Minnesota Health Plans’ Collaboration Plan
2015 – 2019

This Collaboration Plan is developed by the Minnesota Council of Health Plans (MCHP), a trade association, whose members are the following non-profit health plans:

Blue Cross and Blue Shield/Blue Plus of Minnesota (BCBS)
HealthPartners (HP)
Medica
Metropolitan Health Plan (MHP)
PreferredOne (P1)
Sanford Health Plan of Minnesota
UCare

Minnesota Council of Health Plans
2550 University Avenue West, Suite 255 South
St. Paul, MN  55114-1904
www.mnhealthplans.org
December 2014
**Table of Contents**

**Executive Summary**  
Page 5

**Section 1: Health Plans at a Glance**  
Page 5

**Section 2: Health Plan Contact Information**  
Page 8
  - A. Health Plan Contacts for Collaborative Activities
  - B. Health Plan Contacts for Special Services for Members on Medical Assistance and MinnesotaCare
  - C. Health Plan Services for Pregnant Women Who are on Medical Assistance and MinnesotaCare

**Section 3: Coordination with Local Public Health**  
Page 13
  - A. Regional Meeting
  - B. Center for Community Health
    1. Requirements for Community Health Assessments Across Sectors
  - C. Health Plan Data

**Section 4: Shared Public Health Priorities & Key Initiatives Addressing Shared Priority Areas**  
Page 25
  - A. Physical Activity and Nutrition
  - B. Health Disparities and Health Equity
  - C. Mental Health and Chemical Health
  - D. Access to Health Care
  - E. Chronic Disease Prevention and Management

**Section 5: Public Health Accreditation Standards & Health Plan Complementary Roles**  
Page 40

**Section 6: Collaborative Committees Focused on Public Health Issues**  
Page 47
Executive Summary

The Statute: The Minnesota Council of Health Plans (MCHP) Collaboration Plan for 2015-2019 is submitted to the Minnesota Department of Health (MDH) as required by MN Statute 62Q.075. The purpose of the collaboration plan is to demonstrate ways that health plans work with local public health to achieve one or more high priority public health goals. To learn more about the collaboration plan go to: http://www.health.state.mn.us/divs/opi/pm/collaborationplans/

The Process: The Collaboration Plan is submitted by MCHP on behalf of its member health plans every five years. Previous to 2010, each health plan submitted its own plan. However, in an effort to improve collaboration across health plans and reduce administrative redundancies, health plans and MDH agreed to the current Collaboration Plan format that combines information on Minnesota health plans’ public health activities and demonstrates ways health plans collaborate with local public health and community partners.

The 2015-2019 Collaboration Plan is organized in two ways: (1) it describes ways health plans collaborate with local public health agencies and (2) it provides information about Minnesota health plans. The Collaboration Plan is updated regularly and is available on the MDH and MCHP websites.

Layout of the Report:
Section 1 provides general information about Minnesota health plans.

Section 2 lists who to call for collaborative activities by health plan; provides health plan contact information for special services for members; provides contact information for special services such as transportation, interpreters, etc. for Medical Assistance and MinnesotaCare members who are pregnant.

Section 3 lists how health plans coordinate with local public health. This section highlights the regional local public health agency/health plan meetings, the work with the Center for Community Health (CCH) collaborative, and provides information about health plan data.

Section 4 lists shared public health priority areas among the health plans (see side bar) and key initiatives for each priority area.

Section 5 lists ways health plans support public health accreditation activities.
Section 6 lists committees/collaboratives that health plans serve on that address public health issues.

**Summary Comments:**
Minnesota health plans have a long history working with the State, local public health agencies, and community partners to improve the health of Minnesotans. As part of the Collaboration Plan, health plans have identified key priorities for their work with local public health. However, health plans, similar to public health agencies, work on a multitude of public health issues as evidenced by Section 6 which lists current collaboration activities.

Since the last collaboration plan, there are two new initiatives that are changing the direction and approach of our work. The Healthy Minnesota Partnership 2020 set the framework for health improvement, focusing on the opportunities for health. Under the Healthy Partnership 2020 umbrella, there is ongoing work focused on chronic disease, changing the narrative of health, and health in all policies. Health plans have been very active in this work and will continue to do so. Additionally, the Center for Community Health (CCH), a newly reconstituted collaborative with health plans, hospitals, and local public health agencies in the metro area, will work on aligning the community health needs assessments (CHNA) as well as identifying and implementing collective actions. Although both efforts are relatively new, the work to date is very promising. These efforts will improve our ability to address health inequities, leverage resources, and impact health outcomes. Another area that will likely change in the coming years is our ability to share and analyze population health data. Some of this work will occur under CCH but it will also occur as part of health care homes, accountable communities for health and other collaborative work focused on improving health along the continuum of care. Finally, health plans will continue to put significant efforts toward key initiatives such as the State Health Improvement Program (SHIP) as well as committees focused on improving birth outcomes and preventive services for children and adolescents (Child and Teen Check-Up), etc. Health plans will also be strong partners with local public health in the event of an epidemic or other crisis oriented health threat. Health plans value the relationship with State and local public health partners. The Collaboration Plan provides an opportunity to demonstrate how health plans and public health agencies work together on public health issues.

**About MCHP**
MCHP is an association for Minnesota’s seven non-profit health plans. MCHP’s members include: Blue Cross and Blue Shield/Blue Plus of Minnesota, HealthPartners, Medica, Metropolitan Health Plan, PreferredOne, Sanford Health Plan of Minnesota and UCare. The MCHP vision statement aligns with the goals of public health and with the Collaboration Plans’ intent. MCHP’s Vision Statement is: “Minnesota health plans are dedicated to strengthening Minnesota’s position as the nation’s healthiest state by leading or supporting efforts with community partners, that increase the value of health care services.”
SECTION 1: HEALTH PLANS AT A GLANCE

Minnesota health plans are unique organizations. Service areas, enrollment, products and services vary. To learn more about individual health plans, visit:

- Learn more about health plan service areas, enrollment, financial and quality reports [here](#).
- Learn more about health plans’ coverage for State Public Programs by county [here](#):

**Blue Cross and Blue Shield/Blue Plus of Minnesota**
For 80 years Blue Cross Blue Shield of Minnesota has made a healthy difference in people’s lives. A not-for-profit, taxable organization, Blue Cross was chartered in 1933 as Minnesota’s first health plan. Blue Cross continues to carry out its charter mission today as a health company: to promote a wider, more economical and timely availability of health services for the people of Minnesota.

Nearly 2.6 million people depend on Blue Cross and Blue Shield of Minnesota to manage their health needs. Blue Cross is the largest health insurance plan in the state, with members located throughout the Twin Cities and across Greater Minnesota. Blue Cross provides customized solutions for a range of different customers, including individuals; employers; and federal, state and local governments.

Blue Cross and Blue Shield of Minnesota is an independent licensee of the Blue Cross and Blue Shield Association, which serves 100 million members in the United States.

**HealthPartners**
Founded in 1957, HealthPartners is the largest consumer-governed, non-profit health care organization in the nation. The organization is dedicated to improving health and well-being in partnership with members, patients and the community, and provides a full-range of health care delivery and health plan services including insurance, administration and health and well-being programs. HealthPartners serves more than 1.5 million medical and dental health plan members nationwide, and is the top-ranked commercial plan in Minnesota. The care system includes more than 1,700 physicians, seven hospitals, 55 primary care clinics, 22 urgent care locations and numerous specialty practices in Minnesota and western Wisconsin. HealthPartners Clinic, Park Nicollet Clinic, Stillwater Medical Group and Physicians Neck & Back Clinic are all part of HealthPartners. In addition, HealthPartners Dental Group has more than 60 dentists and 22 dental clinics. HealthPartners also provides medical education and conducts research through its Institute for Education and Research. For more information, visit
**Medica**
Serving about 1.5 million members, Medica is a health insurance company headquartered in Minneapolis and active in the Upper Midwest. The non-profit company provides health care coverage in the employer, individual, Medicaid, Medicare and Medicare Part D markets in Minnesota and a growing number of counties in North Dakota, South Dakota and Wisconsin. Medica also offers national network coverage to employers who also have employees outside the Medica regional network.

Medica's vision is to become the community’s health plan of choice, trusted for its integrity, respected for its service, and admired for its commitment to innovation and efficiency.

**Metropolitan Health Plan**
Metropolitan Health Plan (MHP) is a nonprofit, state-certified health maintenance organization that provides health care coverage to residents of Hennepin County who are enrolled in a Minnesota Health Care Program. Currently, MHP offers four products: Hennepin Health (a demonstration Prepaid Medical Assistance Program), Cornerstone Solutions (Special Needs Basic Care for dual and non-dual eligible enrollees), Senior Solutions Premium (MSHO) and Senior Solutions Basic (MSC+). Located downtown Minneapolis, MHP offers a walk-in Welcome Center for our more than 10,000 members.

**PreferredOne**
PreferredOne Community Health Plan (PCHP) is a Minnesota nonprofit corporation organized on December 2, 1994 under Chapter 317A of the Minnesota Statutes. PCHP became operational in 1996. Contributing members of PCHP are Fairview Health Services and North Memorial Health Care. The sole non-contributing member is PreferredOne Physician Associates.

PCHP offers a variety of fully-insured HMO products for both large and small employers and features an open-access provider network. Plans feature a variety of benefit options including 100% preventive coverage and options for out-of-network coverage.

**Sanford Health Plan of Minnesota**
Sanford Health Plan is a not-for-profit, community-based HMO that began operations in 1998. Sanford Health Plan was designed to align physicians and hospitals, establish a framework for providers to efficiently manage the delivery of health care services, and operate on the strength of affordable premiums. Serving nearly 100,000 members, Sanford Health plan is a non-profit company providing health insurance in North Dakota, South Dakota, Iowa and Minnesota. Sanford Health Plan also offers national network coverage to employers who also have employees outside the Sanford Health Plan regional network.

Central to the design of Sanford Health Plan is a collaborative effort between Sanford Health, contracting providers, and member representatives of service area communities. Each of these elements offers unique perspectives, and acknowledgment that health care resources are finite.
Sanford Health Plan offers
- Employer sponsored group plans for both large and small businesses
- Third Party Administration (TPA) services
- Medicare Supplement Plans and Medicare SELECT Plans
- Insurance for individuals
- Marketplace plans in the federally facilitated exchange

**UCare**
UCare has been improving the health of its members through innovative services and partnerships across communities since 1984. Today, it is an independent, nonprofit health plan providing health care and administrative services to more than 450,000 members. UCare is proud to serve more people from diverse cultures and more people with disabilities enrolled in Medical Assistance than any other health plan in Minnesota. The organization partners with health care providers, counties, and community organizations to create and deliver:
- NCQA-accredited plans for Minnesotans shopping on the MNsure health insurance marketplace.
- Medicare plans with an “Excellent” NCQA rating - throughout Minnesota and in western Wisconsin.
- Income-based Minnesota Health Care Programs, such as MinnesotaCare and Prepaid Medical Assistance Program for individuals and families.
- Coverage for adults with disabilities.
- Medical Assistance and Medicare coverage for dually eligible Minnesotans.

UCare addresses health care disparities and care access issues through its UCare Foundation grants and a broad array of community initiatives. The health plan has received Top 100 Workplaces honors for five consecutive years from the Star Tribune since the rankings began in 2010.
SECTION 2: HEALTH PLAN CONTACT INFORMATION

This section provides information on ways to contact health plan representatives or their special service departments. There are three tables:

A. Health plan contacts for collaborative activities: This table lists the individual names, organizations, emails and phones numbers for people you can call for collaborative activities.

B. Health plan department phone numbers for special services (e.g., transportation, interpreter services etc.) for Medical Assistance and MinnesotaCare members.

C. Health plan contact information specific to perinatal services for Medical Assistance and MinnesotaCare members who are pregnant.
# SECTION 2 A: Health Plan Contacts for Collaborative Activities

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Contact</th>
<th>Email</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>MN Council of Health Plans</td>
<td>Janny Brust</td>
<td><a href="mailto:brust@mnhealthplans.org">brust@mnhealthplans.org</a></td>
<td>651-645-0099, x12</td>
</tr>
<tr>
<td>Blue Cross Blue Shield/Blue Plus of MN</td>
<td>Ashlyn Christianson</td>
<td><a href="mailto:Ashlyn.Christianson@bluecrossmn.com">Ashlyn.Christianson@bluecrossmn.com</a></td>
<td>(651) 662-4694</td>
</tr>
<tr>
<td>HealthPartners</td>
<td>Nancy Hoyt Taff</td>
<td><a href="mailto:Nancy.h.taff@healthpartners.com">Nancy.h.taff@healthpartners.com</a></td>
<td>(952) 967-5148</td>
</tr>
<tr>
<td>HealthPartners</td>
<td>DeDee Varner</td>
<td><a href="mailto:deanna.d.varner@healthpartners.com">deanna.d.varner@healthpartners.com</a></td>
<td>(952) 883-5184</td>
</tr>
<tr>
<td>Medica</td>
<td>Kari Bailey</td>
<td><a href="mailto:kari.bailey@medica.com">kari.bailey@medica.com</a></td>
<td>(952) 992-3063</td>
</tr>
<tr>
<td>Medica</td>
<td>Kenneth Bence</td>
<td><a href="mailto:Kenneth.bence@medica.com">Kenneth.bence@medica.com</a></td>
<td>(952) 992-8380</td>
</tr>
<tr>
<td>Metropolitan Health Plan</td>
<td>Shannon Mayer</td>
<td><a href="mailto:Shannon.Mayer@hennepin.us">Shannon.Mayer@hennepin.us</a></td>
<td>(612) 348-7950</td>
</tr>
<tr>
<td>PreferredOne</td>
<td>Heather Clark</td>
<td><a href="mailto:Heather.clark@preferredone.com">Heather.clark@preferredone.com</a></td>
<td>(763) 847-3562</td>
</tr>
<tr>
<td>Sanford Health Plan</td>
<td>Lisa Carlson</td>
<td><a href="mailto:Lisa.M.Carlson@sanfordhealth.org">Lisa.M.Carlson@sanfordhealth.org</a></td>
<td>(605) 328-6859</td>
</tr>
<tr>
<td>UCare</td>
<td>Carol Berg</td>
<td><a href="mailto:cberg@ucare.org">cberg@ucare.org</a></td>
<td>(612) 676-3635</td>
</tr>
</tbody>
</table>
**SECTION 2 B: Contacts for Special Services Medical Assistance and MinnesotaCare Members**

<table>
<thead>
<tr>
<th>HEALTH PLAN</th>
<th>CUSTOMER SERVICE</th>
<th>INTERPRETERS</th>
<th>TRANSPORTATION*</th>
<th>MENTAL HEALTH and SUBSTANCE ABUSE SERVICES</th>
<th>DENTAL CUSTOMER SERVICE</th>
<th>24/7/365 NURSE INFORMATION LINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Plus</td>
<td>651-662-5545</td>
<td>BlueRide</td>
<td>Behavioral Health at Blue Cross Blue Shield of MN 651-662-5545 1-800-711-9862 TTY/Hearing impaired 7-1-1</td>
<td>Delta Dental of Minnesota 651-406-5907 1-800-774-9049 TTY/Hearing impaired 651-406-5915 1-800-916-9514 CivicSmiles network</td>
<td>24 Hour Advice Nurse Line 1-800-622-9524 TTY/Hearing impaired 7-1-1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1-800-711-9862</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>TTY/Hearing impaired 952-883-6060 1-800-443-0156</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medica</td>
<td>952-992-2322</td>
<td>Language Lines</td>
<td>Medica Behavioral Health 1-800-848-8327 TTY/Hearing impaired Call the National Relay Center at 1-800-855-2880 and ask for one of the phone number above.</td>
<td>Delta Dental of Minnesota 651-406-5919 1-800-459-8574 TTY/Hearing impaired 651-406-5915 1-800-916-9514 CivicSmiles network</td>
<td>Medica CallLink® Nurse Line 1-866-715-0915 TTY/Hearing impaired Call the National Relay Center at 1-800-855-2880 and request they call Medica CallLink.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>TTY/Hearing impaired 952-992-2292 1-800-601-1805</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEALTH PLAN</td>
<td>CUSTOMER SERVICE</td>
<td>INTERPRETERS</td>
<td>TRANSPORTATION*</td>
<td>MENTAL HEALTH and SUBSTANCE ABUSE SERVICES</td>
<td>DENTAL CUSTOMER SERVICE</td>
<td>24/7/365 NURSE INFORMATION LINE</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------</td>
<td>-------------</td>
<td>----------------</td>
<td>------------------------------------------</td>
<td>------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>TTY/Hearing impaired 612-676-6810 1-800-688-2534</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TTY/Hearing impaired
Call the National Relay Center at 1-800-855-2880 and ask for one of the phone number above.
SECTION 2 C: Health Plan Services Medical Assistance and MinnesotaCare Members who are Pregnant

Health plans were asked by community partners to assemble a table that highlights services that health plans cover to Medical Assistance and MinnesotaCare members who are pregnant. These services supplement the care these members receive from their health care providers in the clinic setting.

For a current version of the table, go directly to either of these websites:
- Dakota County Public Health (has 2014 version)
- MDH (has 2013 version)

The table contains information on the following:

- **Text4baby**, a mobile service that provides women who are pregnant and new mothers with information about their health and their babies. This program is in Spanish as well as English and can be accessed by texting BABY to 511411
- Contact information for:
  - Health plans’ pregnancy support person
  - Transportation
  - Interpreter
  - Customer services
- Information about the following services:
  - Behavioral health (mental health and chemical dependency)
  - Breast pump purchase and rental
  - Family planning counseling
  - High risk case management
  - 24 hour nurse information line
  - Perinatal nurse advice line
  - Prenatal visits/education
  - Prenatal and childbirth classes
  - Prenatal packet and/or education materials
  - Public health/home visits
  - Doula services
SECTION 3: COORDINATION WITH LOCAL PUBLIC HEALTH

Health plans collaborate with state and local public health agencies in numerous ways. In Section 5, we list ways that health plans support public health accreditation standards. In Section 6, we list the collaboratives/committees that health plans either lead or participate in that address public health issues. In this section, we provide information on:

A. Regional local public health director/health plan meetings.

B. The Center for Community Health (CCH) and the community health need assessment (CHNA) processes for health plans, hospitals, and local public health.

C. Information on health plan data. Local public health agencies requested this information.
SECTION 3 A: Regional Meetings
Local Health Departments’ Regional Meetings with Health Plans

The table below provides information on collaborative local health department regional meetings where health plan representatives and public health directors meet to discuss public health priority areas for the purposes of identifying areas for collaboration and to problem solve. These meetings are focused on local issues and do not replace other meetings focused on public health priorities (see Section 6).

Since the last Collaboration Plan was submitted, many of the groups listed below are either not meeting or meeting infrequently. The Metro group continues to meet three times a year and is closely linked to Center for Community Health. The Southwest group, called the Prairie Regional Health Alliance, is also meeting. *Health plans are interested in meeting with public health directors in all regions of the state.*

<table>
<thead>
<tr>
<th>COLLABORATIVE LOCAL HEALTH DEPARTMENT/HEALTH PLAN REGIONAL GROUPS</th>
<th>Region</th>
<th>Units within Region</th>
<th>Meetings</th>
<th>Representatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>Counties: Benton, Cass, Chisago, Crow Wing, Isanti, Kanabec, Mille Lacs, Morrison, Pine, Sherburne, Stearns, Todd, Wadena, Wright</td>
<td>Not active</td>
<td><em>MCHP:</em> Carol Berg (UCare); Dean Mason (Medica); Nancy Hoyt Taff (HP); Ashlyn Christianson (BCBS)</td>
<td></td>
</tr>
</tbody>
</table>
| Metro                                                        | Cities: Bloomington, Edina, Minneapolis, Richfield, St. Paul; Counties: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington | 3x/year for one hour; additional ad hoc meetings | *MCHP:* Janny Brust (MCHP); Ashlyn Christianson (BCBS); DeDee Varner, Nancy Hoyt Taff (HP); Ken Bence (Medica); Heather Clark (P1); Carol Berg (UCare)  
*Public Health:* Wendy Bauman, Joan Brandt, Merilee Brown, Bonnie Brueshoff, Laurel Hoff, Lowell Johnson, Rina McManus, Todd Monson, Gretchen Musicant, Bonnie Paulsen, Susan Palchick, Marcee Shaughnessy, Randy Wolf |
| Metro Local Public Association (MLPHA)                       | NE MN Public Health Cooperative | This group has not met since 2012. | *MCHP:* Carol Berg (UCare); Nancy Hoyt Taff (HP); Ashlyn Christianson (BCBS); Dean Mason (Medica) |
| Northeast                                                    | Counties: Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, St. Louis | Not active | *MCHP:* Carol Berg (UCare); Nancy Hoyt Taff (HP); Ashlyn Christianson (BCBS); Emily Peterson (Medica) |
| Northwest                                                   | Counties: Beltrami, Clearwater, Hubbard, Kittson, Lake of the Woods, Marshall, Pennington, Polk, Red Lake, Roseau | | |
## COLLABORATIVE LOCAL HEALTH DEPARTMENT/HEALTH PLAN REGIONAL GROUPS

<table>
<thead>
<tr>
<th>Region</th>
<th>Units within Region</th>
<th>Meetings</th>
<th>Representatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Central</td>
<td>Counties: Blue Earth, Brown, Faribault, McLeod, LeSueur, Martin, Meeker, Nicollet, Sibley, Watonwan</td>
<td>Not active</td>
<td>MCHP: Carol Berg (UCare); Ashlyn Christianson (BCBS)</td>
</tr>
<tr>
<td>Southeast</td>
<td>Counties: Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, Waseca, Winona</td>
<td>Have met with SE MN Local Public Health Association in the past (last met in 2011)</td>
<td>MCHP: Carol Berg (UCare); Dean Mason (Medica)</td>
</tr>
</tbody>
</table>
| Southwest               | Counties: Big Stone, Chippewa, Cottonwood, Jackson, Kandiyohi, Lac Quiparle, Lincoln, Lyon, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, Yellow Medicine | Meets 3x/year for two hours                   | MCHP: Carol Berg (UCare); Ashlyn Christianson (BCBS)  
  MDH: Dorothy Bliss  
  Affiliated Community Medical Center: Shawn Franklin, Caryn McGreary  
  Public Health: Liz Auch, Carol Biren, Jill Bruns, Chery Johnson, Marie Meyers, Ann Stehn, Pat Stewart, Diane Winter  
  Southern Prairie Community Care: Mary Fischer |
| West Central            | Counties: Becker, Clay, Douglas, Grant, Norman, Mahnomen, Otter Tail, Pope, Stevens, Traverse, Wilkin | Not active                                   | MCHP: Carol Berg (UCare); Ashlyn Christianson (BCBS); Emily Peterson (Medica) |
### SECTION 3 B: Center for Community Health

**Partners:** Health plans, hospitals and local public health agencies in the 7-county metro area of Minnesota.

**Vision:** Using data and assessment tools, health plans, hospitals and governmental public health agencies will achieve the Triple Aim of improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care.

**Mission:** To improve the health of our community by engaging across sectors and serving as a catalyst to align the community health assessment process and the development of action plans to impact priority issues and increase organizational effectiveness.

**Guiding Principles:**
- Our work will focus on what can be done across all three sectors
- Our level of engagement will reflect our respective priorities and capacity
- Members will be clear about who they are representing (sector, organization or self) when contributing opinions and ideas
- Our work will be data driven
- We will strive for efficiency and avoid added work
- Our efforts should add value to our work
- We will avoid areas that might raise antitrust concerns, such as reimbursement matters and payor/provider relationships
- Membership in CCH does not preclude members from doing individual work in their own sectors
- We will strive to create/achieve health equity

**Members:** Appointed by CCH member organizations. These representatives have responsibility and accountability for community health assessments or other related activities within their organizations.

---

**CCH Partners**

<table>
<thead>
<tr>
<th>Public Health Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anoka County Community Health &amp; Environmental Services</td>
</tr>
<tr>
<td>Carver County Public Health &amp; Environment</td>
</tr>
<tr>
<td>City of Bloomington, Division of Health</td>
</tr>
<tr>
<td>City of Edina Community Health</td>
</tr>
<tr>
<td>City of Richfield Public Safety</td>
</tr>
<tr>
<td>Dakota County Public Health</td>
</tr>
<tr>
<td>Hennepin County Human Services &amp; Public Health</td>
</tr>
<tr>
<td>Minneapolis Health Department</td>
</tr>
<tr>
<td>St. Paul-Ramsey County Public Health</td>
</tr>
<tr>
<td>Washington County Public Health &amp; Environment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross Blue Shield/Blue Plus of MN</td>
</tr>
<tr>
<td>HealthPartners</td>
</tr>
<tr>
<td>Medica</td>
</tr>
<tr>
<td>Metropolitan Health Plan</td>
</tr>
<tr>
<td>MN Council of Health Plans</td>
</tr>
<tr>
<td>PreferredOne</td>
</tr>
<tr>
<td>UCare</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospitals/Health Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allina Health</td>
</tr>
<tr>
<td>Children’s Hospitals and Clinics Ridgeview Medical Center</td>
</tr>
<tr>
<td>Fairview &amp; Fairview Corporate Community Health</td>
</tr>
<tr>
<td>HealthEast: St. Joseph’s, St. John’s, Bethesda &amp; Woodwinds Hospitals</td>
</tr>
<tr>
<td>HealthPartners family of care: Methodist, Regions &amp; Lakeview Hospitals; HealthPartners &amp; Park Nicollet Medica Clinics</td>
</tr>
<tr>
<td>Hennepin County Medical Center</td>
</tr>
<tr>
<td>MN Hospital Association</td>
</tr>
<tr>
<td>North Memorial</td>
</tr>
<tr>
<td>Regina Medical Center</td>
</tr>
<tr>
<td>United Hospital</td>
</tr>
<tr>
<td>Unity &amp; Mercy Hospitals – Northwest Metro</td>
</tr>
</tbody>
</table>

**ExOfficio**

| MN Department of Health |
| Stratis Health |
Organizational Structure:

- Steering Committee: Comprised of 12 members: four representatives from each sector— metro hospitals, health plans, and public health agencies. Non-voting members include Stratis Health (facilitator) and the Minnesota Department of Health. The Steering Committee’s role is to make decisions for CCH and set annual objectives and work plans based on input from the full membership. Steering Committee members serve a two-year term.
- Executive Committee: Has three members. Committee members are chosen by the Steering Committee, with one representative from each sector.

Accomplishments

- Completed four analyses of the community health assessment.
- Provided a document that explains the community health assessment requirements for hospitals, health plans, and public health agencies.
- Created a communication vehicle, CollaboGRAM.
- Formed two work groups: Assessment Alignment and Collective Action.
- Identified Mental Health as an area for collective action. Recently, identified and recommended four evidence-based programs for collective action.
- Work with Metropolitan Public Health Analysts Network on data issues.
- Twice a year host “full” membership meetings as a way of keeping the CCH community informed.
- Attracted more than 30 paying member organizations.
- Received a grant from Robert Wood Johnson to participate in a one-year training session that provides resources and tools on effective collaboration through the Center for Creative Leadership (CCL). Five members of CCH participated.
- Received $10,000 grant from Stratis Health for facilitation.
- Received a $26,000 grant from Robert Wood Johnson, through the Minnesota Aligning Force for Quality, to work on alignment of data and measurement.
- Hired a University of Minnesota graduate student to do the community health assessment analyses.
- Hired a data and research analyst and University of Minnesota graduate student to assist the work group with aligning collective mental health measures and activities.
- Explored possible partnerships beyond CCH members. Examples include the University of Minnesota, Silos to Circles, and other collaboratives outside the seven-county metro area that are working on community needs assessments.
- A model for a common community health assessment for Metro Twin Cities will be developed in 2015, with a pilot following.
Requirements for Community Health Assessments Across Sectors

Background: This document was prepared by the Center for Community Health to describe the different requirements for the Community Health Assessment for hospitals, local public health and health plans. This document will be updated as needed and will be placed on the Washington County public health website.

Community Assessment Goal

The goal of a community health assessment is to identify, quantify and describe community health issues and to characterize community assets that may help meet needs and improve health. In Minnesota, several community sectors engage in assessing a community’s health. These sectors include, but are not limited to, nonprofit health plans, nonprofit hospitals and public health agencies.

Why Collaboration is Important

Recent changes to the requirements or guidelines that define how these assessments should be conducted necessitate better understanding and collaboration between sectors in order to reduce duplication of effort. The Center for Community Health (CCH), a public/private initiative for health improvement in the seven-county metropolitan area of Minnesota, brings partners together to discuss the key components of hospital-health system, health plan and local public health requirements related to community health assessment. One of CCH’s initial goals is to assure general understanding about key assessment components as well as identify intersections and opportunities for streamlining community health assessments across these sectors.

How Community Health Assessment Fits into the Big Picture

Community Health Assessment is typically the first stage of a multi-step process which includes assessment, prioritizing, planning, implementation and evaluation. Improved coordination and collaboration between Minnesota’s health Plans, hospitals-health systems and public health during the assessment, prioritization and planning stages will result in better use of community and organizational resources. The Centers for Disease Control and Prevention has described a similar desired state for multiple stakeholders that unifies community health improvement efforts.

---

1 Community Health Assessment and Community Health Needs Assessment are used interchangeably throughout this document with both referring to the systematic collection of data and information to be used in the development of strategies to address a community’s health.

2 Center for Disease Control (CDC) [www.cdc.gov/policy/ohsc/docs/currentanddesired_frameworks.pdf](http://www.cdc.gov/policy/ohsc/docs/currentanddesired_frameworks.pdf)
Why Community Health Assessment is important

**Hospitals & Health Systems**
The community health needs assessment is an important tool for hospitals in meeting their mission. The assessment allows hospitals to utilize available public health data as well as their own data to identify the needs of the community and direct their community benefit activities to address those needs. As a result of the passage of the Affordable Care Act and accompanying IRS requirements, completion of a community health needs assessment is required of non-profit hospitals every three years.

**Public Health**
Assessment is a foundational activity of public health and is a basis for setting priorities, planning, developing programs, seeking funding, and changing policy. Community health assessments in public health describe the health of the population, identify areas for improvement, identify contributing factors that impact health outcomes, and identify community assets and resources that can be mobilized to improve population health. These assessments provide the general public and policy leaders with information on the health of the population and the broad range of factors that impact its health. Public health assessment activities have recently been influenced by the Public Health Accreditation Board’s Voluntary Standards and Measures document which serves as the official guide for public health department accreditation. Community health assessment requirements are outlined in Standard 1.1.

**Health Plans**
Local public health community health assessments, Minnesota public health goals and health plans’ own data analyses are used to determine health plan priority areas. Health plans are required by the State to collaborate with local public health departments on public health goals. In 2010, Minnesota allowed the health plans to submit one collaboration plan for its seven health plans. Priority areas become the focus of collaborative health improvement efforts. The collaboration plan has evolved from a report to a working document that can be used by stakeholders for collaboration and public health improvement.

---

3 Public Health Accreditation Board (PHAB) [www.phaboard.org](http://www.phaboard.org)
# WHAT ARE THE COMMUNITY HEALTH ASSESSMENT TASKS BY SECTOR

<table>
<thead>
<tr>
<th></th>
<th>HEALTH PLANS*</th>
<th>HOSPITALS &amp; HEALTH SYSTEMS</th>
<th>PUBLIC HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FREQUENCY</strong></td>
<td>Every 5 years</td>
<td>Every 3 years</td>
<td>Every 5 years</td>
</tr>
<tr>
<td><strong>REQUIREMENT</strong></td>
<td>Minn. Stat. 62Q.075</td>
<td>Affordable Care Act</td>
<td>Minn. Stat. 145A</td>
</tr>
<tr>
<td><strong>REPORTING</strong></td>
<td>To MDH</td>
<td>To IRS, Form 990 Schedule H</td>
<td>To MDH</td>
</tr>
<tr>
<td><strong>AVAILABILITY OF COLLABORATIVE PROCESS MODELS OR TOOLKITS</strong></td>
<td>ACHI Toolkit, Catholic Hospital Association Assessing Community Health Needs</td>
<td>Mobilizing for Action through Planning and Partnerships (MAPP)</td>
<td></td>
</tr>
<tr>
<td><strong>TASKS THAT ARE COMMON ACROSS SECTORS</strong></td>
<td>Describe target population/audience</td>
<td>Develop an assessment plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Partner with other community sectors</td>
<td>Review primary and secondary data</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Collect quantitative and qualitative data</td>
<td>Analyze all data</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Seek community input</td>
<td>Describe causes that contribute to the identified health issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Describe existence and extent of health disparities</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Describe community assets and resources available to address priority health issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inform partners and community organizations about the assessment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Communicate findings to the public</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monitor and update findings on an ongoing basis</td>
<td></td>
</tr>
</tbody>
</table>

*Although individual health plans do the tasks listed under community health assessment for their organizations, it is not a requirement of the collaboration plan. Health plans work with local public health and hospitals on community health assessments through collaborative projects.

**ONLINE RESOURCES**

Minnesota Collaboration Plan 2015-2019 [revised 12/26/14]
Minnesota Council of Health Plans
Collaboration Plan
http://bit.ly/1x14dVz

Minnesota Department of Health
Local Public Health Assessment and Planning
http://bit.ly/1AXXyeg

Minnesota Hospital Association
Community Health Needs Assessment
http://bit.ly/1CDJmrZ
SECTION 3 C: Health Plan Data

Health plans provide their expertise on data and measurement on a number of collaboratives (see Section 6). And, health plans work with the State on various initiatives to improve the collection of data related to race, ethnicity, language and socio-demographics.

Additionally, local public health agencies asked health plans to provide an overview of their key data sources and also asked health plans to answer specific data questions (provided below).

Key data sources:
- **MN Community Measurement (MNCM)** Health plans were founders of MNCM, which measures outcomes on the triple aim, including cost, quality and patient experience. Health plans provide data to MNCM and participate on various workgroups. Annual reports include health care quality reports, which provide comparative data at the medical group level. Additionally, MNCM issues an annual report, *A Health Care Disparities Report*, which provides comparable clinical data by race, ethnicity, language and health insurance coverage. Recently MNCM published a Total Cost of Care measure.

- **Healthcare Effectiveness Data and Information Set (HEDIS)**. HEDIS measures, developed by the National Committee for Quality Assurance (NCQA), provide data by health plans about the quality of care, access to care, and member satisfaction with health plans and providers. HEDIS data provide consistent measurements that can be compared and reported yearly.

- **MN Statewide Quality Reporting and Measurement System (SORMS)**. This is a standardized set of quality measures for health care providers across the state. Health plans require providers to submit data on measures that are part of the standardized data set.

Health Plan Data Q&A

How is health plan data collected?
All available data is collected through claims data on individual members. This data includes clinic visits and hospital stays. The data is only as good as the claims that are submitted. These data can be filtered by payor (Medicaid), race, clinic, hospitalizations, etc.
- **Birth Data**: The Center for Health Statistics has birth and death information. Health plans receive birth notifications from the Minnesota Department of Health (MDH), who receives birth certificate information from the hospitals. The health plans then send the list of newborns to the county to update enrollment files. Some county public health agencies use the information for outreach purposes.
- **Persons identifying as smoking cigarettes:** We are not able to identify who is a current smoker based on claims data. There may be other data available through claims, such as if the member is participating in smoking cessation programs, or had smoking cessation counseling. The statewide Consumer Assessment of Healthcare Provider Survey (CAHPS) data may have self-declared smoking data available.

**How does the health plan use its data?**
The health plans use data to help inform performance and quality improvement projects, and develop better ways to serve members. For example, if the data shows a disparity in a particular service, the health plans can develop initiatives to help reduce this disparity.

**Who would be the primary contact at a health plan?**
Please see the contact sheet provided by the health plans in the collaboration plan or connect with your county representative at each plan.

**What is the process and/or capacity to share data?**
Data sharing agreements vary by health plan and topic, often on a case-by-case basis and dependent on data privacy laws. The health plans have data sharing agreements with the counties, and are able to set up data exchanges on a case-by-case basis. Health plans protect member identify and would not share data if there is any possibility that an individual could be identified. This is a possibility in counties with small population sizes. MN Community Measurement (MNCM) develops, collects, analyzes and reports quality measures in the health care industry. See [MNCM](#) for more information.

**Has the health plan been involved with the hospitals that are now required to do community health assessments every three years?**
Health plans share data as requested or needed to complete the hospital assessments. We also work closely with our hospitals to align our initiatives and goals based on these assessments. The health plans participate in a number of community wide collaborations, such as the Center for Community Health (metro area) and the Chisago County Needs Assessment group. These collaborations address the barriers and opportunities for collaboration around the various needs assessments conducted in a community.

**What data might the health plans be interested in that is currently being collected by public health?**
Health plans are interested in the information that public health collects on their communities as that helps better serve members. For example, it’s helpful to know if members are participating in public health programs where members may be eligible.

**What are some challenges in the exchange of information?**
The timeliness and accuracy of claims data is reliant on the timelines and submission of claims. If the claim is not submitted quickly, or with an accurate billing code, health plan data is not as accurate as it could be.
Another issue is that the health plans are not always billed for services. If a member has dual coverage with private insurance, Medicaid is billed last. Many clinics do not bill Medicaid for remaining components, or there is no need to bill Medicaid for the service if the primary insurance covers the service. In these situations, the Medicaid health plan is not aware the service has occurred.

One major area of concern is the accuracy of member contact information. Many members are highly mobile and often do not have permanent addresses or phone numbers.

When requesting data from health plans, the specifications and metrics of the data must be clear so the health plan is able to pull the correct information and so it is comparable across health plans and in aggregate. Sample of size of data must be considered for data privacy concerns.

**Are there some opportunities for partnerships/collaboration?**

YES! Health plans welcome the opportunity to explore better opportunities for data exchange. Much of the data sharing health plans do with counties is a manual process, and a more fluid communication systems is envisioned for the future. Examples of the data provided to counties at this time for outreach work are lists of pregnant women and missed C&TC visits. Similar data sharing could be arranged to better coordinate care across systems.
SECTION 4: SHARED PUBLIC HEALTH PRIORITIES & KEY INITIATIVES
ADDRESSING SHARED PRIORITY AREAS

How priority areas were chosen: Health plans identified five public health priority areas after review of a number of analyses and reports. First, the MCHP Community Health Committee reviewed their priority areas from their last collaboration plan. Those priority areas were aligned with local public health. Health plans also reviewed the analysis done by the Center for Community Health (CCH). The CCH analysis reviewed all the public health the priorities from the last Community Health Needs Assessments (CHNA) submitted by public health and hospitals. Additionally, health plans serve on the Healthy Minnesota Partnership which sets the framework for the State’s goals through 2020. Based on these reviews, MCHP identified the five topics below for their priority areas for 2015-2019. While these five topics will be key priority areas for health plans’ work with local public health, health plans will continue to work on other public health issues as well.

- Physical Activity and Nutrition
- Health Disparities and Health Equity
- Mental Health and Chemical Health
- Access to Health Care
- Chronic Disease Prevention and Management

The following pages highlight key initiatives that health plans work on with public health:

A. Physical Activity and Nutrition: While health plans have myriad activities focused on physical activities and nutrition, this section highlights the Minnesota Partnership on Pediatric Obesity Care and Coverage (MPPOCC). However, in addition to MPPOCC, health plans have actively worked on the State Improvement Health Program (SHIP) and the Community Transformation Grants (CTG). Other activities focused on physical activity and nutrition are listed in Section 6.

B. Health Disparities and Health Equity: Health plans address health disparities and health equity as employers, health plans, and community members. This section describes the type of activities most health plans typically do as well as list individual health plans’ programs.

C. Mental Health and Chemical Health: MCHP has a Behavioral Health Sub-committee that has been meeting for many years to address behavioral health and chemical health issues. Most of the discussion is focused on treatment. In addition to collaborating across health plans,
this sub-committee works with community partners and state agencies on a variety of behavioral and chemical health issues. MCHP provides a leadership role for the Collective Action Work Group of the Center for Community Health, which is directing its efforts on community mental health initiatives, focused on awareness and prevention.

D. **Access to Health Care:** MCHP’s goal is to assure broad access to health care coverage and affordable, quality services. This section details ways health plans work to assure members and the community have access to coverage. Additionally, while there is considerable data on the quality of care, it has been more difficult to access cost data. Over the past year, health plans have worked with MN Community Measurement to develop comparable cost data through the total cost of care measure.

E. **Chronic Disease Prevention and Management:** Minnesota is recognized for its high level of quality care by various national groups. With community partners, health plans work on initiatives that span the continuum of care. Additionally, MCHP health plans are committed to helping members take an active role in their health through disease and condition management programs. These programs are free for eligible members. Examples of specific diseases or conditions that have management programs include asthma, cancer, coronary artery disease, chronic obstructive pulmonary disease, depression and alcohol use disorder, diabetes, Parkinson’s disease, rheumatoid arthritis. Check with your health plans if you are interested in being in one of their programs.
SECTION 4 A: Physical Activity and Nutrition

Health plans offer programs for their members that address physical activities and nutrition. Additionally, they work together on collaborative activities that address these issues as well (See Section 6). Health plans have also actively worked on the State Improvement Health Program (SHIP) and the Community Transformation Grants (CTG). For this priority area, though, we chose to highlight the Minnesota Partnership on Pediatric Obesity Care and Coverage (MPPOCC). This is a collaborative that initially began between the Minnesota Council of Health Plans and the Minnesota Chapter of the Academy of Pediatrics, with the goal of improving clinical services and community referrals. The Partnership also includes state and local public health partners.

Minnesota Partnership on Pediatric Obesity Care and Coverage (MPPOCC)

**Partners:** Minnesota Council of Health Plans (MCHP) and the Minnesota Chapter of the American Academy of Pediatrics (MNAPP). The Partnership was formed in 2012 and is comprised of organizations dedicated to reducing childhood obesity through clinical and community services.

**Purpose:** To gain a better understanding of (1) childhood obesity coverage and service packages; and (2) what the health plans would need to do to support these packages.

**Addressing Barriers:** MPPOCC worked to address barriers identified by pediatricians. The barriers were related to reimbursement, coding, community referrals, communications, both for providers and for parents and children, and finally improving data collecting reporting both for BMI and for other key clinical measures.

**What We Have Learned So Far:** Reimbursement is not a significant barrier to in-clinic care. Children who are obese or overweight can receive nutritional and/or physical activity counseling which is then reimbursed according to their individual coverage. Information on coding is also not a barrier. Coding information has been disseminated and training sessions are available. BMI data is being improved. MPPOCC came to consensus on data measures that clinics could collect beyond BMI. Multiple levels of communication have been developed and there was consensus to use the 5-2-1-0 messages. There are multitude of resources to draw on which the MPPOCC has also disseminated. The barrier that remains is reimbursement for community referrals. A work group will begin meeting to determine the best way to support care outside clinic walls.

**MPPOCC Partners**

- Blue Cross Blue Shield/Blue Plus of MN
- CentraCare
- Children’s Hospitals and Clinics of MN
- Entira Family Clinics
- Essentia Health
- Fairview
- HealthPartners
- Hennepin County Medical Center
- Medica
- Minneapolis Health Department
- MN Academy of Family Physicians
- MN American Academy of Pediatrics
- MN Community Measurement
- MN Council of Health Plans
- MN Dept. of Health
- MN Medical Association
- Park Nicollet
- PartnerSHIP 4 Health
- PreferredOne
- Sanford Health
- UCare
- University of Minnesota
- YMCA – Twin Cities
- Youth Determined to Succeed
Accomplishments

- Communication
  - Partnership formally adopted the 5-2-1-0 program/messages
  - Resources (including 5-2-1-0 counseling) are posted on the MNAPP website
  - “Treating Childhood Obesity” article published in January 2014 edition of Minnesota Medicine
  - Disseminated billing guide to providers.

- Data
  - MPPOCC members on the MN Community Measurement (MNCM) Measures Work Group. MNCM is part of the Partnership Stakeholder group. MNCM is developing a child preventive measure that includes BMI. Clinic pilots are being conducted and data will be available in 2015.
  - Consensus on key measures for clinics to track.

- Community Referrals
  - Support Breastfeeding Coalition
  - Support SHIP efforts

- Coding
  - Work with Minnesota Department of Human Services on community covered benefits
  - A coding/billing webinar will be held in 2015.

- Resources
  - ICSI guidelines
  - Developed a “discussion guide” for clinics to use for pilot projects with health plans
  - MN Academy of Pediatrics (MNAAP) billing guide is posted on this site
  - Institute of Medicine (IOM) [http://www.iom.edu]
  - Statewide Health Improvement Program (SHIP) [http://www.health.state.mn.us/ship/]
SECTION 4 B: Health Disparities and Health Equity

Minnesota health plans are addressing racial and ethnic disparities and health equity as employers, as community partners through collaborative work, by covering special services such as interpreter services, and by providing culturally sensitive care. In terms of collaborative work, health plans serve on the MDH Office of Minority and Multi-cultural Health Advisory Committee. Health plans also serve on the MN Healthy Partnership steering committee and work groups that focus on health in all policies and changing the narrative of health. Additionally, health plans provide leadership through the Minnesota Public Health Association which advocates for health equity through policies and system changes.

Examples of health plans’ work to reduce health disparities and increase healthy equity:

- **Employment**
  - Staff Training and Education
    - Offer diversity training to all employees
    - Provide materials/resources on cultural competence
    - Organize diversity celebrations/activities on different cultures throughout the year
    - Offer ongoing training sessions to employees regarding culturally competent care
  - Employee Recruitment
    - Actively recruit by advertising jobs/positions in diverse publications and at job fairs and community festivals
    - Identify workforce diversity goals
  - Employee Retention
    - Have internal diversity committees to foster supportive working environment to help retain diverse staff

- **Increased access** to culturally and linguistically appropriate care through
  - Interpreters
    - Provide interpreter services for health care services
    - Offer language assistance both in person and over the phone
    - Employ bilingual staff, especially in customer services
    - Publish provider directories that indicate language capacity of clinics
    - Publish notice of right to interpreters in member guides and in other resources (such as video on You Tube)
    - Disseminate posters or other notices to place in clinics to help patients indicate their need for interpreter services
    - Include language block on all member materials explaining how to get the information communicated in their language
    - Include interpreter services information (e.g., how to arrange for interpreters, how to work with interpreters, etc.) in provider materials
    - Review interpreter services policies and procedures annually.
  - Written Materials in Other Languages
- Offer member information at appropriate health literacy level
- Provide materials in identified languages and respond to requests for special language needs
- Many health plans support the Multilingual Health Resource Exchange that has thousands of translated health resources
- Use many methods of communication with diverse communities (partner with ECHO, support radio programs, etc.)
  o Facilitating Complaint Process
    - Notify members of their right to file complaints or grievances in member information
    - Provide interpreter services for complaint and grievance process
  o Prioritizing Culturally Responsive Care
    - Have internal Health Plan cultural competence committees
  o Soliciting Community Input
    - Convene Member Advisory Committees to receive ongoing input about services
    - Hold focus groups among diverse members to solicit feedback from particular population groups
    - Participate in diverse community events and health fairs to have a presence in the community
  o Literacy for members and employees

- Improved quality of care of diverse populations through
  o Provider Education
    - Offer cultural competence training for health care providers (e.g., sponsor conferences, workshops and onsite clinic training sessions).
      > Offer conferences on best practices, screening, health disparities
      > Provide materials/resources on cultural competence
  o Quality of Care Improvement Initiatives
    - Address cultural needs in quality improvement initiatives
    - Consider available Race/Ethnicity/Language (REL) data in planning initiatives
    - Research (e.g. healthy environments)
    - Implement CLAS standards
  o Data Analysis
    - Review public programs data on race and language as part of their program planning process
    - Review published data and community assessments/surveys on cultural and linguistic needs of Minnesota populations as part of their program planning process
    - Measurement: Data collection on REL
  o Pay for Performance provider incentives for reducing inequities (e.g. colorectal cancer, BMI, smoking)
  o Incentives for Minnesota Health Care Program members (e.g. cancer screenings and other preventive health services, smoking cessation, etc.)

- Grants to providers and community partners to reduce disparities
- Health plans partner with the Minnesota Public Health Association to advocate for policies and systems changes that create health equity and put Health in All Policies into practice

<table>
<thead>
<tr>
<th>EXAMPLES OF INDIVIDUAL HEALTH PLAN PROGRAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blue Cross Blue Shield/Blue Plus of Minnesota</strong></td>
</tr>
<tr>
<td><strong>The Center for Prevention</strong> collaborates with organizations statewide to increase health equity by addressing barriers to healthy eating and physical activity, as well as disparities related to commercial tobacco use. Through its Health Equity in Prevention funding initiative, the Center is currently providing approximately $1.7 million annually to support 13 projects specifically focused on increasing health equity. Organizations supported through its Active Living for All funding initiative, are also addressing health equity by ensuring that more Minnesota communities provide opportunities for people to engage in physical activity safely and conveniently. To see a full list of initiatives the Center is supporting across Minnesota, visit: CenterForPreventionMN.com.</td>
</tr>
<tr>
<td><strong>The Blue Cross and Blue Shield of Minnesota Foundation's (Foundation)</strong> mission is to make a healthy difference in communities by advancing health equity and improving conditions where people live, learn, work and play. The Foundation awards $4.5 million annually to create healthier, more equitable communities. Our strategic aims support and build: Equitable systems: this work ensures that people are positioned to engage with the tools, networks and resources necessary to fully participate in community life. They can achieve optimal health because key community resources and systems are designed and geographically distributed to be fair, easily navigable and accessible. Social connections: help ensure that community members have increased connectedness, confidence, self-efficacy and networked leadership to bring about positive change where they live. Stable lives: will help ensure that children, their families and caretakers are engaged and supported so they can have solid educations that lead to strong, healthy futures. Vibrant communities: help ensure that health considerations are at the forefront of community decisions, equity assessments are routine practice and core community institutions come to define their role as advancing health equity. For more information on Foundation programs and grantees, please visit Blue Cross MN Foundation.</td>
</tr>
<tr>
<td><strong>HealthPartners</strong></td>
</tr>
</tbody>
</table>
| **EBAN 3D Collaborative**: In 2013, HealthPartners and Park Nicollet committed to a year-long collaborative titled “EBAN 3D Collaborative™” to improve diabetes outcomes in African American or African born populations. The collaborative, which concluded mid-
## EXAMPLES OF INDIVIDUAL HEALTH PLAN PROGRAMS

<table>
<thead>
<tr>
<th>Plan</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medica</strong></td>
<td>The Medica Foundation funds community-based programs and initiatives that provide sustainable, measureable improvements in the availability, access and quality of health care. In addition, the Foundation supports efforts that reduce health care disparities and address the social issues driving health care costs. The 2012 funding priorities were primary care and prevention for people with disabilities, appropriate utilization of the health care system, behavioral health and early childhood health. Eighty-eight grants totaling $1.35 million were provided to organizations throughout Medica’s service area in 2012. For 2013, the funding priorities include behavioral health, healthy lifestyles for people with disabilities, early childhood health and organizational core mission support.</td>
</tr>
<tr>
<td><strong>Metropolitan Health Plan</strong></td>
<td>Outreach staff regularly visit locations, such as community centers, shelters and clinics, where members who are homeless may be available. Quarterly member services meetings are held to not only allow members to access health education, but also to receive direct member feedback on how MHP might better assist members in achieving better health outcomes. Community Reinvestment: In 2013, MHP provided reinvestment funding to 11 community programs. Applicants responded to an RFP and 11 recipients were awarded funding for programs that have proven to be creative and supportive to the disabled population. Recipients were: YouthLink, Reach for Resources, Touchstone Mental Health, Vail Place, BeechWood, Community Involvement Programs, Community University Health Care Clinic, Pillsbury United Communities, Rise, Spectrum and The Link.</td>
</tr>
<tr>
<td><strong>UCare</strong></td>
<td><strong>Provider and Member Focus Groups:</strong> UCare annually conducts member focus groups in the Somali, Hmong and Latino communities with discussions focused on building relationships with members, understanding cultural practices and beliefs about health care and sharing feedback so the UCare can provide quality service to their communities.</td>
</tr>
</tbody>
</table>

2014, brings together community partners, patients and health professionals to find solutions that reduce diabetes care disparities. **Interpreter Services:** Invested $7.3 million in FY2012 in on-site services; language access integral component; provide interpreter services in all key languages spoken by patients and members, and more than 150 other languages through telephone and video remote interpreter services; Members Services department delivers services in multiple languages to assist members with questions and finding culturally appropriate providers. **Promise Neighborhood Work** partners with the St. Paul Public Schools, Ramsey County, City of St. Paul, St. Paul Foundation and Wilder Foundation to provide “cradle to career” continuum of supports to children in the St. Paul Promise Neighborhood to overcome socioeconomic barriers and ensure their success. Success has been achieved in prioritizing health needs to focus on three elementary schools and families; initiating school health program with a new clinical model, connecting to family resource centers; and integrating work with PMAP population health initiative.
**EXAMPLES OF INDIVIDUAL HEALTH PLAN PROGRAMS**

<table>
<thead>
<tr>
<th><strong>Culture Care Connection (CCC):</strong> UCare partnered with Stratis Health to create an online learning and resource center aimed at supporting health care providers, staff, and administrators in their ongoing efforts to provide culturally-competent care in MN. The site provides information on cultural competence concepts, health topics, ethnicities, stakeholder organizations, and resources that are most reflective of the needs of Minnesota’s diverse populations. CCC provides actionable tools to assist organizations in achieving their cultural competence goals.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UCare Foundation:</strong> Established in 1998, the UCare Foundation (formerly the UCare Fund) is a community-directed initiative supporting programs and initiatives that improve the health of underserved populations in the Twin Cities and throughout Greater Minnesota and western Wisconsin with innovative services, education, community outreach, and research.</td>
</tr>
</tbody>
</table>
SECTION 4 C: Mental Health and Chemical Health

MCHP members work collaboratively with providers, health systems, counties, and community members to improve mental health and chemical health care. MCHP has a standing Behavioral Health subcommittee where health plans collaborate with each other and community members on mental health and chemical health activities. The Behavioral Health subcommittee also meets with DHS regularly on a quarterly basis. In addition, MCHP hosts DHS sponsored meeting focused on implementing the new Early Intensive Developmental and Behavioral Intervention benefit. Finally, MCHP members serve on a number of community collaboratives aimed at improving mental and chemical health (See Section 6).

MCHP Behavioral Health Subcommittee: This subcommittee, comprised of health plan representatives, meets monthly to discuss an array of issues and activities focused on adult and children’s mental health as well as alcohol and drugs. This subcommittee meets with DHS behavioral health and alcohol and drug staff quarterly. Additionally, in the past year, this group has met with DHS behavioral staff and county-based organizations to learn more about and provide guidance on the implementation of the autism benefit. Community members often ask to attend the subcommittee meetings to discuss issues of concern. Examples of topics include mental health screening and coordinating of services for refugees, and prescription opioids. The National Alliance on Mental Illness (NAMI) MN often consults with this subcommittee on system issues. Additionally, counties have met with this subcommittee to discuss diversion and recovery for chronic substance abuse users, residential treatment for children and sobering centers.

Autism Work Group: MCHP has been hosting meetings with the Minnesota Department of Human Services and county-based organizations to develop and implement the infrastructure needed for the Early Intensive Developmental and Behavioral Interventions (EIDBI) benefit that will go into effect mid-summer 2015.

Key Initiatives: MCHP works with providers, health systems, and the community on a number of key initiatives that span the continuum of care. Some examples include:

- **Center for Community Health, Collective Action Work Group:** This work group identified mental health as a priority area for collaborative activities. MCHP received a small grant that will assist health plans to align their activities with public health and hospitals. The grant will provide funding to support a measurement analyst.

- **Make It OK:** In 2013, HealthPartners and Regions Hospital announced the launch of a new campaign to target the stigma surrounding mental illness. Developed in collaboration with community partners and the Minnesota chapter of NAMI, the Make It OK campaign is designed to encourage people to talk more openly about mental illness and ask for help. Instead of simply raising awareness about the need to have a conversation about this, the Make It OK initiative provides concrete steps on how to hold one and, above all, say something helpful, not hurtful. The ads and resource-rich Make It OK website aim to get people thinking about why mental health disorders are still treated differently than so-called traditional diseases. Make It OK also includes documentaries on tpt. Nearly 70,000 people have tuned in to watch...
the first three Make It OK documentaries. Watch the documentaries on the Make It OK website. Make It OK is one of four programs that Center for Community Health, Collective Action Work Group is recommending for collective action.

- **The Diamond project:** Sponsored by the Institute for Clinical Systems Improvement (ICSI), a new model for treating depression. It involves physician, care manager and consulting psychiatrist, working as a team to care for people in primary care clinics. Health plans have been involved in all phases of this project, from development to implementation to evaluation.

- **Performance Improvement Project (PIP):** Health plans individually or collaboratively work on PIPs under the Minnesota Health Care Program contracts. A recent PIP that health plans undertook was to improve care for those members who are depressed. Using a simple screening tool, the patient health questionnaire (PHQ-9), to diagnose the conditions, health plans then help the member receive treatment as needed. Typically, this involves an antidepressant medication with information on how to self-manage their care. Find out more information about PIPs (also called Quality Improvement Programs) [here](#).  
  - PMAP/MinnesotaCare (DHS 2015-2017): Eliminating racial disparities in Antidepressant Medication Management - Continuation Phase (AMM)  
  - SNBC (DHS): Behavioral Health Measure: Follow-up After Hospitalization for Mental Illness (FUH) seven-day and 30-day measures

- **Screening, Brief Intervention and Referral for Treatment (S-BIRT):** S-BIRT is sponsored by ICSI. It is an early intervention program to reduce risky alcohol and drug use. The program provides a screening to identify people at risk for a substance use disorder; a brief intervention to raise awareness of risks and consequences, motivation for change, and help with setting healthier goals; referral to treatment to help those who need to access treatment and coordinate services. Health plans have been involved in all phases of this project, from development to implementation to evaluation.

**Key Committees and Meetings:**

- **Adult Mental Health Initiative Regional Groups:** MCHP sends representatives to public health adult mental health regional work groups. This work is focused on identifying and responding to the needs within their community by using DHS funding and local resources.

- **Committees and Collaboratives:** MCHP sends representatives to a multitude of mental health meetings (see Section 6). Focus areas over the next few years includes topics such as residential treatment options, children’s assertive community treatment rates, behavioral health homes, and access to services that meet people’s needs. In addition, health plans support DHS’ work focused on offenders with mental illness as well as child and adolescent behavioral health services. MCHP also participated in the State Community Health Services Advisory Committee, “[Improving Mental Health and Well-Being: A Vision for Minnesota’s Public Health System.](#)”

- **Mental Health Targeted Case Management:** ([MH-TCM](#)). Working with county social services, health plans help adults and children with a serious and persistent mental illness (SPMI) and children with a severe emotional disturbance (SED) gain access to needed medical, social, educational, vocational, financial and other services as they relate to the member’s mental health needs. Find out more information on MH-TCM [here](#).
SECTION 4 D: Access to Health Care

One of the MCHP’s goals is to assure broad access to health care coverage and services. While this is a core function of health plans, this work is often done in collaboration with the state, local public health and community partners. In this section, we provide examples of ways that health plans’ assure access to health care coverage, improve the quality of care, and provide information on health care costs.

Access to Health Care Coverage: The following are the key ways health plans have supported access to health care coverage.

- **MNsure**: MCHP has been working with the Minnesota Departments of Human Services, Health, and Commerce and counties for several years to assure that those using MNsure are able to access coverage as seamlessly as possible. This has involved extensive systems’ work to align operations across health plans, state, and federal agencies. Health plans have also worked to align coordination, and communications. Additionally, MCHP has advocated for increases in eligibility for public programs (e.g., expanding Medicaid), simplifying enrollment through continuous enrollment; affordability (e.g., working to keep care affordable); support navigators, and support choice for Minnesota Health Care Program members.

- **Portico Healthnet**: MCHP members have supported Portico Healthnet for many years. Portico Healthnet is a nonprofit health and human services organization provides personalized application and enrollment assistance for Minnesota Health Care Programs (i.e., Medical Assistance, MinnesotaCare) and coverage through MNsure.

- **Health Plan Services**: The following are examples of services health plans provide to increase access to care.
  - **Nurse Lines** provide assistance to members who are have questions about their health.
  - **Customer Service support** links members to services and programs.
  - **Health and Wellness Programs**: To improve health and wellness, health plans offer their members’ health incentives, fitness benefits, smoking cessation, web site resources, member accounts to participate in own health and care, etc.
  - **Interpreter Services**: Health plans offer interpreter services for all medical appointments for Medicaid members. Health plans contract with a variety of interpreter service agencies to ensure that the appropriate languages are available and interpreters can be onsite at appointments. When in person interpreters are not available, in an emergency situation for example, clinics and hospitals use the language line to assist with interpretation. Health plan phone centers also have interpreter services available through staff native speakers or through the language line.
  - **Transportation services**: For Medicaid members, health plans offer transportation to and from medical appointments, including the pharmacy. To arrange transportation, members should call their health plan member services.
  - **Mobile vans** for dentists and for breast cancer screening: Some plans use mobile vehicles as a way to increase access to services.
Collaboratives with Health Plan Participation Focused on Improving Quality of Care:

- **Minnesota Community Measurement (MNCM):** Provides outcomes data on quality measures by medical systems.
- **Shared Decision Making:** Provides guidelines on ways patients can make decisions for their care with their providers.
- **Reducing Avoidable Readmissions Effectively (RARE):** Offers support and resources to clinics and community partners to reduce avoidable hospital readmissions.
- **Statewide Innovation Model (SIM)-Accountable Communities for Health (ACH):** The grant will test the Minnesota model goal to improve health in communities, provide better care, and lower health care costs. The model strives to ensure all Minnesotans have the option to receive team-based, coordinated, patient-centered care that increases and facilitates access to medical care, behavioral health care, long term care, and other services.
- **Multilingual Health Resource Exchange:** This collaborative provides an online resource center for the many language learning activities taking place across Minnesota.
- **ECHO:** ECHO bridges the gap for immigrants and refugees in Minnesota by crafting high quality programming for television and radio broadcast and phone, print, web, DVD on health and safety issues.

Access to Cost Information:

- **Total Cost of Care (TCOC):** MN Community Measurement has developed a Total Cost of Care measure and released its first TCOC report in December 2014. Health plans provided the data for this measure as well as expertise for a common methodology.
- **Customer Services Support:** Health plans will estimate costs of service for members. Some health plans have information on the cost of services on their websites.
SECTION 4 E: Chronic Disease Prevention and Management

Minnesota is recognized for its high level of quality care by various national groups. Health plans offer chronic disease programs and care coordination as ways to improve care for those with chronic diseases. Health promotion incentives are also offered as ways to prevent chronic diseases. In addition, health plans work with community partners on initiatives that span the continuum of care in order to prevent or manage chronic diseases (See Section 6).

Health Plan Programs: Examples of health plan programs include:

- **Health Plans’ Disease Management Programs**: Developed to proactively identify populations with, or at risk for, chronic medical conditions. The programs support the practitioner-patient relationship and plan of care. The focus is to prevent exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies. These programs continuously evaluate health and economic outcomes with the goal of improving overall health status. Among the conditions for which health plans have Disease Management Programs include: asthma, diabetes, chronic heart failure (CHF), and chronic obstructive pulmonary disease (COPD).

- **Coordination of Care**: Health plans partner with counties, providers and health systems to provide care coordination services to better coordinate care for people with multiple health and social needs. Care coordinators reach out and connect members in meaningful ways with other sources of service and link with them, so that information is communicated appropriately, consistently and without delay. This is vital to reduce fragmentation of care when someone may be seeing multiple providers and have social condition needs in addition to their health care needs.

- **Medication Management**: Health plans provide assistance for those members on multiple medications to assure they are taking them appropriately.

- **Evidence-based Care and Quality improvement**: Health plans assess evidence-based information and quality improvement projects to continually improve care.

- **Performance Improvement Project (PIP)**: Health plans individually or collaboratively work on PIPs under the Minnesota Health Care Program contracts. Examples of these project include improving colorectal cancer and breast screening rates in disparate populations, reducing unnecessary emergency room use, and reducing hospital readmissions. For more information on PIPs see [Quality Improvement Programs](#).
  - Readmissions/Improving Transitions of Care (2012-2015): Focuses on improving the care individuals receive as they transition from receiving care in one facility to another. This work focuses on enhancing care coordinator support for members. By encouraging coordination and continuity of care between health care locations, providers and different levels of care, the goal is to reduce readmissions and stay responsive to member’s condition and care as needs change over time.
Chlamydia Screening in Women (2013-2015): Working with providers to support efforts to increase Chlamydia infection screening rates in the clinical setting, supporting the Minnesota Chlamydia Partnership, and collaborating with key organizations to implement goals and strategies outlined in the Minnesota Chlamydia Strategy to raise Chlamydia infection screening across Minnesota.

**Health Promotion Incentives:** Health plans provide a number of incentives for Minnesota Health Care Program members. Examples include gift cards for receiving preventive examinations, immunizations, or prenatal care. Smoking cessation, discounts for fitness organization, and youth camps for children with health care needs are additional examples.

**Health Plan Collaborative Activities:** Examples of health plan collaborative activities include:

- **Evidence-based care:** Institute of Clinical Systems Improvement (ICSI) is a non-profit organization whose original purpose was to help improve patient care in Minnesota through collaboration and innovations in evidence-based medicine. Today ICSI is focused on “health” as well as health care reform, and is working to co-create solutions that engage community resources and help consumers and patients share ownership in their health and care. MDH works with ICSI on many initiatives. Health plans have provided professional and financial support.

- **Data measurement and reporting:** MN Community Measurement (MNCM) is a non-profit organization that collects and reports comparable data across health systems. MNCM reports statewide data on quality, cost and patient experience. Annual Health Care Quality and Disparities reports can be found on its corporate website. A consumer site, MNHealthscores.org, provides information on quality performance across clinics and find providers close to home.

- **Chronic disease goals:** Healthy Minnesota Partnership 2020 – MCHP has been an active participant of Healthy Minnesota Partnership which has a workgroup focused on chronic disease. The work group developed targets for the chronic disease and injury data reporting dashboard. Additionally, health plans provided examples of their initiatives that are focused on improving the targeted conditions. Find out more on the 2020 website.

- **Screenings:** Health plans work with the state and other community partners to improve screenings for breast and colorectal cancer screenings for Minnesota Health Care Program members.

- **Leadership:** MCHP members have provided leadership by acting as the chairs of two key chronic disease initiatives, MDH Heart Disease and Stroke Prevention Steering Committee and the Cancer Alliance.

- **Resources to community groups on coverage issues:** MCHP Community Health Committee meets with community partners when there are issues related to coverage. For example, health plans put together a grid for the American Lung Association with detailed information on each health plan’s policies on prescription and durable equipment for Minnesota Health Care Program pediatric members who have asthma.
### SECTION 5: Public Health Accreditation Standards & 
Health Plan Complementary Roles

This table lists examples of health plans' activities that support public health accreditation standards.

<table>
<thead>
<tr>
<th>Public Health Accreditation Standards</th>
<th>Health Plans' Complementary Role</th>
</tr>
</thead>
</table>
| **Standard 1.1:** Participate in or Conduct a Collaborative Process Resulting in a Comprehensive Community Health Assessment | • Working with metro public health, hospitals and plans as the collaborative Center for Community Health (CCH) to coordinate community needs; assess, develop and implement.  
• Regularly report on Health Care Effectiveness Data and Information Set (HEDIS) measures.  
• Continue to participate in their community-specific CAN processes.  
• Provide data for MN Community Measurement and MN Community Measurement Data Set (HEDIS)  
• Provide data for All Payer Claims Database (APCD)  
• Participate in data analysis review through CCH and other community collaboratives  
• Analyze and utilize race, ethnicity and language (REL) data, as available, for quality improvement programs and other activities.  
• Continue to participate in collaborative local health department regional meetings (such as Metro LPHA, Prairie Regional Health Alliance).  
• Worked on statewide assessment through MN Healthy Partnership 2020.  
• Utilize local health department data.  
• Provide member-level data to Child & Teen Checkup (C&TC) coordinators and other public health staff, when possible.  
• Support MDH on statewide surveillance related to tobacco, physical activity and healthy eating.  
• Health plan involvement in MCHP Community Health Committee (meets monthly).  
• Participate actively on community collaboratives as previously mentioned. Health plan representatives are sent to over 60 groups (including regional public health groups).  
• Provide leadership on MN Public Health Association and the MPHA Policy and |
<p>| <strong>Standard 1.2:</strong> Collect and Maintain Reliable, Comparable, and Valid Data That Provide Information on Conditions of Public Health Importance and On the Health Status of the Population | |
| <strong>Standard 1.3:</strong> Analyze Public Health Data to Identify Trends in Health Problems, Environmental Public Health Hazards, and Social and Economic Factors That Affect the Public's Health | |
| <strong>Standard 1.4:</strong> Provide and Use the Results of Health Data Analysis to Develop Recommendations Regarding Public Health Policy, Processes, Programs, or Interventions | |</p>
<table>
<thead>
<tr>
<th>Public Health Accreditation Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard</strong></td>
</tr>
<tr>
<td><strong>Advocacy Committee.</strong></td>
</tr>
<tr>
<td><strong>INVESTIGATE - Domain 2: Investigate health problems and environmental public health hazards to protect the community</strong></td>
</tr>
</tbody>
</table>
| **Standard 2.1:** Conduct Timely Investigations of Health Problems and Environmental Public Health Hazards | Identify and address needs of vulnerable groups through various initiatives, such as:  
- Family Home Visiting Advisory Work Group, MDH Maternal Child Health Task Force,  
- MN Coalition for Targeted Home Visiting  
- Provide Minnesota Senior Health Options (MSHO) care coordination for those with dual eligibility for Medicaid and Medicare  
- Participate in East Metro Children’s Crisis Service Partnership, a tri-county partnership offering mobile mental health crisis services for children  
- Support coalitions to address high priority populations including communities of color and GLBT to reduce tobacco use.  
- Participate in emergency preparedness activities.  
- Participate in Healthy Homes collaboration.  
- Have a history of working together (health plans, local public health, MDH, DHS and community partners) on such issues as pandemic flu, bioterrorism, cancer screening forms. Typically this is through collaborative committees or through the Council’s Community Health Committee. |
| **Standard 2.2:** Contain/Mitigate Health Problems and Environmental Public Health Hazards |
| **Standard 2.3:** Ensure Access to Laboratory and Epidemiologic/Environmental Public Health Expertise and Capacity to Investigate and Contain/Mitigate Public Health Problems and Environmental Public Health Hazards |
| **Standard 2.4:** Maintain a Plan with Policies and Procedures for Urgent and Non-Urgent Communications |
| **INFORM & EDUCATE - Domain 3: Inform and educate about public health issues and functions** |
| **Standard 3.1:** Provide Health Education and Health Promotion Policies, Programs, Processes, and Interventions to Support Prevention and Wellness | • Communication with providers and members about programs regarding various health issues and concerns (via web sites, in-person meetings, and materials)  
• Leadership for MN Community Measurement, which provides consumers data and information on various health conditions.  
• Educating providers on selected diseases/conditions and health disparities.  
• Offer incentives to children and adolescents to get preventive care (C&TC Incentive Program).  
• Collaboration with MDH, DHS and others to produce and disseminate research findings related to the prevention of tobacco use, obesity, cancer, diabetes, low birth weight, etc. (see Section 6).  
• Promote the use of health literacy best practices in written and verbal communication.  
• Participate in the development and promotion of Community Health Workers (CHW) |
<p>| <strong>Standard 3.2:</strong> Provide Information on Public Health Issues and Public Health Functions Through Multiple Methods to a Variety of Audiences |</p>
<table>
<thead>
<tr>
<th>Standard</th>
<th>Health Plans’ Complementary Role</th>
</tr>
</thead>
</table>
|          | and MN CHW Alliance.  
|          | • Provide transportation and interpreter services to help members access health care services (including preventive health visits).  
|          | • Support production of culturally specific health videos and programs in different media (such as C&TC).  
|          | • Support production of some programs through Emergency Community Health Outreach (ECHO).  
|          | • Use multilingual media channels to disseminate health information.  
|          | • Maintain culturally diverse customer services to address member needs.  
|          | • Health plan websites, provider and member newsletters.  
|          | • Partner with MDH, LPHA, MPHA and others to disseminate key public health messages/information.  
|          | • Provide health promotion programs (examples):  
|          |   o Tobacco prevention and cessation programs  
|          |   o Physical activity programs offered to members and communities  
|          |   o Discounted health club memberships for members  
|          |   o Healthy eating programs offered to members and communities  
|          |   o Incentives to help promote receipt of preventive health services (see Section 3)  
|          |   o Car seat programs  
|          |   o Asthma and diabetes camps for children  
|          |   o Nurse line support programs  
|          | • Disseminate information on services and resources through various programs, such as:  
|          |   o 10,000 Steps® program that helped to establish multiple community partnerships with Be Active Minnesota, Hennepin County Parks and Excel Energy Center  
|          |   o Multilingual Health Resource Exchange, which is a collaboration whose partners are consolidating/producing multilingual health resources available through one website (www.health-exchange.net)  
|          |   o Do Campaign, which promotes physical activity  
<p>|          |   o Every Helping Helps campaign, which promotes increased consumption of fruits and vegetables |</p>
<table>
<thead>
<tr>
<th>Public Health Accreditation Standards</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COMMUNITY ENGAGEMENT - Domain 4: Engage with the community to identify and address health problems</strong></td>
<td><strong>Health Plans’ Complementary Role</strong></td>
<td></td>
</tr>
</tbody>
</table>
| **Standard 4.1:** Engage with the Public Health System and the Community in Identifying and Addressing Health Problems Through Collaborative Processes | • Identify needs voiced by community/members (participate in CHNA, conduct focus groups, etc.).  
• Participate in community meetings regarding community health needs.  
• Participate in public health-led committees and activities.  
• Use various public reports for priority setting and program planning.  
• Engage with state and local public health to track and reduce low birth weight babies.  
• Work through the MN Public Health Association to advocate for increased public health funding.  
• Participate in Healthy Minnesota Partnership 2020.  
• Participate in over 150 collaboratives around the state to build on community initiatives to address identified needs (see Section 6). |
| **Standard 4.2:** Promote the Community’s Understanding of and Support for Policies and Strategies that will Improve the Public’s Health | |
| **POLICIES & PLANS - Domain 5: Develop public health policies and plans** | **Standard 5.1:** Serve As a Primary and Expert Resource for Establishing and Maintaining Public Health Policies, Practices, and Capacity | • Meet with MDH leadership quarterly to discuss priority public health issues and potential for further collaboration on policies and programs.  
• Actively participate in CCH for CHNA and implementing collaboration.  
• Healthy Minnesota Partnership 2020: Provide input to statewide assessment and collaborate on health improvement framework, including Partnership subgroups.  
• Health Plan Collaboration Plan: Prepare and submit this plan to MDH, which describes health plan support of population health improvement activities throughout the state.  
• Health plans have emergency business continuity plans.  
• Receive health alerts from MDH and disseminate. |
| **Standard 5.2:** Conduct a Comprehensive Planning Process Resulting in a Tribal/State/Community Health Improvement Plan | **Standard 5.3:** Develop and Implement a Health Department Organizational Strategic Plan | |
| **Standard 5.4:** Maintain an All Hazards Emergency Operations Plan | **Standard 5.5:** Review Existing Laws and Work with Governing Entities and Elected/Appointed Officials to Update as Needed | |
| **Standard 5.6:** Educate Individuals and Organizations On the Meaning, Purpose, and Benefit of Public Health Laws and How to Comply | **Standard 5.7:** Conduct and Monitor Public Health Enforcement Activities and Coordinate Notification of Violations among | |
| **Standard 6.1:** Review Existing Laws and Work with Governing Entities and Elected/Appointed Officials to Update as Needed | **Standard 6.2:** Have health plan lobbyists reviewing public health laws on ongoing basis.  
**MCHP Policy and Health Reform, Government Programs and Community Health Committees:** Review public health laws and assure implementation of those impacting health and human services (e.g., immunizations, school law changes).  
• Maintain quality of care complaint investigation process.  
• Promote public health issues (e.g., support for Minneapolis trans-fat ban and calorie labeling on restaurant menus). |
<table>
<thead>
<tr>
<th>Public Health Accreditation Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard</strong></td>
</tr>
<tr>
<td>Appropriate Agencies</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>ACCESS TO CARE - Domain 7: Promote strategies to improve access to health care services</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>WORKFORCE - Domain 8: Maintain a competent public health workforce</strong></td>
</tr>
<tr>
<td><strong>Standard 8.1: Encourage the Development of a Sufficient Number of Qualified Public Health Workers</strong></td>
</tr>
<tr>
<td><strong>Standards 8.2: Assess Staff Competencies and Address Gaps by Enabling Organizational and Individual Training &amp; Development</strong></td>
</tr>
<tr>
<td><strong>QUALITY IMPROVEMENT - Domain 9: Evaluate and continuously improve processes, programs, and interventions</strong></td>
</tr>
<tr>
<td><strong>Standard 9.1: Use a Performance Management System to Monitor Achievement of Organizational Objectives</strong></td>
</tr>
<tr>
<td><strong>Standard 9.2: Develop and Implement Quality Improvement</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Standard</td>
</tr>
<tr>
<td>----------</td>
</tr>
</tbody>
</table>
| Processes Integrated Into Organizational Practice, Programs, Processes, and Interventions | • Conduct quality improvement initiatives focused on health behavior and conditions such as:  
  o New member preventive health visits  
  o Diabetes control  
  o Heart health  
  o Women’s health  
  o Post-partum depression  
  o Maternal health  
  o Children’s preventive health  
  o Immunizations (both adult and childhood)  
  o Migraine management  
  o Medication compliance  
  o Hypertension  
  o Depression  
  o Calcium plus vitamin D  
  o Cancer screening  
  o Chlamydia screening |

**EVIDENCE-BASED PRACTICES - Domain 10: Contribute to and apply the evidence base of public health**

• Health plans support the Institute for Clinical Systems Improvement (ICSI) and the development/dissemination of best practice standards. |
| Standard 10.2: Promote Understanding and Use of Research Results, Evaluations, and Evidence-based Practices With Appropriate Audiences | |

**ADMINISTRATION & MANAGEMENT - Domain 11: Maintain administrative and management capacity**

| Standard 11.1: Develop and Maintain an Operational Infrastructure to Support the Performance of Public Health Functions | • Maintain ongoing communication with public health partners, outstate and regional level, to identify ways that health plans can complement public health functions.  
• Each health plan complies with financial reporting requirements, files 990s and has reserves. They also report on Community Benefit Program. |
| Standard 11.2: Establish Effective Financial Management Systems | |

**GOVERNANCE - Domain 12: Maintain capacity to engage the public health governing entity**

<p>| Standard 12.1: Maintain Current Operational Definitions and | • Participate in cross-sector collaboratives such as CCH. |</p>
<table>
<thead>
<tr>
<th>Standard</th>
<th>Health Plans' Complementary Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statement of the Public Health Roles, Responsibilities, and Authorities</td>
<td>• Participate in statewide regional and local collaboratives with MDH and LPHA.</td>
</tr>
<tr>
<td><strong>Standard 12.2:</strong> Provide Information to the Governing Entity</td>
<td>• Meet regularly with the MN Association of County Social Service Administrators (MACSSA) on mental health and policy issues. Have issued joint recommendations on ways to improve the Medicaid procurement process.</td>
</tr>
<tr>
<td>Regarding Public Health and the Official Responsibilities of the Health Department and of the Governing Entity</td>
<td></td>
</tr>
<tr>
<td><strong>Standard 12.3:</strong> Encourage the Governing Entity's Engagement In the Public Health Department's Overall Obligations and Responsibilities</td>
<td></td>
</tr>
</tbody>
</table>
SECTION 6: COLLABORATIVE COMMITTEES FOCUSED ON PUBLIC HEALTH ISSUES

Public Health Collaboratives/Committees Focused on Public Health with Health Plan Representation

This table provides information about public health or health care related collaboratives and committees that have MCHP representation.

As a way of aligning health plans’ work with local public health, the table is organized using the community health issues as designated by the Minnesota Department of Health. There are six key categories:

- Emergency preparedness (EP)
- Environmental health (EH)
- Health Quality - Access (HQ)
- Healthy Communities - Behaviors (HC)
- Infectious disease (ID)
- Other (O)

Each key category has sub-topics. For example, under Health Communities – Behaviors (HC) there are sub-categories for alcohol, chronic disease, eating habits, etc. There is also flexibility to create new sub-categories. Under Health Quality-Access, quality of care, collaboration, infrastructure and public health training was added. To view the State’s categories and sub-categories, go to www.health.state.mn.us/lhap.

The table is organized by listing the community health issue, the name of the committee, the purpose and key activities of each group, and health plan membership.

This list is extensive but not comprehensive. Because of the sheer number of collaboratives, committees, and work groups, information may become outdated. However, MCHP updates information regularly. Additionally, health plan representation may vary by group. Some groups may have several health plans participating, while others request one health plan to represent all MCHP health plans. If a health plan representative is serving as a MCHP representative, that person is responsible for providing relevant information or requests to the MCHP through its committees.

For more information about the table contact Janny Brust, brust@mnhealthplans.org or 651-645-0099, Ext. 12.