Purpose

- Using the example of a Minnesota county’s safety net hospital’s response to health care reform, “Hennepin Health,” provide information on the opportunities and challenges of:
  - Partnership
  - Use of data
  - Draw connections to the challenges that public systems in general face in the new world of health care reform

Hennepin County

Largest county in MN, home of Minneapolis
Population: 1.8 M, 600+ square miles
Population: White 71%, African American 12%, Other 16% (16% speak language other than English at home)
12% below poverty level

Hennepin County Medical Center (HCMC)

- Mitigated risk
  - Set up VERY narrow network
  - Risk stratified patients
  - Started Coordinated Care Center (CCC) for most complex
  - Began integration of primary care and behavioral health services
  - Focused on care coordination
  - Lost $ but less than we expected!

Origin of Hennepin Health

- Since 1974, Minnesota had a coverage program for those without dependent children (10 % of HCMC’s revenue), <75% fpl, 18 – 64 y.o, not disabled, majority are African American
- Born out of Crisis – General Assistance Medical Care (GAMC) line-item veto in 2010.
- Coordinated Care Delivery System (CCDS) – Block grant = 21 percent of former GAMC payments to serve 7,500 patients. Lasted from 6/2010 – 3/2011

Birth of Hennepin Health

- New governor – Mark Dayton (DFL) – signed 2011 MA expansion – Section 25 allowed for Hennepin County specific safety net Medicaid demonstration project (ACO)
- Signed Leadership challenge to county commissioners by Senator Bone Deterberger
- 1/1/2012 Medicaid demonstration project based on a contract between the MN Department of Human Services (DHSS) and Hennepin County
- County partners:
  - HCMC
  - NorthEast Health and Wellness Clinic (NEHHC)
  - Metropolitan Health Plan
  - County’s public health clinics (Mental Health, Health Care to the Homeless, and local services

California Delivery System Reform Incentive Program Concepts

Dr. Thomas Bodenheimer and colleagues from the UCSD Center for Innovations in Community Health, building blocks for transformed primary care and a successful patient-centered medical home.
Core Concepts

- Need to meet individuals' basic needs before you can impact health
- Social disparities often result in poor health management and costly revolving door care
- By coordinating systems and services, we can improve health outcomes and reduce costs
- Build on the model of Medical Home (Health Care Home in MN)
- All partners will work together to develop a care model, determine the financial arrangement, work on data and analytics together

Financial Model

- "Traditional" managed care contract between state and Metropolitan Health Plan, with capitated, pmpm arrangement (enrolled, vs. attributed)
- Narrow network: most of primary and specialty care provided by partners, with major exception mental health

Team-based care: building the teams

- Increased staffing in clinics with RN clinical coordinators, additional social workers, psychologists, licensed alcohol and drug counselors
- Developed the roles and how they work with physicians, advanced practice providers, pharmacists, and other members of clinic staff

Hennepin Health Population

- Racially/ethnically diverse group of adults w/o children (> 50% African American)
- Income < 75% of the federal poverty level and on Medical Assistance
- 32% are likely experiencing homelessness or unstable housing
- High degree of mental health issues (42%) and chemical dependency (40%) or both (60%)
- Lack of ongoing primary care connection, frequent ED use
- Lack of consistent health insurance coverage due to 6 month MA eligibility churn
- Nine over 6,000 enrolled members

Business Case

Problem:
- High need population
- Top 5% utilizing 64% of dollars
- Crisis driven care
- System fragmentation
- Safety net - cost shifting

Need:
- Address social disparities
- Improve patient outcomes
- Increase system efficiencies
- Increase preventive care

Hennepin Health model

- 100% at risk contract
- Partners share in success

Initial Work

- Learning to play in the sandbox together
- Developing a governance and committee structure
- Developing a care model
- Staff the care model
- Begin to invest in data and analytics

Administrative Support

- Assistant County Administrator - Health
- Deputy Director - Hennepin Health
- Associate County Administrator - Health
- Hennepin Health Clinical Manager
- Hennepin County Health Housing Coordinator

Governance

- Hennepin Health Steering team
- Collaborative
- Analytics
- Operations
- Finance
- Nurse Model
- Privacy officers

Northpoint Wellness Clinic (FQHC)

- Home health analytics
- Management impact
determine
- Shifting coordination partners to in on outcomes

Hennepin County Health

- Human Services (DHS)
- Metropolitan Health Plan
- Services (DHS)
- Medical Center
- Medical Center
- Hennepin Health

PAHP

- Social workers
- Psychologists
- Pharmacists
- RN
- Drug counselors
- Alcohol and drug counselors
- Additional social workers
- Physicians
- Advanced practice providers
- Pharmacists
- Other members of clinic staff

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- Northpoint Wellness Clinic (FQHC)
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Oversees:
- Withhold Quality admissions
- Both Provider – huge
- Quality of Rx – TBD
- Provider satisfaction – TBD
- Quality of Rx – TBD
- Overseas subcommittee focused on coordination of care

Utilization:
- subcommittees,
- Quality
- EHR function
- Strategic planning for DHM
- Insertion of EHR
- Quality
- Provider satisfaction
- Quality of Rx

Employment:
- Empanelment
- Build

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Patient-team partnership
- Devised a care plan WITH THE PATIENT that goes across the continuum including the patient goals, tactics, and who is responsible
  - What’s most important to you?
  - Build trust with the patient by working on their goals first
  - Empanelment: we assign a single accountable individual to manage each patient

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Analytics Committee
- Originally 2 separate committees: IT and Quality Safety – all partners represented
- Former focused on:
  - Development of Hennepin Health data warehouse
  - Spread of Epic (EHR) to social services and plan
  - Development of Epic tools such as across continuum care plan, radar, etc
  - Data privacy issues
- Latter ultimately defined the scorecard
- Now, combined into Analytics Committee

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Leveraging the Electronic Health Record
- Expanded to all the partners including the health plan and social services to improve continuity of care
- Both read and write access – all partners can document in the medical record with limitations
  - Some social service data can’t come into the medical record (e.g. child abuse reports)
  - The plan is limited to recording their engagement calls
- Created Lifestyle Overview survey to collect key info on social factors that influence health
- Use EHR for real-time identification of ED and inpatient admissions for prompt follow-up
- Identifying patients across different settings and systems is a huge challenge

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Prompt Access to Care Challenges
- Primary care – especially after inpatient discharge
- Neurology, pain
- Behavioral health
- Dental

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Contents of Hennepin Health Data Mart
- Encounters
- Procedures
- Diagnosis
- Medications
- Lab Orders
- Vital Signs
- Surgery
- GI Lab
- EDXAP– Gastro
**Risk/Gain Sharing**
- Finance committee determines and brings to Steering Committee for approval
- Partner provider Risk Sharing Distribution (% of primary care touches) – 34% (in 2012 was 55%)
- Performance Incentive (key indicators and DHS withhold measures) – 55%
- Reinvestment fund (annual proposals) – 11%

**Successes**
- Decrease in ED visits
- Increase in primary care visits
- Increase in quality measures
- Cost less than expected
- 128 patients housed
- 5 patients with jobs
- Reinvestment initiatives funded as well as payouts to partners
- Roles defined, training developed and implemented
- Data warehouse developed
- EHR spread to all partners

**Reinvestments**
- 2012 initiatives:
  - Interim housing
  - ED outreach
  - Vocational services
  - Video psych consulting
  - Sobering Center
- 2013 initiatives:
  - Expand CCC
  - Continue vocational services
  - Increase dental outreach
  - Improve risk documentation
  - Increase CHW outreach
  - Huddle facilitators to improve quality scores

**Challenges**
- Churn
- Reaching those who do not engage
- Identification of patients (modifier)
- No improvement in readmission and IP utilization overall
- Extra work on top of “day job”
- Issue of Hennepin Health vs other patients and additional risk contracts

**Rapid cycle innovation**
- Data-driven improvement: constantly evaluating what’s working and what isn’t and adjusting as needed – examples:
  - Hired vendor to find people in anticipation of their eligibility renewal – started in March
    - By August was clear we didn’t see any enrollment improvement
    - Ended contract
  - Access clinic
    - Set up outpatient clinic for patients as they left inpatient stay to connect them with primary
    - Only ½ day a week; high no-show rate
    - In 2014, closing the access clinic and expanding Coordinated Care Center as a site to see patients five days a week in an outpatient setting

**Dental Analysis**

**Hennepin Health Utilization**

**Modern Healthcare**

- IF YOU BUILD IT, THEY WON’T COME BACK.
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Beyond Hennepin Health

- Possible contract with Department of Human Services for traditional shared savings risk/gain contract for attributed M.A. patients
- Additional risk/gain contracts with other payers
- Our long term goal is managing populations under a global budget like Hennepin Health

State Innovation Model

- Minnesota received a $45 million State Innovation Model grant from CMMI
- $3.5 million to fund “Accountable Communities for Health”
  - Significant opportunity in managing care
  - Significant benefit in “Systems” (health plans, providers, public health) being on level playing field
  - Systems motivated to shared outcomes - create huge opportunities (both health and savings)

California Delivery System Reform Incentive Program Concepts

Dr. Thomas Bodenheimer and colleagues from the UCSF Center for Excellence in Primary Care identified ten building blocks for transformed primary care and a successful patient-centered medical home:

- Template of the future

- Lots of experimentation and collaboration
- How does a provider deal with all of the payer contracts and variations?
- How do we find models that work and scale them nationally?