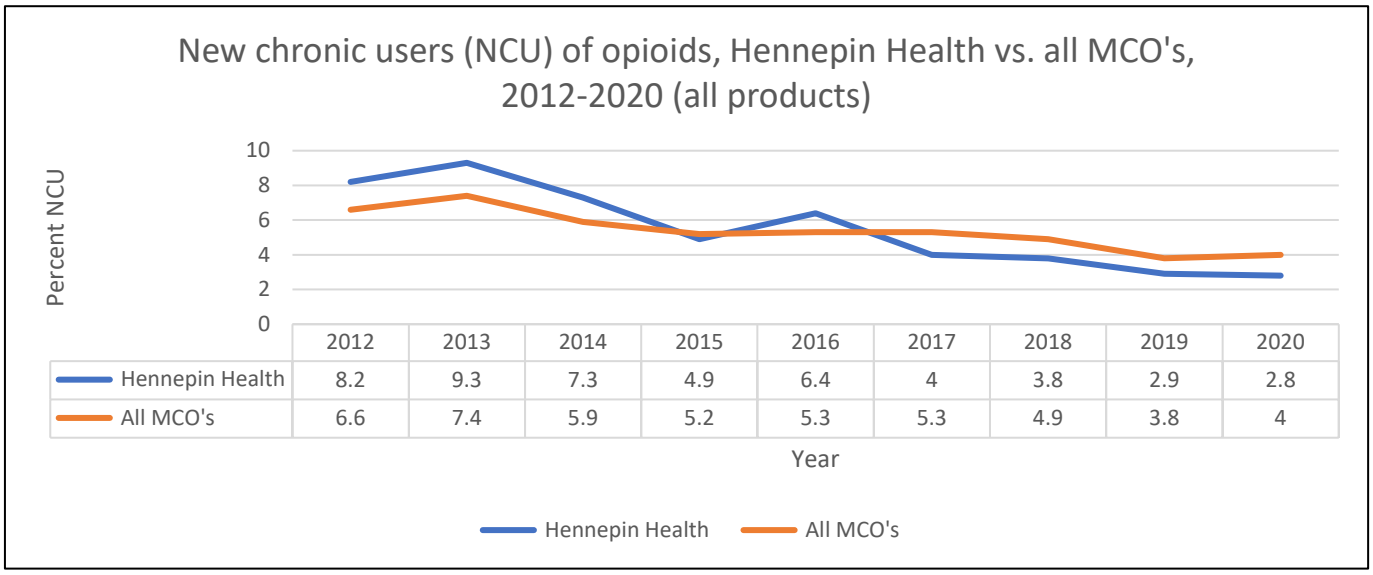
III. Patient Safety: Decreasing opioid dependence

Goal 1: Reduce the number of opioid naïve members receiving an opioid pain medication who continue to use opioids 45 days later.

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

The following figures display the proportion of new chronic users (NCU) of opioids for Hennepin Health and all MCO's combined, as reported by DHS. The NCU of opioids measure developed by DHS is used to monitor success in preventing chronic opioid use.

Figure 3. New chronic users (NCU) of opioids, Hennepin Health vs. all MCO's (all products)



	2012	2013	2014	2015	2016	2017	2018	2019	2020
Hennepin Health	8.2	9.3	7.3	4.9	6.4	4	3.8	2.9	2.8
All MCO's	6.6	7.4	5.9	5.2	5.3	5.3	4.9	3.8	4

Figure 4. New chronic users (NCU) of opioids, Hennepin Health vs. all MCO's (PMAP and MinnesotaCare)

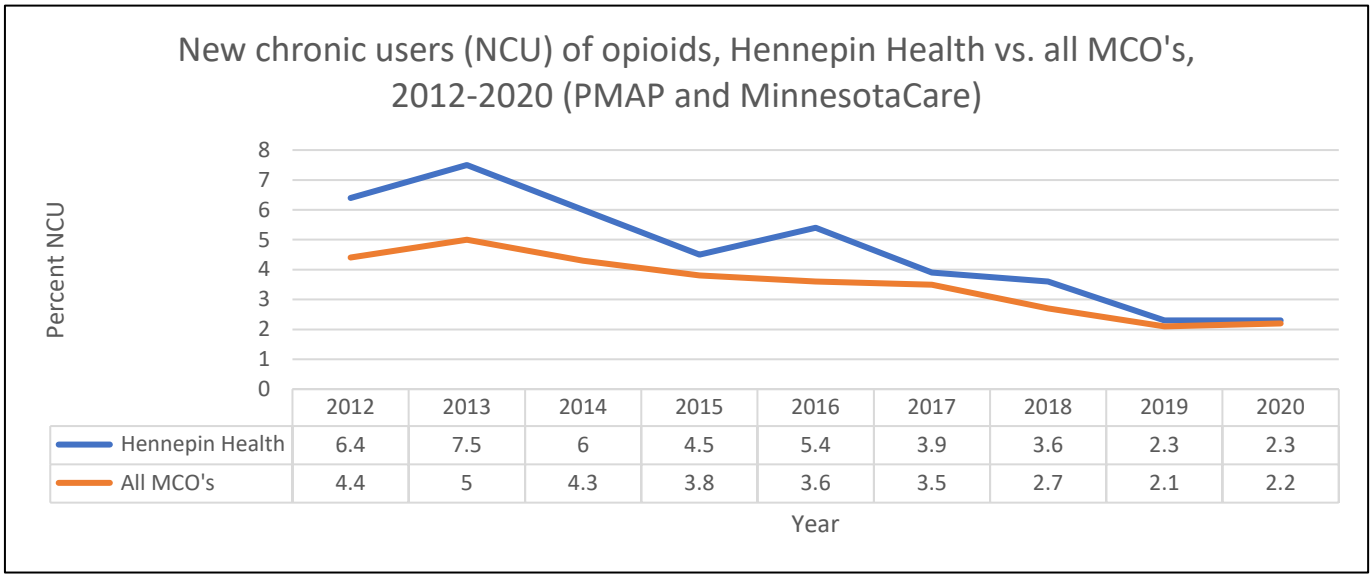
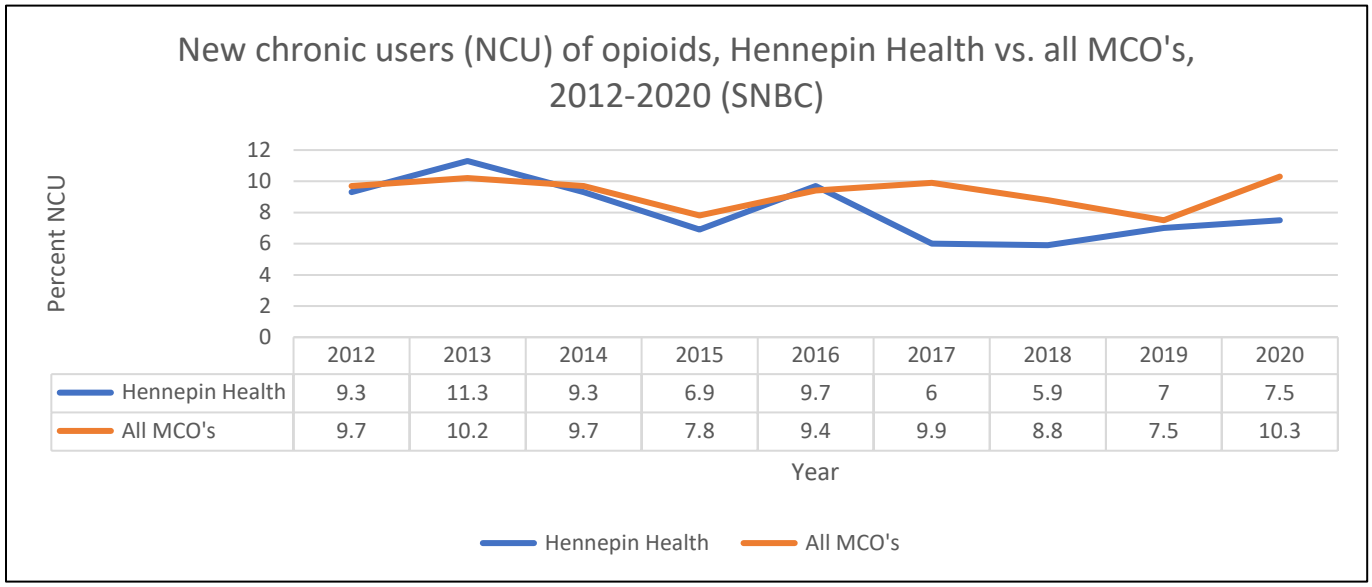


Figure 5. New chronic users (NCU) of opioids, Hennepin Health vs. all MCO's (SNBC)



In the population of all Hennepin Health members (Figure 3), the proportion of members who are new chronic users of opioids decreased from 4% in 2017 to 3.8% in 2018 to 2.9% in 2019 to 2.8% in 2020. In the PMAP and MinnesotaCare population (Figure 4), the proportion of new chronic users decreased from 3.9 in 2017 to 3.6% in 2018 to 2.3% in 2019 and 2020. The

proportion of new chronic users in the SNBC population (Figure 5) decreased from 6.0% in 2017 to 5.9% in 2018, but then increased to 7.0% in 2019 and 7.5% in 2020.

Comparison of results with a benchmark or goal

The comparison group is the combined population of all MCO's in Minnesota who participate in the Minnesota Health Care Program. Each population of Hennepin Health members is compared with the same population (i.e., the same product(s)) in all MCO's combined.

For the total Hennepin Health population, the proportion of new chronic users remains lower than the comparison group, as it has been since 2017. Hennepin Health had a higher proportion than the comparison group in 2012-2014. For the PMAP and MinnesotaCare population, the proportion of new chronic users has always been higher for Hennepin Health than for the comparison population. However, the gap between the two populations was lower in 2020 than it has ever been. The Hennepin Health SNBC population has had a lower proportion of new users since 2017 when compared to the comparison population.

Interpretation of results

There has been a steady decline in the proportion of new chronic users of opioids among Hennepin Health members as a whole, and among the two subpopulations examined. This means that each year fewer members have become new chronic users of opioids. This is an important step in reducing the prevalence of opioid addiction. Hennepin Health currently has one of the lowest levels of new chronic users among all Minnesota MCOS's. This is remarkable, given the large portion of adults without dependents in the plan's membership. This population has a higher rate of substance abuse than the families and children population.

The increase in new chronic users seen in the Hennepin Health SNBC population in 2019 and 2020 is concerning. However, this population is very small, and the increase may be the result of random variation. Hennepin Health will continue to follow this population carefully in the future.

Goal 2: Reduce the total number of opioid prescriptions filled by members.

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

In 2017, opioids were the 6th most commonly prescribed group of medications among all Hennepin Health members combined. In 2018, opioids were the 9th most commonly prescribed. In 2019, opioids were the 10th most commonly prescribed. In 2020, opioids moved back to the ninth most prescribed medication. The move back to ninth was attributed to increased use of buprenorphine/naloxone (Suboxone) prescribed to treat opioid addiction rather than pain. Therefore, the shift is a positive one as more members seek treatment for opioid addiction. When the most prescribed medication report was re-analyzed without including buprenorphine, opioids were no longer in the top ten prescribed medications in 2020. The source of this data is pharmacy claims.

Comparison of results with a benchmark or goal

For this metric, there is both a historical benchmark (opioid prescribing in 2017) and the comparison with other groups of medications. Opioid prescribing is becoming less common than it was in 2017 and therefore lower in the ranking of most commonly prescribed medications.

Interpretation of results

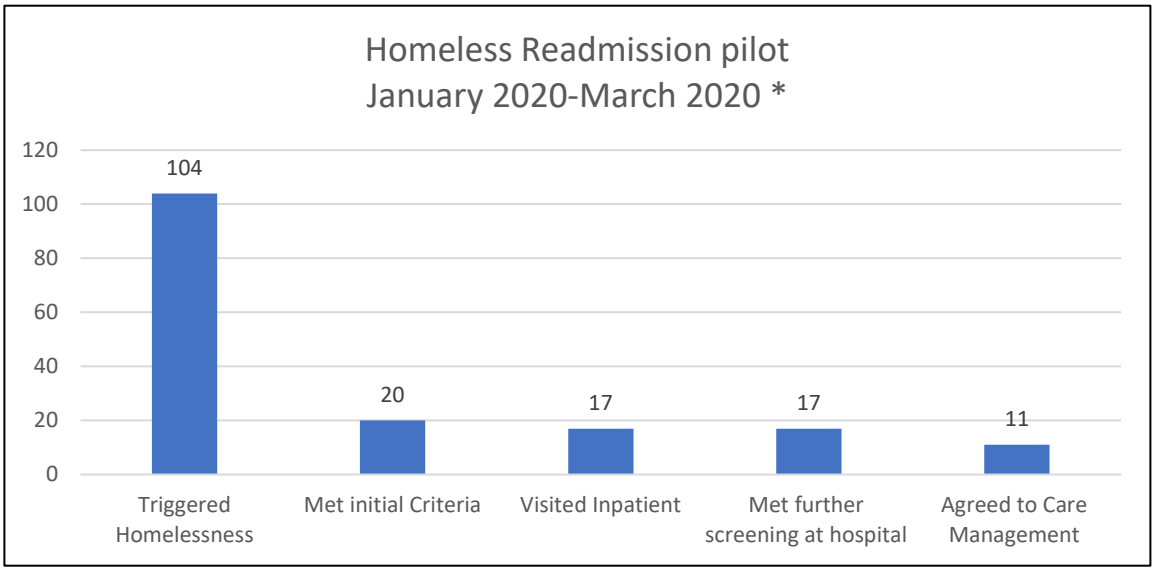
As with the new chronic user metric, this metric indicates that prescription opioid use is declining over time among Hennepin Health members. The decline in opioid use is expected to lead to reductions in adverse consequences, including addiction, overdose and use of illegal opioids.

IV. Managing outcomes across settings: Inpatient care coordination services for members experiencing homelessness

Goal 1: Hennepin Health care coordination team will engage 100% of all targeted members in the inpatient hospital setting.

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

Figure 6: Inpatient hospital admission results (*Efforts paused due to COVID-19 pandemic)



Comparison of results with a benchmark or goal

From January 1, 2020 through March 13, 2020, 104 patients were screened Monday through Friday for enrollment. Following an additional eligibility review, 20 members met criteria for an inpatient hospital visit (Figure 6). The goal was set at 100% to learn, track, and trend the results as there was not a benchmark for this type of intervention. During the first months of 2020, prior to the COVID-19 pandemic a total of 17 members or 100% were visited and offered services in the inpatient setting.

The leading reasons for ineligibility were confirmed housing and existing case management through Hennepin Health or community partners. Following a hospital visit and chart reviews, 17

members were visited in the hospital, met criteria for the program, and 11 members agreed to engage in care management services (Figure 6). The program is offered during the business work week (Monday- Friday excluding holidays). When a member was admitted late on a Friday often the member was discharged over the weekend or early on a Monday morning and care management staff was unable to connect.

Interpretation of results

The care management staff was successful at engaging with members experiencing homelessness while they were hospitalized. This required a coordinated effort between hospital and health plan staff.

Goal 2: Readmissions among the targeted population would be reduced by 10% if the first goal was achieved.

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

There were no 30-day readmissions during the time for the members that agreed to services.

Comparison results with benchmark or goal

The percentage of readmissions in the intervention group was 0%.

Interpretation of results

The results reflect the importance of correctly identifying the right patients and providing personalized, high touch community-based services. Additionally, while not the primary focus, members who admitted in February and March were able to discharge to the hotels that were set-up by Hennepin County to provide safe isolation from the early phases of the pandemic. Members and residents who were homeless with an increased risk for COVID-19 were offered the opportunity to move into hotels managed by Hennepin County.

V. Focus managing multiple chronic conditions complex care management

Goal: Members identified with multiple chronic conditions, co-occurring behavioral health disorders, substance use and chronic medical conditions will be evaluated for complex care management and managed as appropriate.

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

Throughout 2020, 352 members were identified and screened as potential candidates for complex care management programs and 269 were referred to complex care management. Members were identified through a variety of passive and active monitoring.

Table 2. 2020 Special health care needs screening assessments completed

Special health care needs category	Adults screened	Referrals care management programs
AHRQ admissions	22	22
Admissions/readmissions – housing instability	104	21
High emergency dept utilizers	45	45
High dollar claims	21	21
Direct care referrals – social service/care mgmt	160	160

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 only 269 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

Admissions for AHRQ ambulatory sensitive conditions

The admission rates for most conditions were low for the past four years. However, there is a noted decline for all conditions in 2020. There was a total of 61 admissions due to ambulatory sensitive conditions and no readmissions, therefore, all 61 were unique members. The highest admission rate was for congestive heart failure with a total of 22 admissions. While congestive heart failure resulted in the highest member admission rate in 2020, the rate is significantly decreased over the last four years from 18.57 per 1000 to 10.14 per 1000 members for 2020. Members with congestive heart failure had additional chronic conditions and were referred for complex care management screening.

High dollar claims

Review of the high dollars claims report that captures claims starting at $50,000 and identifying members with claims greater than $100,000, 31 (21 adults and 10 children) members exceeded the $100,000 amount.

Referrals for social service and care management

Hennepin Health accepts and receives referrals from primary care clinics, community organizations, Hennepin County Human Services and Public Health, as well as 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 complex care management for members with multiple chronic conditions. Referrals are received through a shared electronic health record order entry system (Epic) and screened for service needs and care management.

MEMBER EXPERIENCE WITH POPULATION HEALTH PROGRAMS

Hennepin Health launched Healthwise® Knowledgebase resources and shared decision-making tools in June 2019 on the external member-facing website. The external facing website is available for members, providers, care managers, and internal staff to use without limitations to search evidenced-based educational materials, including videos, and shared decision-making tools.

Healthwise provides a custom tool that allows for the tracking of unique visitors and top topics accessed by Hennepin Health members. This allows Hennepin Health to tailor topics, newsletters, and social media posts that are most important for the membership.

During 2020, Hennepin Health provided multiple demonstrations of Healthwise Knowledgebase topics through online meetings. Member demonstrations were provided at the SNBC member stakeholder meeting and the Enrollee Advisory Council. Additionally, information on Healthwise Knowledgebase topics were shared with external care coordination/care guide agencies, Hennepin County Public Health, Healthcare for the Homeless, Hennepin County Adult, and Children's' Mental Health collaborative, Hennepin Healthcare, and NorthPoint Health & Wellness Center. Feedback from all groups was positive, and the customer tracking tool showed a steady increase in usage over the year. The Enrollee Advisory Council specifically asked for health and wellness resources, and when Healthwise Knowledgebase was presented, the committee representatives had positive comments and appreciation for the new resources.

The inpatient care management program for members experiencing homelessness had a 65% engagement rate for accepting services in 2020, which demonstrates the effectiveness of the intervention. The program addressed homelessness by assisting several members in finding long-term housing solutions and ending years of homelessness. High praise has been given to this program at a national level. Hennepin Health and Hennepin Healthcare received a national first-place Healthcare Innovation Award for this work in 2020. Additionally, Hennepin Health received the National Association of Counties 2020 Achievement Award for addressing

readmission in county health plan population experiencing homelessness and presented this program at the Institute for Healthcare Improvement (IHI) annual Quality Forum.

No complaints or grievances were received in 2020 regarding the Hennepin Health Population Health Management programs.

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

hennepinhealth.org