



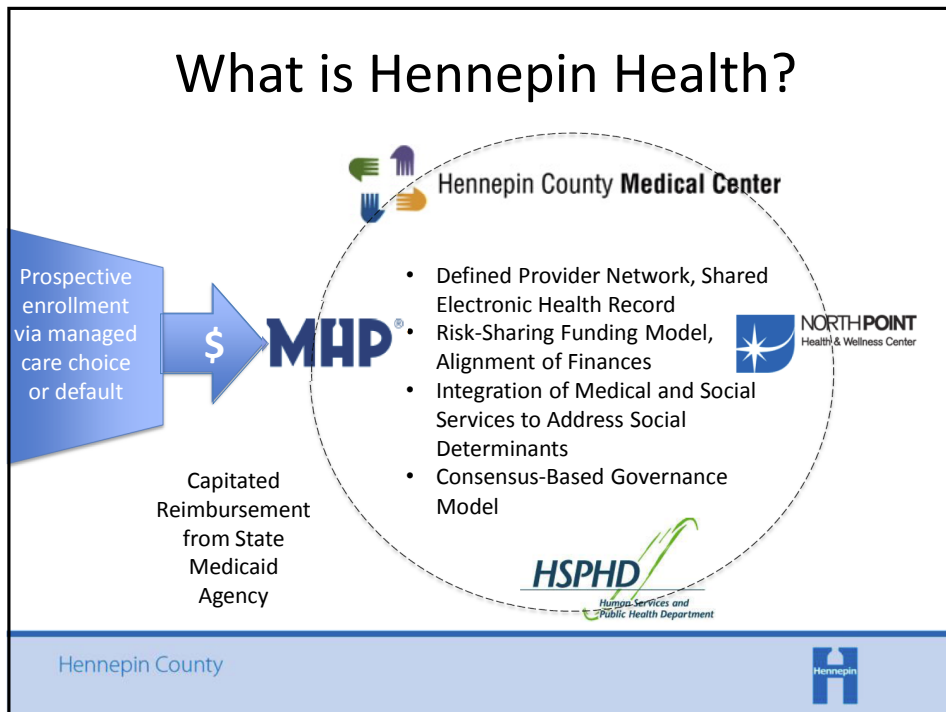
Hennepin County Minnesota

Hennepin Health
PEOPLE. CARE. RESPECT.

June, 2015

Hennepin County

What is Hennepin Health?



Prospective enrollment via managed care choice or default

Capitated Reimbursement from State Medicaid Agency

MHP

Hennepin County Medical Center

- Defined Provider Network, Shared Electronic Health Record
- Risk-Sharing Funding Model, Alignment of Finances
- Integration of Medical and Social Services to Address Social Determinants
- Consensus-Based Governance Model

NORTH POINT Health & Wellness Center

HSPHD Human Services and Public Health Department

Hennepin County

Population Served

- Current Enrollment ~ 11,000 members
- Medicaid Expansion in Hennepin County
- 21 - 64 year-old Adults, without Dependent Children
- At or Below 133% of the Federal Poverty Level (\leq 75% prior to 2014)
- Not Certified as Disabled



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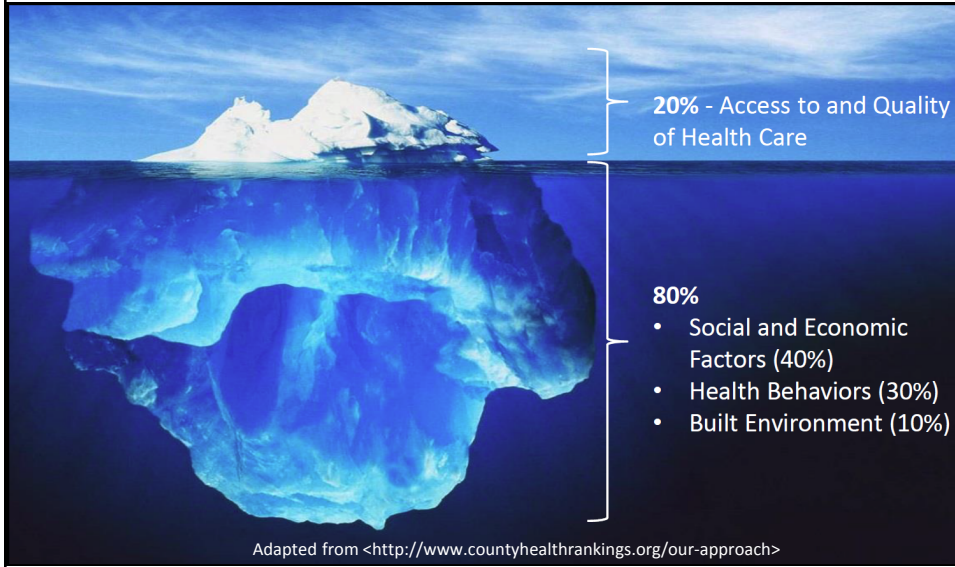


Population Characteristics

- 67% Male
- 63% Racial/Ethnic Minority
- Common Overlapping Issues:
 - Mental Health Conditions
 - Chemical Dependency
 - Homelessness/Unstable Housing
 - Chronic Physical Conditions
 - Lack of Social Support
- Frequent Use of the Emergency Department (ED) to Access Care



Factors Influencing Health Outcomes



Premise

- Need to Meet Individuals' Basic Needs Before We Can Meaningfully Impact Health
- Social Challenges Often Result in Poor Health Management and Costly "Revolving Door" Care
- By Financially Aligning and Coordinating Systems, we can Improve Health Outcomes and Reduce Costs



Financial Model: Impact

	Before Hennepin Health / Traditional Health Care	With Hennepin Health
Method of Paying Providers for Care	Fee-for-Service (<i>Volume</i>)	Total-Cost-of-Care (<i>Value</i>)
Health Plan <---> Provider Financial Incentives	Opposed	Aligned
Remaining Funds if Financially Successful	Health Plan Margin	Reinvestment to Further Improve the System
Services Offered to Patients	Medicaid Benefit Set (<i>Rigid</i>)	Medicaid Benefit Set + Care Coordination + Targeted Social Service Interventions (<i>Flexible</i>)

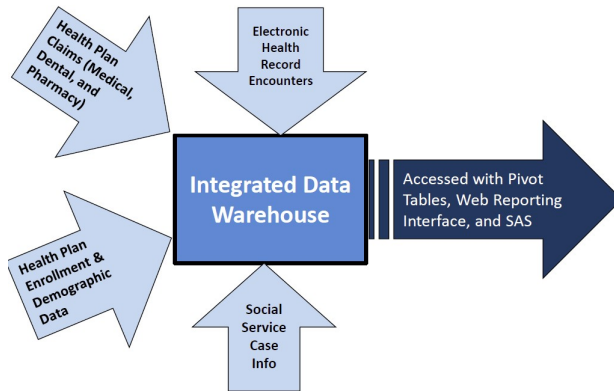


Care Model: Care Coordination

- Based on a Primary Care Medical Home with a Strong Community Health Worker Role Inside and Outside the Clinic
- Referral to “Ambulatory ICU” Clinic for Most Complex
- Supplementing Clinic Care Coordination with Targeted Behavioral Health and Social Service Interventions
- Documenting and Communicating in Shared Electronic Health Record (EHR)



Analytics Model: Integrated Data Warehouse

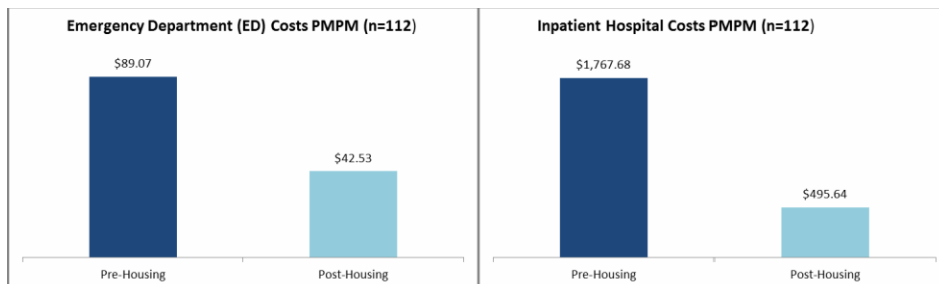


Analytics Opportunity:

- Fill in clinical gaps by combining EHR and claims
- Real-time Rx picture
- Model how social service use relates to health care utilization

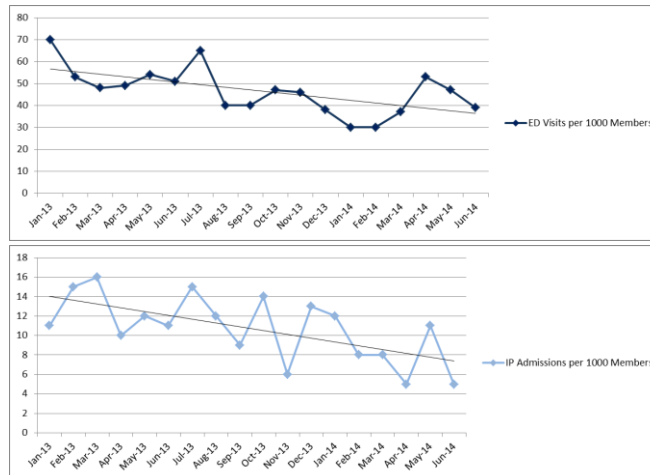
Innovation Highlight: Housing Navigation

- Dedicated staff work to place medically complex Hennepin Health members in supportive housing available to them
- Resulted in considerable reductions in ED and hospital use post-housing



Outcomes: Continuously Enrolled Members

Jan 2013 – Jun 2014 (n=932); Epic EHR Data



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Opportunities and barriers for HITPC to consider

- Laws (state and national) make two-way sharing of social services data with medical providers difficult
- Identity matching – introduces waste in the healthcare system and is a patient safety issue
- Payment systems that put dollars in caregivers' hands and allow creativity across settings
- Appropriate risk adjustment of payment rates for social determinants of health
- Electronic health records are designed to be transactional – one patient at a time – and for medical settings.
 - We need policies that incent vendors to develop systems that work for across social service, public health AND medical care?

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Thank You!



Videos, newsletter, and more information:
www.hennepin.us/hennepinhealth

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