Hennepin County, Minnesota

HENNEPIN HEALTH

People.Care.Respect

Submitted on Behalf of Hennepin County

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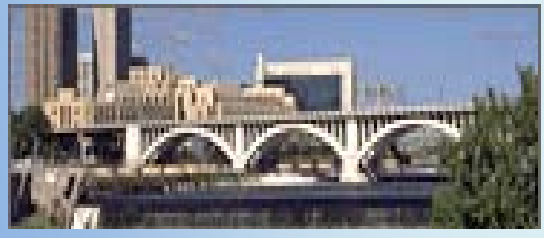
A Social Disparities Approach to Health & Health Care



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I. General Description

Hennepin County is pleased to submit this proposal for Hennepin Health, a pilot integrated healthcare delivery network to serve the unique needs of one of the most challenging and costly segments of the county's safety net population. By integrating medical, behavioral health, and human services in a patient-centered model of care, this pilot seeks to improve health outcomes dramatically and lower the total cost of providing care and services to this population.

Hennepin Health will measure not only medical costs, but also health care costs beyond the medical assistance benefit set, including uncompensated care, human services, and public health costs. The pilot also will quantify law enforcement, correctional, and court costs and savings, as well as the impact on community agency costs.

Hennepin Health involves shared risk among partners and incentives based on performance and outcomes.

This pilot enjoys the support of:

- State government - The Minnesota Department of Human Services (DHS) and the State Legislature, which approved development of the pilot in 2009;
- Local government (Hennepin County Commissioners);
- Providers - The four core partners, Hennepin County Medical Center (HCMC), Metropolitan Health Plan (MHP), NorthPoint Health & Wellness, and Hennepin County Human Services and Public Health Department (HSPHD) have collaborated extensively over the development of this model and have begun similar collaborations and planning sessions with extended partnerships, such as the local Federally Qualified Healthcare Center (FQHC) community.

II. Premise

Treating a safety net patient's medical problems without addressing underlying social, behavioral, and human services barriers and needs, produces costly, unsatisfactory results -- both for the patient and the programs providing and paying for care. Conversely, addressing all of these issues and incorporating them into a coordinated patient and family-centered, comprehensive care plan should end the cycle of costly crisis care.

A program in Camden, New Jersey[1] that has some similarities to the Hennepin Health approach, reported that one percent of the Camden enrollees accounted for one-third of the city's medical costs. A blended medical/behavioral/social model produced a 40% reduction in emergency room visits and a 56% overall cost reduction for the targeted population. Hennepin County believes it can improve upon these results through the Hennepin Health model. See Appendix A-Innovation and Integrated Care Experience.

III. Objectives:

Implement a patient and family-centered care model that:

- Improves the enrollees' quality of life;
- Improves the patient experience for enrollees;
- Improves the quality of care;
- Improves the provider/staff experience
- Provides greater value at lower cost to the county, the state, and the federal government;
- Reduces health/social disparities in the target population;
- Addresses health/social risk factors to increase life expectancy
- Is sustainable and can be replicated throughout the state and in other parts of the country.

See Appendix B- Goals and Objectives-HHS Strategic Plan Comparisons for more details.

IV. Target Population:

A group of approximately 12,000 individuals will participate in the Hennepin Health pilot. The initial target population will be 18- to 64-year-old adults, with no dependent children in the home, living in Hennepin County, with incomes at or below 75% of the Federal Poverty Guidelines ($677/month or $8,124/year for one person) who qualify for Medical Assistance (MA). The population primarily includes individuals previously enrolled in General Assistance Medical Care (GAMC)/Coordinated Care Delivery System (CCDS) state programs, as well as previously uninsured persons. See Appendix A for CCDS details.

Below are some defining characteristics of this population, based on 2008 GAMC member data (or CCDS statistics where noted*):

- ~ 68% Minority status (see Appendix C for details)
- ~ 45% Some level of chemical dependency
- ~ 42% Mental health needs
- ~ 30% Chronic pain management*

Overlap with ~60% of the population having at least one of these

- ~ 32% Unstable housing situation*
- ~ 30% More than one chronic disease (diabetes and/or heart disease are most common)
- Significant underemployment or unemployment
- Tendency to access health care services through emergency centers, both for emergencies that often are due to failure to receive early medical intervention and for non-emergent situations due to lack of outpatient connections or relationships

This population often receives minimal preventive care, is at high risk for acute care needs, and has poor health outcomes and health status. This is precisely the population that will benefit most from the proactive, comprehensive, and integrated care management offered by Hennepin Health.

V. Core Elements of the Hennepin Health:

- A patient and family centered care approach
- Delivery of primary care services in a patient centered medical home setting
- Designation of a health care team that includes medical, behavioral health, and human services professionals for each patient based on the patient's unique needs
- A comprehensive patient assessment tool
- Personalized care plans crafted with enrollees as partners, which incorporating medical care, behavioral care, and human service needs
- A systemic, objective tiering system to identify patients with the greatest needs
- An integrated system of providers that can provide comprehensive care, including emergency, inpatient, and outpatient services, primary care, dental care, community mental health and substance abuse services, and public health and human services
- Enhanced services through Community Health Workers as critical liaisons for enrollment, health education, and patient support
- Ability to leverage Hennepin County housing and social service programs, resources, and community partners
- An electronic health record (EHR) accessible by all providers and members of the patient's health care team. The EHR system will provide access to all patient data in real time, including human services information, assessments, care plans, provider alerts, lab results, etc.
- An integrated data warehouse and analytics infrastructure supporting timely, actionable feedback to members, providers, and administrators

See Appendix D for Care Model Overview.

Below are additional details regarding the core elements:

Blended Approach

The innovative feature of the Hennepin Health model is the *true blending of social, behavioral, and medical services* to meet the needs of complex enrollees in a community model. The most vexing limitation of medical-focused models is the inability to resolve the social circumstances and barriers of the neediest enrollees. Medical intervention without addressing these social and behavioral issues is not likely to produce sustainable results and will only perpetuate the health disparities prevalent in this population. In the Hennepin Health model, clinicians will collaborate with expert human services staff on the care team to assist in service provision for the enrollee.

Patient Assessment Tool

An *assessment of basic needs* will be completed for each enrollee to identify health care problems, as well as human service needs. This assessment will be reviewed with the enrollee. Based upon this assessment and enrollee feedback, a prioritized care plan will be developed. This care plan will include treatment goals and will assist in defining the members of the enrollee's treatment team. It also will be the mechanism for assigning the enrollee to a "care tier".

Each treatment team will be accountable to the enrollee for reaching the goals and revising the care plan. The team will ensure linkage to necessary supports, provide feedback to all team members, document information into the enrollee's record, and assist with treatment plan updates to ensure positive outcomes.

The assessments will be routinely updated to ensure that new needs are identified and that resolved issues are removed from the care plan as appropriate. Doing so allows constant reassessment of needs and step-down approaches when goals are being met. This approach also provides for a constant feedback loop and ensures that each enrollee is served at an appropriate level of intensity.

Case example:

John has unstable diabetes and is in crisis. In most medical care systems, John is medically stabilized and provided his medications and follow-up instructions for outpatient care. However, if John does not have a comprehensive assessment of his medical, behavioral, and social support needs, the intervention will fall short at best and ultimately result in a return emergency visit.

The pilot proposes that at the point of initial contact (and periodically thereafter through treatment), a comprehensive needs assessment is completed to identify additional barriers to enrollee wellness that may impact overall functioning. With this case example, John did not have access to a refrigerator to maintain medications, hence the discharge plan and treatment did not succeed in improving functioning, and within a month, John returned to the ED in crisis.

In a blended medical/behavioral/human services model, the treatment team would identify John's housing, utility, and basic refrigeration needs and establish a link to the human services team members best able to assist him in successfully following through with medically necessary diabetic care. The cost of a refrigerator ultimately is less expensive than repeat emergency room visits and/or admissions with no enrollee functional/medical gain.

Patient Centered Medical Home (PCMH)

A primary feature of the Hennepin Health is the patient centered medical home as a means to improve care coordination and patient outcomes. Access to consistent, clinic- and home-based primary care (prevention, education, intervention, and monitoring of chronic illnesses) is critical to improving wellness and ensuring functional health.

At enrollment, Metropolitan Health Plan (MHP), a Hennepin Health core partner, will complete a welcome call/visit, educate the enrollee about benefits, protections (i.e., appeal rights, right to disenroll), and enrollee responsibilities. MHP will complete a brief triage to determine service history and enrollee needs and preferences to best match the patient with an appropriate patient centered medical home. If the enrollee is already linked to primary care, the model will attempt to work with current treatment providers as feasible. If the enrollee does not have a patient centered medical home, the triage process will determine the assignment that best meets the enrollee's needs.

For example, if an enrollee has a history of behavioral health problems, the enrollee would be connected with a behavioral health clinic with onsite medical care. An appointment at the identified patient centered medical home would then be coordinated to proactively connect the enrollee to a care team. In addition to identifying the patient's needs, the patient centered medical home will link the patient to specialists and ensure coordination of services in a patient-centered, cost-effective manner. The objective is to bring about rapid improvements in overall wellness and maintain that wellness and functioning over time. See Appendix E-Enrollment Flow for more details.

Personalized Care Plan

Based upon the in-depth intake assessment findings and enrollee treatment preferences, a care plan will be tailored to the enrollee's specific needs. This plan will include recommendations and a course of action to address any medical, behavioral, and social needs. The plan also will include a crisis plan, developed in conjunction with the enrollee, which gives him/her concrete steps to take in the event of a medical, behavioral, or social service crisis and/or exacerbation of symptoms or social issues. The crisis plan will be accessible across the care spectrum so that if the enrollee presents in an emergency setting, staff will be able to review the plan, will know which provider or team member to contact, and can provide the best treatment recommendations. This will help reduce duplication, effectively manage resources, ensure system-wide knowledge of treatment goals, and ideally assist in acute care diversion as clinically appropriate. See Appendix F- Initial Visit Flow for more details.

Care Team

Each enrollee will be served by an integrated team of medical professionals, behavioral health providers, human services and public health staff, and community health workers.

Team Composition:

- Physician or Advanced Nurse Practitioner
  - Role: Oversight of enrollee care and medical issues management
- Care Coordinators
  - 1-3 specialists assigned to enrollee team, dependent upon needs; one lead assigned based on dominant treatment area
    - Nursing
      - Role: medical needs assessment/management
    - Behavioral Health Specialist
      - Role: mental health/ chemical health needs assessment/management
    - Human Services Specialist
      - Role: coordination of the vast array of human service needs
- Pharmicist
  - Role: Medication education and management
- Community Health Worker

  - Role: enrollment, outreach, engagement/follow-up, education, information-gathering, reporting of barriers to treatment, and support for success of enrollee in meeting treatment goals
- Extended team members
  - Role: specialized needs. Examples include housing specialists, medical specialists, and employment specialists

Team composition will be determined at intake and will be driven by enrollee needs. The team will be adjusted based on new needs and/or successful goal completion. Staffing ratios are dependent upon tiering levels (higher and lower intervention needs). See Appendix G for staff-to-enrollee ratios.

The lead care coordinator, as the primary contact for the patient, is charged with ensuring communications to the entire team on status and needs. The lead care coordinator will respond to service access issues and work with the enrollee on crisis prevention and planning. Hennepin Health is developing protocols for addressing key issues (e.g., what does each partner do with an enrollee who is a substance abuser, overusing ED, drug seeking, medication noncompliant, etc.?) The protocols will be measured for compliance and effectiveness.

Care transitions will be proactively managed by the lead care coordinator to ensure collaborative planning, communications, and efficient warm hand-off's occur among systems with the ultimate goal of community based care via the Patient centered medical home. (See Appendix H- Acute Care- Transitions Workflow for one example of this flow.)

Team location will be based upon enrollee preference and needs. Teams may be located in hospital-based outpatient clinics, neighborhood-based FQHC's, other community clinics, shelter-based clinics, and behavioral health centers. The pilot will continuously re-evaluate geographic location and barriers to access to make certain that Hennepin Health is meeting the enrollees' needs.

Electronic Health Record (EHR)

Hennepin Health enrollees will have a single, comprehensive, electronic record that is inclusive of many facets of their treatment, tells their story, tracks their goals, includes the care plan and outcomes data, and evaluates their responses to interventions across a continuum of care. The record will also facilitate cost-effective, non-repetitive care through information sharing by all providers.

In Hennepin County, the Epic electronic health record is already in place for most of the care system. With enhancement, this system will provide a strong foundation for easy accessibility to enrollee records, communications, and consultations. The shared system will help hold providers accountable for optimal patient care management and outcomes. This ability to link primary care, specialty care, behavioral interventions, and social service needs into one seamless system is critical to improving enrollee health status.

Care teams will have access to real-time data on achievement of key results. The pilot will create patient dashboards that measure goals and capture health trends and areas of plateau. This will enable the team to adjust goals and interventions in a timely manner. The Epic system also has a web-based enrollee portal (My Chart), which can be utilized by the enrollee for records access. Hennepin Health is collaborating with a local partner on training peer navigators to teach enrollees how to access their health records.

Currently, case management records for human services are maintained in alternative systems and are often not accessible to medical teams. The pilot will incorporate these records into a single, comprehensive EHR. This will provide valuable updates to the treatment team and will also flag when an enrollee accesses care or assistance elsewhere in the system. A similar model is being developed for linking external partner data into the Epic system to ensure meaningful use and access to comprehensive data by all care partners.

A final component of the comprehensive enrollee record will be integration of data from the claims payment system. Doing so will enable tracking and reporting of claims from outside of the network to manage enrollee costs and behaviors and identify total costs of care.

Tiering System

Hennepin Healths' tiering system was developed to identify those enrollees in need of the greatest amount of support services to improve functioning and wellness. Tiering is based primarily on utilization of acute care and high-cost, crisis-driven services. Enrollee needs are assessed to determine the medically necessary level of care and social needs that may exacerbate medical conditions and result in high cost service utilization.

It is anticipated that the lower intensity, more populous tiers would consist of enrollees who are projected to need relatively few medical/behavioral services. The higher, more lightly populated tiers would include enrollees who have demonstrated (or anticipated) higher utilization of care services.

This cost model is driven by the top 5% of enrollees who are utilizing the highest amount of care. The implication is that the health care system is not meeting the individual's needs; thus, a more intense outpatient regime may better fit his/her needs. This model provides equal service (all benefits are available at all levels); however, the intensity of care will vary among the levels. Enrollees likely will move between tiers as behaviors, functioning, and wellness improve over time. See the Tiering Model in Appendix G for more details.

Patient and Family Centered Approach

Patient and Family Involvement

Critical to this model is involvement by enrollees and their family members in system development and enhancements. As such, in developing Hennepin Health we have engaged patients in feedback groups, as well as, invited them as members on development work groups. The pilot will also utilize multiple patient advisory committees across the provider systems for development activities. Hennepin Health believes engaging these groups, surveying feedback

from participants throughout the system of care, as well as adding interested individuals into core work groups for on-going system development is imperative for its success.

Flexibility

Given the often transient nature of the target population and its lack of access to telephones, stable housing, transportation, and other basic needs, it is imperative that the provider treatment model remain fluid and flexible to meet the enrollees' needs.

One way that Hennepin Health will offer flexibility is through walk-in access to care. If given the option to present on the same day or the next day to a known provider, enrollees likely will choose this option over the emergency department. Extended office hours in the evenings and on weekends, as well as walk-in capacity each day, should encourage appropriate utilization of the clinic and decrease inappropriate utilization of the ED. Due to the highly transient nature of this population, Hennepin Health also plans to offer core services in the shelters to reduce barriers to enrollees.

Benefits/Enrollment

Ideally, enrollment will be automatic with an enrollee opt-out option. It is important that enrollees agree to the system of care based on a thorough understanding of the benefits of the pilot and its ability to improve their individual health and wellness and maintain continuity of care with their providers.

It is critical that the pilot's enrollees maintain eligibility for at least one year to minimize churn and disruption of services. If the system has access to benefit termination dates, it can provide proactive financial counseling for enrollees. This will allow Hennepin Health to assist enrollees with benefits re-enrollment prior to termination and ensures continuity of care.

Access to 24/7 Crisis Services

To assist enrollees in obtaining services in the least restrictive environment, the pilot will encourage all enrollees to have behavioral health and medical crisis plans on file with the Hennepin County mobile crisis teams and the Hennepin Health 24-hour nurse telephonic care line. These crisis plans will be built into the enrollee's Personalized Care Plan and will be accessible to the enrollee's natural supports and care providers (with HIPAA-compliant releases). The treatment team will work with the enrollee to ensure that he/she obtains comprehensive crisis and stabilization services.

Hennepin Health care line nurses will assist members by answering symptom-based questions. This may result in home-care advice or referral to an appropriate provider. All telephone encounters will be documented electronically to protect callers and monitor staff performance. The Care Coordinator will have this information available for review and treatment team involvement.

Other patient-centered features of the pilot can be found in Appendix I.

Integrated System of Providers

Core Partners

Hennepin County, the largest unit of local government in Minnesota, serving a population of 1,152,425[2], provides health care services to more than one in ten residents, and human services to about one in five residents. Hennepin County is uniquely equipped to provide integrated, coordinated, patient-centered care using a total cost of care delivery model through the county-owned and operated health care system. (See Appendix J-for additional Hennepin County details.)

Service collaboration will be coordinated through four primary Hennepin County service entities:

- Hennepin County Medical Center (HCMC): a 477-bed safety net Level 1 Adult trauma center and Level 1 Pediatric Trauma Center with a robust network of primary and specialty care clinics throughout Hennepin County. HCMC provides a complex array of nationally recognized emergency, inpatient, and outpatient services. In collaboration with Hennepin Faculty Associates (HFA), an independent medical group of nearly 400 healthcare providers, HCMC has been recognized for the past 14 years by US News and World Report as one of America's best hospitals. HCMC is operated by Hennepin Healthcare Systems, Inc., a public corporation established under state law as a wholly-owned subsidiary of Hennepin County.

- NorthPoint Health & Wellness Center: a Hennepin County full-service outpatient primary care clinic and the first Federally Qualified Health Center (FQHC) in Minnesota to be certified as a health care home. NorthPoint provides primary, dental, and mental health care, in addition to community services. NorthPoint uses an integrated model of care that incorporates multidisciplinary teams including Community Health Workers. It provides on-site access to laboratory, pharmacy, and chemical dependency services, as well as, housing, food, employment, and advocacy supports. It is accredited by Joint Commission and several of its programs and providers have been recognized for innovation, quality, and excellence.

- Human Services and Public Health Department (HSPHD): an agency of Hennepin County that provides greater than 20% of Minnesota's human services and contributes to Minnesota's ranking at or near the top of numerous national surveys across nine human services measures (see Appendix K). HSPHD determines eligibility for Medicaid, as well as other health and economic support programs, administers community mental health and substance abuse services, and provides public health and human services. Inclusive within HSPHD, is Healthcare for the Homeless, an FQHC/HRSA 330H program.

- Metropolitan Health Plan (MHP): the state's only publicly-owned HMO, MHP is a premium-based enterprise of Hennepin County. Its governing board is comprised of seven elected Hennepin County commissioners, with operational responsibility assigned

to Hennepin County administration. MHP is a leader in providing managed health care services to public program members. Its mission is to integrate healthcare and services to enhance the health and well-being of its members and the community. MHP tracks total costs, collects population quality measures, and provides a wide range of customer services, including disease management, referral assistance, service alerts, crisis episode alerts, and case management.

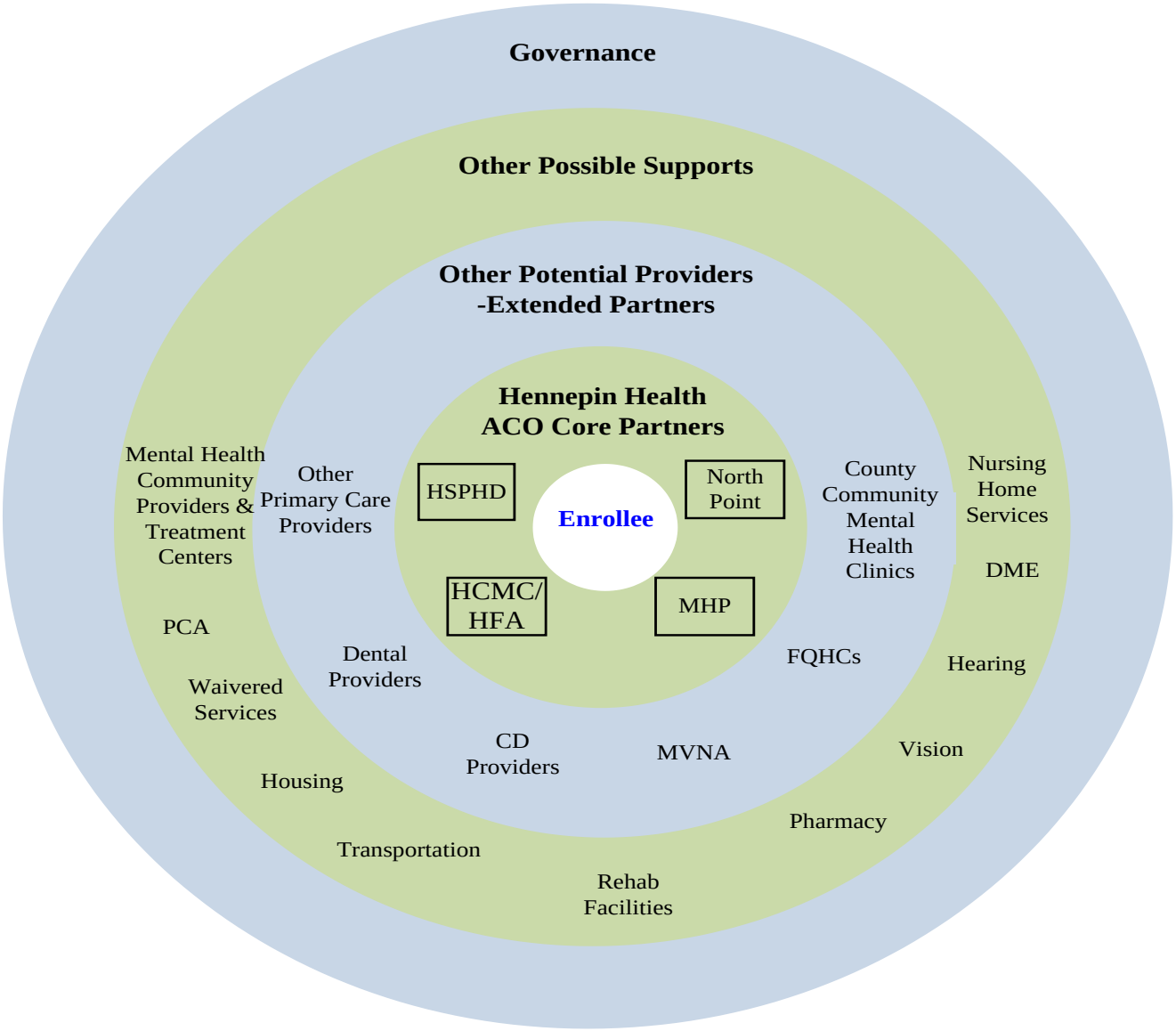
One benefit to the above partnership is the ability for this program to manage the *total cost to the county*, including jail, medical, and human services costs. The ultimate goal is to develop an integrated delivery system that results in transformative care and savings to the county, the state, and the federal government.

Extended Partners

Though Hennepin Health has four core partners, the population has expansive needs, such as dental care, transportation, mental health care, vision, housing, home care, and rehabilitation services, and the treatment model must address such needs. Hennepin Health will contract with specialty providers and primary care providers to satisfy demand and ensure geographic access. These providers will participate in the pilot's defined network and will share the same patient centered medical home and coordinated care vision espoused by Hennepin County. They also will share in the risk and gains related to caring for our target population. MHP will manage the extended partner contracts and will oversee the defined network.

The core partners have the ability to provide core safety net services, as well as more traditional benefits. The extended partners are critical for ensuring service provision in the enrollee's community, ensuring continuity of care with changes in benefits and/or health status, and ensuring sustainability of the system. The extended partnerships form the foundation of a larger state-wide care system that allows for replication of the model to additional payer sources and communities and ensures scalability to additional populations.

See the next diagram for relationships of services wrapped around the enrollee.



Enhanced Services through Community Health Workers

The pilot also invests in Community Health Workers (CHW, Promotoras[3]) as a means to change behaviors in the individual's home environment, groom local supports in the community, and assist in minimally disruptive care that improves overall health. Community Health Workers will conduct outreach for enrollee engagement, prompt preventive care, and follow up on treatment goals and team recommendations. In addition, they will assist the care team with information-gathering for outcomes monitoring. They will assist the enrollee in understanding and implementing treatment recommendations. The PCP directs the treatment in conjunction with the team, the Care Coordinator facilitates the treatment, and the Community Health Worker is the liaison for the enrollee to ensure that needs are met and troubleshoots any barriers in the community that have not been resolved.

Case example:
Sarah did not report any issues at home. However, during a home visit, her Community Health Worker identified that she had only scarce food in the house and was often skipping meals, which led to medication upsets (upset stomach secondary to taking meds without food). Thus, her medication compliance was partial at best (when food was available). Although clinic staff asked Sarah about her finances and food at the clinic, she was too embarrassed to report her situation accurately and was not receiving needed services. The Community Health Worker educated Sarah on the importance of her medications and also linked Sarah to financial assistance workers who helped her obtain food. Within weeks, Sarah's medical situation improved, and she learned to ask for help without fear of stigma.

Leveraging County Programs and Resources

Human Service Supports

In addition to traditional medical and behavioral health benefit sets, Hennepin Health will incorporate a comprehensive set of human services. These services include but are not limited to:

- Initial Contact and Assessment
  - Call Center for consult and assessment
  - Chemical Health assessment
  - Chemical Health treatment authorization
  - Mental Health intake
  - Housing Access

- Financial Assistance/Eligibility Determinations
  - Application assistance and handling
  - Disability and Waiver determinations
  - Emergency Assistance
  - Food Support programs
  - Medical Assistance/Medicaid – public programs
  - Home Care Screenings
  - Rule 185 Screening for persons with a developmental disability or related condition(s)
  - Rule 79 Eligibility for people with serious and persistent mental illness
  - Shelter

- Work Services
  - Supportive Employment
  - Refugee Program

- Crisis Response and Protection Services
  - Protection intake and investigations
  - COPE- Mobile Crisis response
  - Forensic case management

- Case Management
  - Mental Health
  - Chemical Health
  - Home and Community-based Medicaid Waiver and Non-Waiver Case Management

- Housing Options (see detailed description below)

- Public Health
  - Communicable diseases
  - Environmental health
  - Epidemiology services
  - Health Care for the Homeless
  - Immunization services
  - Mental Health Center
  - Public Health Assessments and promotion

Housing Initiatives

Housing is often reported as the most significant barrier for high acuity enrollees not following through with outpatient services (preventative or follow-up care). Consequently, an increased focus on these social supports is warranted. HSPHD promotes the development of supportive housing for people with disabilities or who are considered homeless or at imminent risk for being homeless. Options include: emergency shelter and secure waiting spaces, transitional housing, and permanent supportive housing in either congregate sites or "scattered sites" in apartments throughout the community. For most of these options, residents pay a portion of the rent, with the remaining amount subsidized by taxpayers.

Telephone Program

For enrollees with high acute care system utilization and who are difficult to reach, the pilot will offer pre-paid telephones with the treatment team key contact information pre-programmed. Pre-programming of phones will include family and/or community supports. Access to voicemail and email through a local partnership will help support individuals needing communication options (example: those seeking employment).

VI. Evaluation and Quality Measurement

The evaluation of care quality and enrollee/family experience is integral to the program. Evaluation will occur at the enrollee level, at the care team level, at the population level, and at the program level for enhancements and timely action.

The care model measures metrics that will be continuously focused on the "Triple AIM:"

- Decreasing the total cost of care
- Improving quality of care and quality of life
- Improving satisfaction of the enrollee, the family, and the provider

The model will be measured against its ability to:

- Reduce hospitalizations
- Increase compliance to keep chronic diseases in control
- Reduce Emergency Department visits
- Reduce detox utilization
- Assist with a safe and stable living situation
- Increase functional skills/independence
- Decrease substance abuse
- Decrease health risk factors
- Assist with a healthy natural support system
- Maintain Medicaid eligibility for each enrollee

Joint Quality Committee

Hennepin Health will establish a joint quality committee comprised of representatives of the core partners. This committee will:

- Develop specific quality measures
- Determine the best way to collect and distribute quality data to teams so that they have near "real time" access to data
- Determine whether special studies should be undertaken

A performance improvement (PI) team will investigate problems identified through monitoring, studies, or complaints. PI staff will then develop and implement strategies to address problems and improve performance. Network providers must cooperate with PI audits and information-gathering as established in each contract.

Although the clinical program will be in place quickly, outcome improvements will be gradual as the system feedback changes behaviors and interventions. The expectation is that at the end of

year one, there will be some improvements in health outcomes, significant improvements in enrollee satisfaction, and significant reductions in acute care costs. However, with the need to increase primary care capacity and access, significant overall cost savings may not be realized until years two or three.

VII. Financial Model

Hennepin Healths' innovative financial model will reward providers as a network for positive enrollee outcomes, reductions in duplication, collaborative approaches, and realized cost savings in a system that links costs and outcomes.

This model utilizes new approaches to paying for care which fit within federal and state reform—paying for results.

Overview

Hennepin Healths' model is based on a total cost of care calculation where the total cost of care is based on the Minnesota Medical Assistance benefit set as determined by the CMS approved plan document. Given this benefit set Hennepin Health assumes that it will enter into a contract with CMS (MN MA) for an agreed upon per member per month amount. Metropolitan Health Plan (MHP) will provide administrative services for Hennepin Health.

Medical services provided under the benefit set will be paid by MHP to providers at contracted rates for both partners of Hennepin Health and non-partners. Providers will submit their detailed bills and be paid by MHP at contracted rate. This interim rate will be paid to the partners at an amount reduced by an agreed upon withhold amount. The withhold amount will build a financial risk pool that will be distributed to partners based upon an internally agreed upon formula. Some of the non-partner contracts for services may be held by MHP or one of the partners.

MHP acting as the administrator will track and report on the monthly revenue and claims from providers and estimating the incurred but not reported (IBNR) amount for Hennepin Health. MHP will also provide utilization review. Data resulting from services provided to patients will be available from claims data at MHP and from providers' use of sophisticated EHR information. More detailed provider data will be made available to MHP to better evaluate the total cost of care and quality of care.

Shared Savings Pool

The shared savings pool of the model will be funded from two sources. First, Hennepin Health assumes an increase in savings created by a more efficient care model that reduces expensive re-hospitalizations and avoids health complications. A second source of funds to the shared savings pool will come from partners who agree to withholds on their interim payments. The withholds will be individually set depending on the amount of risk and utilization for each partner. An assumption about expected shared savings is derived from actuarial data and experience with the former CCDS model. See Appendix A for CCDS details.

The partners will share savings in the financial risk pool according to an agreed upon percentage and time frame. Given the complexity of the care model Hennepin Health suggests a three year time frame before a full evaluation of the financial savings. Savings are expected to accumulate

from the care model which will invest heavily in preventive care in the early years. This implies that the model may incur significant increases in costs during year one while savings are realized in later years with reduced hospital readmissions and health complications.

Shared Savings Distribution/Contract Benchmarks

CMS (MN Medicaid) will determine a benchmark of the amount of expenditures per beneficiary based on actuarial data. It is anticipated that the benchmark determined will be compared to actual expenditures over a three year period to accurately measure the effectiveness of the Hennepin Health model. Hennepin Health, in turn, will use internal actuarial data to negotiate a contract with CMS (MN Medicaid) that will adequately reimburse for the agreed upon benefit set. Savings will be determined by comparing the expected benchmark that was negotiated between CMS (MN Medicaid) and Hennepin Health.

Risk Sharing

The maximum amount of risk sharing is represented by the negotiated per member per month payment, but providers would expect a maximum risk corridor equal to 10% of the fee-for-service equivalent. This amount will be negotiated in good faith by the parties. Hennepin Health will make the necessary up-front investments to develop a care model which is expected to show savings in years two and three. Hennepin Health may contract with a re-insurer (or the state) to protect against extraordinary claims.

Exclusions

This model assumes the exclusion of enhanced funding from the per member/per month calculations. Direct Graduate Medical Education (DGME), Indirect Medical Education (IME), Disproportionate Share Hospital (DSH), Upper Payment Limits (UPL), and FQHC enhanced payments are outside of the benchmark and performance expenditure calculations.

This model does not currently factor in the social service costs (pmpm) which will be tracked and evaluated within the pilot.

See Appendix L- Finance Modeling

Appendix A

Innovative & Integrated Care Experience

The innovative efforts described below have provided the partners in this pilot with insights that have been used in designing the details of Hennepin Health

Summary of Program Innovations

Program Innovation	Objective	Lessons Learned
Coordinated Care Delivery System (CCDS)	To reduce costs and reform the care model, the State of Minnesota changed its General Assistance Medical Care payment model from a combination fee-for-service/HMO for all providers to a block grant to participating hospitals	Savings and better care were achieved through enhanced clinic utilization and decreased emergency department and inpatient utilization for certain populations, but funding was significantly inadequate to sustain the model at block grant rates paid by the state. High level of community work required to engage enrollees; behavioral health services and comprehensive human services are critical
Integrated Care Initiative, Cornerstone Solutions, Preferred Integrated Network (PINS)	Development of an integrated network for persons with co-occurring mental health and medical needs (special needs basic care program)	Benefits of high touch services to support enrollee needs and impact outcomes
African American Men Project (AAMP)	Reducing disparities for this population	Focused programs produced results
Project to End Homelessness	Address the cycle of homelessness	Housing is imperative to health outcomes
Client Services Delivery Model	Integration of Human Services and Public Health care - places services in the enrollee's community in one accessible location	Increased engagement by communities, improved satisfaction, and increased appropriate utilization
Adult Behavioral Health Diversion and Recovery Team (DART)	Comprehensive approach to chronic substance abusers	Criticality of integrated teams with comprehensive human services in addition to medical care to decrease public costs
Eligibility Supports at Points of Care	Provide financial supports and enrollment activities at points of service	Gained staff efficiencies and improved enrollee access/follow-through
Gateway	Address disparities and increase family self reliance through service linkage	Given the proper tools and resources, families can improve health and self reliance
Health Care for the Homeless	Integrated approach to services in shelters and drop-in centers	Importance care in the enrollee's environment, Patient-centered goals, & basic needs being met alongside medical interventions

Detailed Descriptions

The Coordinated Care Delivery System (CCDS) at HCMC

In 2009, as part of budget negotiations, Minnesota's governor vetoed funding for the General Assistance Medical Care program, which had provided funding for health care for certain low-income individuals (mostly unemployed adult males) who were ineligible for other state or federal programs. GAMC had provided funding through a combination of fee-for-service and HMO capitation payments. In April 2010, the state enacted a new plan whereby the GAMC population would receive health care through participating hospitals which were called Coordinated Care Delivery Systems (CCDS). The new program provided a block grant of money to each participating hospital, but the block grants were significantly lower (by approximately two-thirds) than amounts previously allocated for this population. Hennepin County Medical Center was one of only four hospitals to contract with the state to be a CCDS.

From June 1, 2010 through February 28, 2011, when the program ended, HCMC cared for 10,206 unique CCDS patients. HCMC also partnered with additional community health care organizations, including NorthPoint Health and Wellness Center (primary care), Hennepin County Mental Health Center (mental health services), Hennepin Faculty Associates clinics (multispecialty care), and the Minnesota Visiting Nurse Agency (in home services).

HCMC initiated strategies to decrease readmissions and increase clinic use. One intervention included the establishment of the HCMC Coordinated Care Center (CCC) for enrollees with the highest utilization. The CCC's philosophy is very "high touch" care, including case management, chemical dependency counseling, pharmacist support for medication management, and easy walk-in access. Results show that for the 67 tier 3 (highest tier acuity based on utilization), CCDS enrollees who came to the CCC post hospital discharge; there was a **42% decrease in repeat hospitalizations,** and a **38% decrease in ED visits** after enrollment. In addition, *78% of enrollees (who had at least 3 admissions in the prior 12 months) stayed out of the hospital completely or decreased their rate of hospitalization after enrollment. While decreasing hospitalizations and ED visits, enrollees also increased their primary care outpatient visits by 349%.* The CCC sees each enrollee on average once every 2.2 weeks, but has some form of contact with them on an almost weekly basis (3.60 times per month) compared to a primary care visit about once every 2.5 months prior to their enrollment.

Hospitalized enrollees are assisted in getting post discharge appointments within seven days; follow-up visit completion rates significantly exceed prior GAMC rates. Further, the Emergency Department has established processes to redirect enrollees directly to on-site clinics after initial medical screening as appropriate. In seven of the first eight months of the CCDS-HCMC program, inpatient readmission rates were lower than HCMC's prior GAMC readmission rate.

Enrollee satisfaction surveys in the Coordinated Care Clinic are very positive, with all surveyed enrollees answering that they would "highly recommend" the clinic to others.

While the CCDS model demonstrated that meaningful cost savings and patient care improvements could be achieved, its funding was so low as to be unsustainable over time. Minnesota has now repealed the CCDS program and replaced it with early Medicaid Assistance expansion pursuant to opportunities available under the federal health care reform law. This offers the possibility of carrying forward the positive lessons learned under the CCDS experiment with a more stable and reliable funding base, thus allowing for sustainable cost savings and scalability to other populations.

Integrated Care Initiative

Individuals with chronic disabling conditions may need a combination of health services and social supports to live in the community. In 2006, Minnesota passed legislation that allowed for the coordination of care for people with disabilities through managed care plans. This created an opportunity for Hennepin County's Human Service and Public Health Department (HSPHD) and Metropolitan Health Plan (MHP) to work together to improve the delivery of services for citizens of Hennepin County.

Staff from both HSPHD and MHP created an integrated model of care that built on the strengths of both organizations and optimized both medical and social services for the well-being of people with disabilities. This model of care was incorporated into a new product called Cornerstone Solutions.

Cornerstone Solutions

Starting in January 2008, state and federal law allowed managed care organizations to combine basic Medicaid covered services with Medicare covered services, including Part D prescription drug coverage, to service all voluntary enrollees between the ages of 18 and 64 who are certified disabled within Hennepin County.

The three main goals are:

1. Create and maintain a consumer-centered health plan which is specifically designed to meet the needs of people with disabilities.
2. Improve access to all services – physical health, mental health, oral health and human services.
3. Establish a high quality system of care by developing processes that ensure accountability.

The program's success is linked to every member being assigned to a care guide who completes with each member a comprehensive health risk assessment and develops a care plan including services and supports that will enhance the likelihood of positive health outcomes.

Preferred Integrated Network (PINS) Project

In August of 2008, MHP and HSPHD responded to a request for proposals (RFP) to develop a Preferred Integrated Network (PIN) for Medicaid eligible adults and children with a mental health diagnosis. MHP and HSPHD's response to the PIN RFP was one of three pilot sites

chosen by the state to demonstrate partnerships between a county and managed care organization. Planning for the PIN included extensive stakeholder feedback including potential enrollees, providers, advocates, community members and county staff. Although the PIN was never formally implemented many of the protocols developed are utilized in the Cornerstone Solutions program and are relevant to this care model.

African American Men Project (AAMP) Initiative at NorthPoint

The African American Men's Project (AAMP), through Hennepin County's NorthPoint health and Wellness Center, includes initiatives to improve health and wellness. This program, which began in 2008, has focused on reducing disparities for this population, including:

- Criminal Justice Involvement (re-entry training)
- Economic Empowerment (connect with training and employment, connect with livable wages and healthcare)
- Education (expose high school males to college opportunities), foster academic achievement and mentorships, reading groups, connect k-8 population to positive African American "babas"- father role models)
- Health (teach health as a priority, ensure access to health care, prostate cancer screenings, group meetings for goal setting/parenting skills/life skills)
- Civic and Community Involvement (reduce guns/violence, ensure neighborhood security, violence reduction strategies and media)
- Housing (connect families to affordable and temporary housing options)
- Family (connect to services needed)

Some examples of outcomes: Over 340 inmates graduated from re-entry training in the criminal justice program, over 58 men obtained jobs through the employment program, and over 500 high school students participated in education forums to increase college attendance.

Hennepin County Project to End Homelessness

On any given night in Hennepin County, more than 3,000 men, women, children, and young adults are homeless. Homelessness is an expensive and unacceptable community problem.

In 2006, the City of Minneapolis and Hennepin County adopted a 10-year plan to end homelessness, entitled *Heading Home Hennepin*. This plan was developed by a commission of business and civic leaders, human service support agencies, advocates, and individuals who have experienced homelessness, and it has since garnered community-wide support. Part of a burgeoning national initiative, Heading Home Hennepin was created to address the continued cycle of homelessness and change the cultural paradigm from managing it to ending it.

The plan's goals include:

- **Prevention**
  Keep people in their housing whenever possible and ensure that no one becomes homeless when they leave public institutions such as prisons, hospitals or foster care.
- **Outreach**
  Develop a comprehensive street outreach program to provide housing and resources to people sleeping outside.
- **Housing**
  Create housing opportunities for all individuals and families in need.
- **Improve Service Delivery**
  Increase access to services so people can obtain and remain in housing.
- **Build Self-Support**
  Assist individuals and families in building their personal income through employment, education, and benefits.
- **System Improvements**
  Enhance the efficiency and effectiveness of service systems already in place.

In creating this plan, Hennepin County and Minneapolis have joined over 300 cities and communities nation-wide that have drafted and implemented similar plans.

Hennepin County's Human Services and Public Health Department (HSPHD) - Client Services Delivery Model (CSDM)

Many human services are traditionally provided in silos. Each often has its own intake, eligibility, and service rules with limited knowledge of other community resources. This means potential clients may be referred around, often from phone number to phone number, must tell their story many times and must try to figure out what they need in terms of federal and state categorical programs. This is daunting for most people, and impossible for many of HSPHD's clients. They get lost in the maze. HSPHD's CSDM is intended to provide an integrated approach to the daunting array of categorical human services and public health services.

HSPHD's new model for client service delivery integrates a variety of specialty staff into teams that focus on three main functions:

- Initial contact – where clients receive information, assistance, initial consultation and connection to services and community resources.
- Eligibility determination and in-depth assessment – where clients needing more than information and referrals apply for programs and services and receive short-term assistance.
- Ongoing services/supports and long-term case management – where clients who are eligible receive on-going services and support.

Client Services Delivery Model - (CSDM) This is an integrated model of care which places services in the client's community in one comprehensive center to increase consumer access to the continuum of services in one location and the key horizontal initiatives that support it.

Hennepin County Adult Behavioral Health - Diversion & Recovery Team (DART)

DART was developed by HSPHD to provide a comprehensive approach to chronic substance abusers. DART uses an integrated team to provide intensive interdisciplinary case management, chemical dependency day treatment, vocational services, and housing. DART works to reduce the number of chemical dependency commitments, detoxification and emergency department visits, decrease involvement with the court system, correction and law enforcement and decrease public costs in this group.

Eligibility Support Staff at HCMC and NorthPoint

Hennepin County identified a need for eligibility determination services at HCMC and NorthPoint as main portals for high need, uninsured individuals accessing health care services. Hennepin County developed on site staffing to bring the service to where the enrollees are. This has been a highly successful collaborative with gained efficiencies and improved enrollee access to needed resources.

For example, at the HCMC Disability Evaluation Center (DEC), the DEC aggressively pursues transitioning eligible enrollees to Medical Assistance for the disabled. As of February 2011, the DEC had facilitated the conversion of 199 CCDS-HCMC enrollees to Medical Assistance as disabled persons

Gateway at NorthPoint

Nationally, African-American children are nine times more likely to have parents in prison than Caucasian children. The Gateway project goal is to increase family self reliance by connecting families to the services needed and working closely with them to achieve their goals. All Gateway families are on the Minnesota Family Investment Program (MFIP), Gateway staff work with families to remove barriers to employment and family stability. A 2009 evaluation by the Urban institute identified the Gateway model as a promising model that yielded high employment and earning results. The model was noted for its integrated team approach that included mental health, chemical dependency, domestic violence, and public health. Gateway refers fathers to the African-American Men Project (AAMP) and the AAMP staff facilitate co-parenting groups.

Health Care for the Homeless

Health Care for the Homeless is an integrated approach to serving homeless persons in shelters and drop in centers. It is a model for working together with medical, mental health, chemical health, and social service organizations. Health Care for the Homeless has developed the foundation for expansion that has changed silo-type services into a coordinated range of supports for individuals.

Appendix B

Goals and Objectives cross-walked with HHS -Strategic Plan FY 2007-2012

HHS Strategic Plan Goals and Objectives- FY 2007-2012

Goal[1]	Objective	Hennepin Health Initiatives
Health care: improve the safety, quality, affordability, and accessibility of health care, including behavioral health care and chemical health.	Increase health care service availability and accessibility	Community based service initiatives
		Connection of persons to patient centered medical homes
		Expanded service hours and locations
		Access to phone program for enrollee connectivity to health care
		Primary care services within behavioral health care, chemical health, shelter, or other environment to best support needs
		Expanded network options to keep enrollees with provider of choice
	Improve health care quality, safety, cost, and value	Patient centered primary care model
		Timely performance reporting and quality improvement initiatives
		Shared EHR for improved communications, reduction of duplications, and shared service planning/assessments
		Focus on reduction of Emergency services and expansion of primary and preventative care
		Utilization of community health workers to ensure coordination and follow-up of health initiatives/goals for individuals
		Enrollee directed goal setting for improved outcomes
		Identify and address social determinants of health and health disparities
		Results based payment system-across partnerships
Public Health Promotion and	Promote and encourage	Primary care model with embedded mental health and chemical health services

Protection, Disease prevention, and Emergency preparedness: prevent and control disease, injury, illness, and disability across the lifespan, and protect the public from infectious, occupational, environmental, and terrorist threats.	preventive health care, including mental health, lifelong healthy behaviors, and recovery.	Health education and community based teachings to transition from acute care episodes, prevent recidivism, and increase healthy opportunities
		Emphasis on health coaching to increase lifelong skills and positive behaviors
		Tiered care approach to encourage recovery and minimally disruptive care individualized for the enrollee
Human Services: Promote the economic and social well-being of individuals, families, and communities.	Promote the economic independence and social well-being of individuals and families across the lifespan.	Model provides for financial assessment and resources to meet basic needs through economic assistance, benefits enrollment, housing initiatives, employment supports, education supports, etc.
	Encourage the development of strong, healthy, and supportive communities.	Services are community based for sustainability and accessibility, and utilize community strengths for on-going supports
	Address the needs, strengths, and abilities of vulnerable populations.	Outcomes are analyzed based on racial, ethnic, language, and other social determinants so as to identify disparities and target actions for resolution

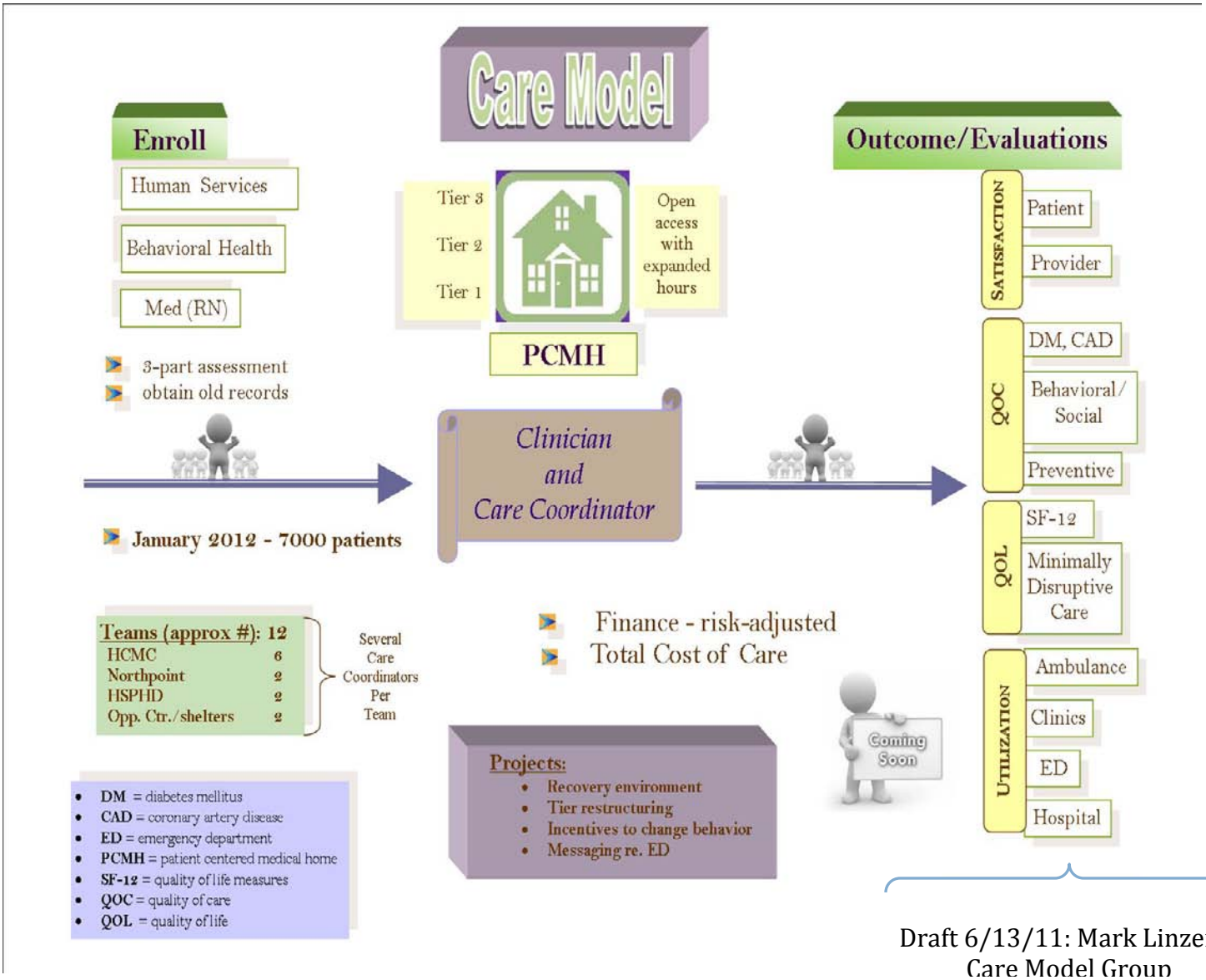
Appendix C

Payor by Race for Hennepin County Targeted Population

	General Assistance Payor		CCDS Payor	
	Total Enrollee Count (n)	Total Enrollee Count (%)	Total Enrollee Count (n)	Total Enrollee Count (%)
Race				
American Indian (Native American)	876	7.84%	742	7.77%
Asian	108	0.97%	140	1.47%
Black (African American)	5503	49.24%	4859	50.87%
Cannot Answer	19	0.17%	39	0.41%
Hispanic (Latino)	313	2.80%	265	2.77%
Multi-racial	166	1.49%	179	1.87%
Native Hawaiian or Pacific Islander	19	0.17%	23	0.24%
Other	281	2.51%	347	3.63%
Refused To Answer	11	0.10%	24	0.25%
White (Caucasian)	3477	31.11%	2876	30.11%
(blank)	402	3.60%	58	0.61%
Grand Total	**11175**	**100.00%**	**9552**	**100.00%**

Appendix D

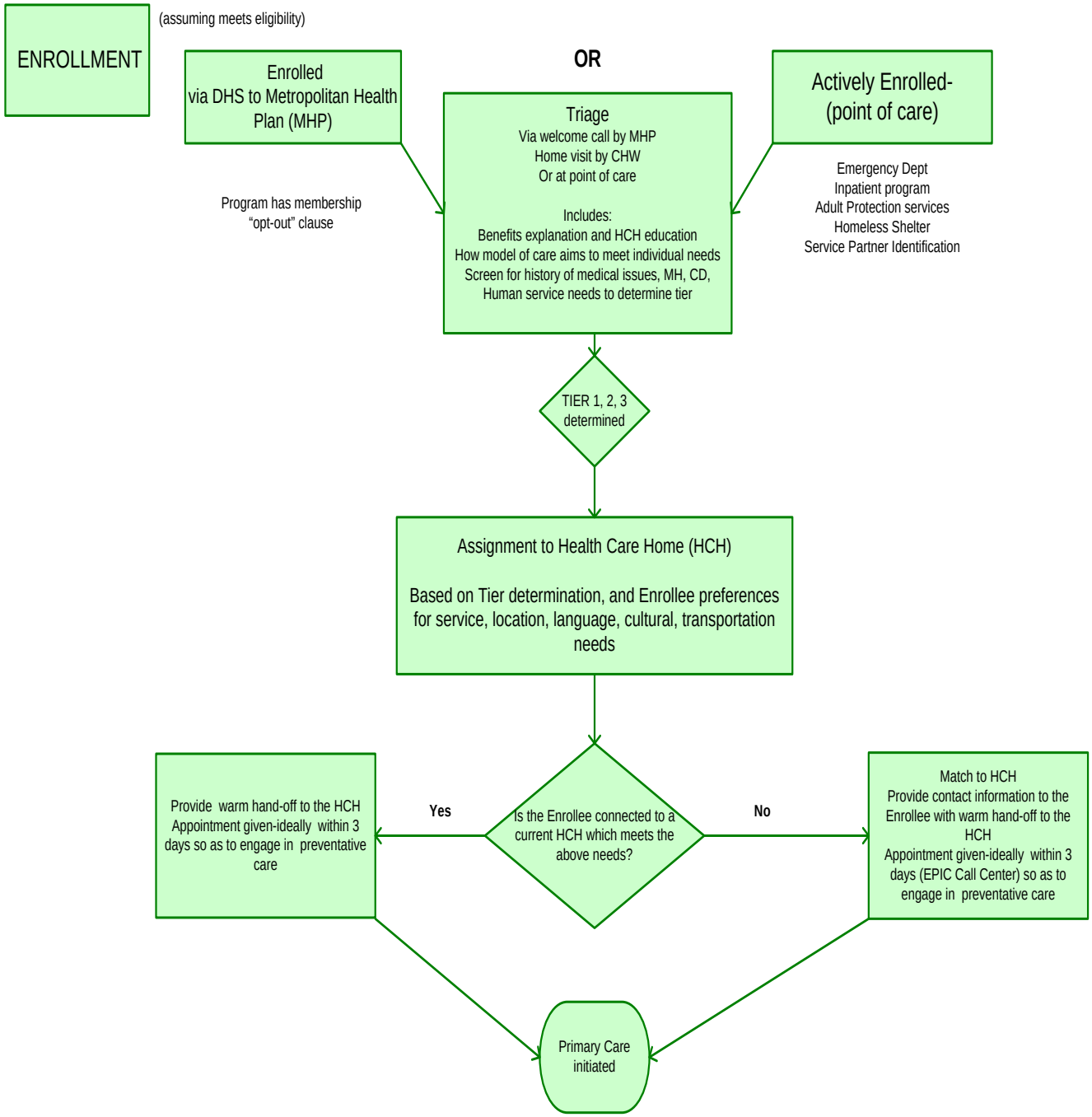
Care Model



Draft 6/13/11: Mark Linzer & Care Model Group

Appendix E

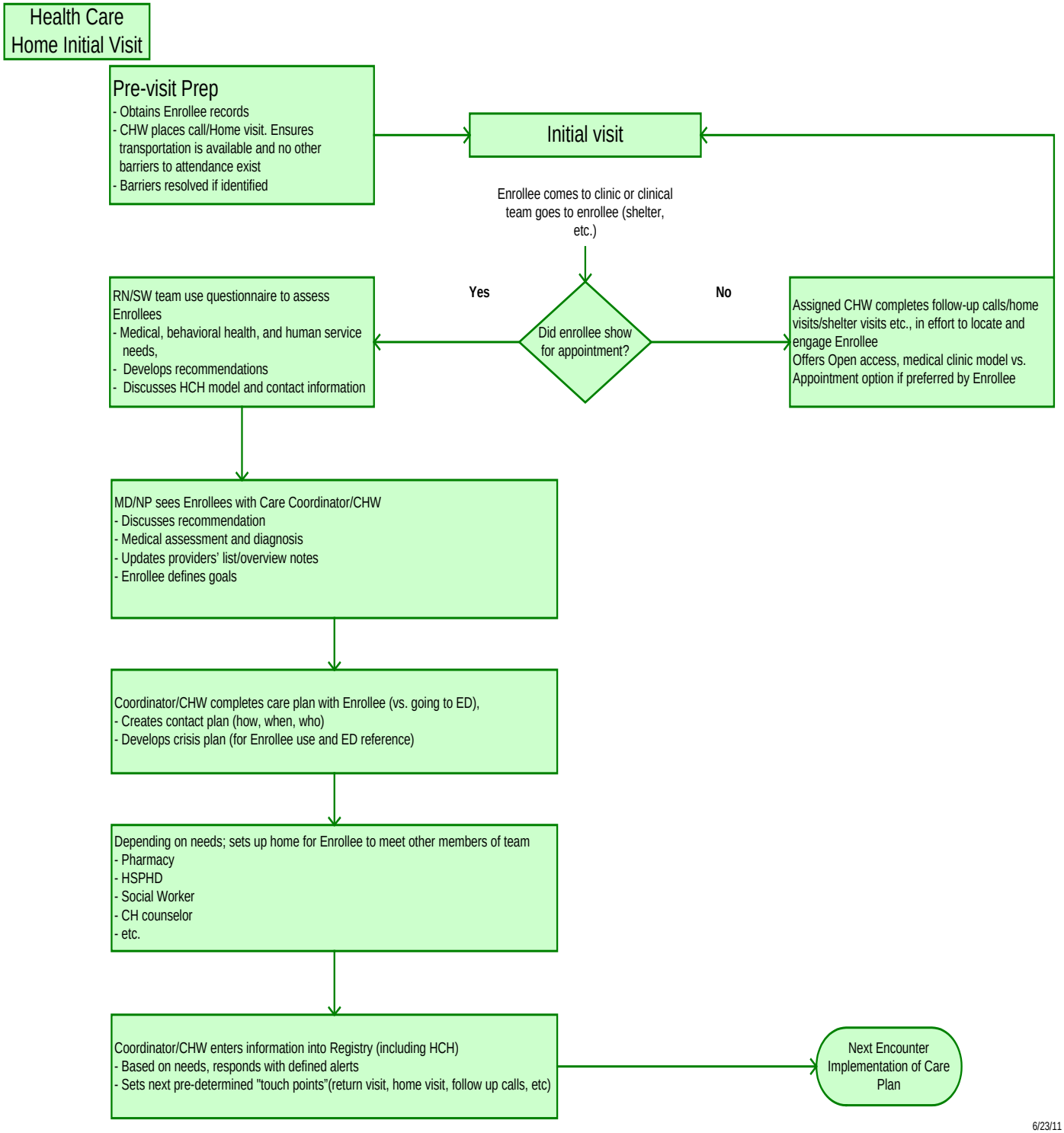
Enrollment Flow



6/23/11

Appendix F

Initial Visit Flow



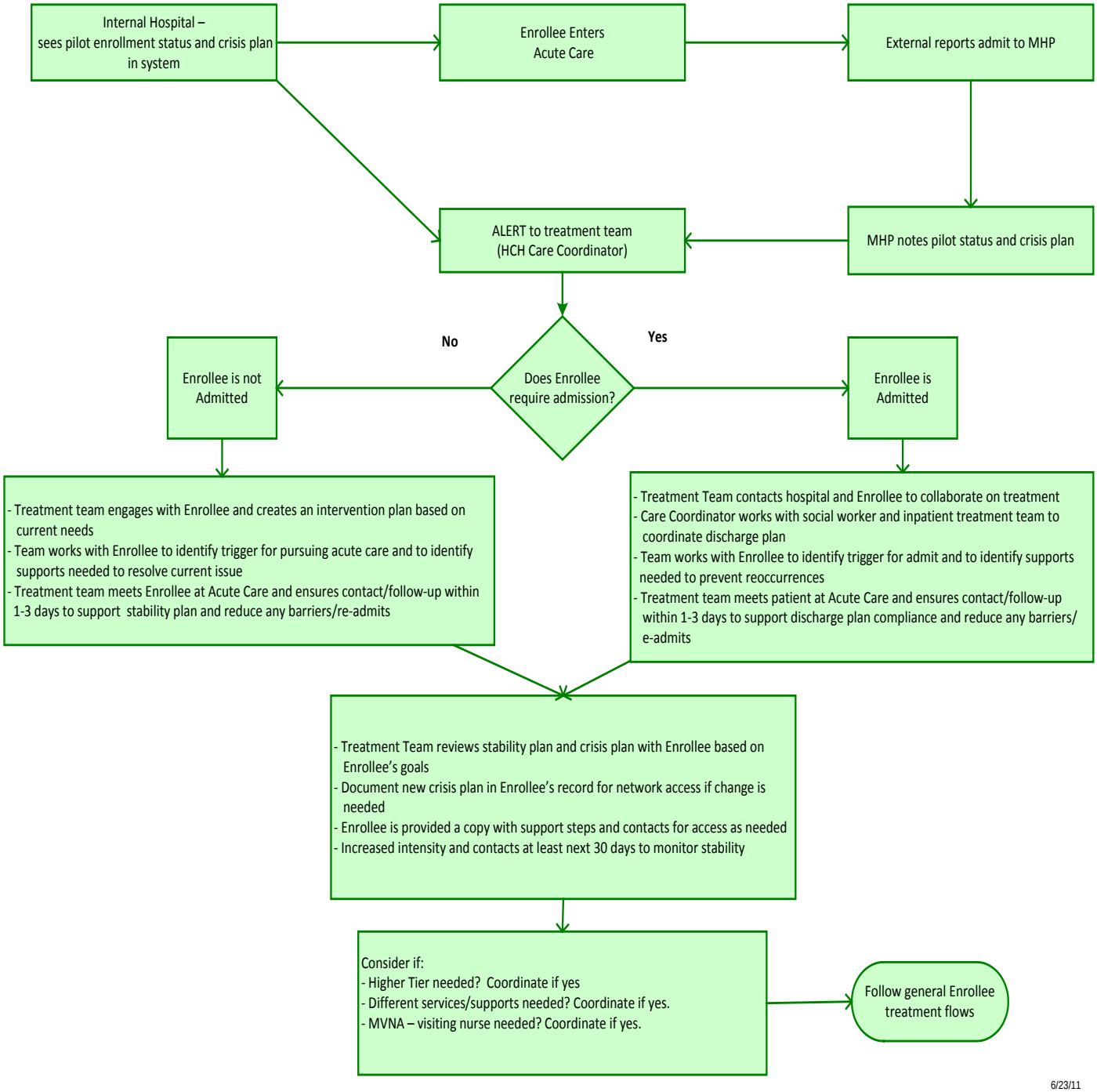
Appendix G

Tiering System for Clinical Care Levels

Tier	Stratification Criteria	Member Estimate (based on 7000 prior GA/CCDS members)	Model (defines locus of care coordination)	Care model elements	Site of Medical Care	Enrollee/Coordinator Ratio (# needed)	Primary Metrics of success
III (Med high)	3 inpatient admissions/year	200	Medical high team management	Multidisciplinary team care	CCC	50:1 (4)	IP utilization Enrollee engagement DzM Quality metrics
III (MH high)	2 inpatient MH admits/year	50-100	MH high team management	ACT (plus/minus) Medical care Less intense ratios	MH high team	50:1 (2)	IP utilization Enrollee engagement DzM Quality metrics
III (CD high)	-Any IP CD treatment/last year -Does not meet IIIm or IIIcd criteria -Civil commitment/last 3 years -Multi detox stays -Mult ED visits for AMS/ETOH etc	600	CD high team management	DART (plus) Add Pain specialist More MH Medical care	CD high team	75-100:1 (6)	IP utilization Detox rates Jail rates ED rates DzM Quality metrics
II	-Any Dz management condition (RAD, DM, HTN, Pain….) -Any IP admit/1 year - > 4 medications	3500	PCMH	-Relational care coordination (for DHS T3 and T4) -Dz management -Transition management (CCDS T2 intervention) - MH triage fxn (CCDS Psych) -Improved PCP access -Robust registry functions	PCMH Multiple sites: HCMC, NPHC, off site clinics, FQHCs	250:1 (14)	-Reduced ED use -DzM Quality metrics -Hosp readmission rates -Reduced first admission rates -Increased PCP visists
I	Housing/ SS issues at screen Does not meet criteria for other Tiers	1500	Human service team center	-Focus on prevention e.g. nutrition, exercise, and health maintenance	PCMH (as in TII)	400:1 (4)	HM measures e.g. immunizations, mammos, etc

Appendix H

Acute Care Transitions Workflow



Appendix I

Patient-Centered Features

Enrollee Rights and Responsibilities

Standard: Hennepin County health care partners (providers and support staff), respect the rights of Hennepin Health enrollees and are committed to serve and treat enrollees in a manner that holds their privacy, treatment decisions, experiences and cultural and ethnic qualities in the highest regard.

Hennepin Health will actively support enrollee rights, as provided by law, by:

- Treating the enrollee with respect and dignity
- Providing enrollees with information about the partners, services, providers of care and enrollee rights and responsibilities
- Respecting the enrollee's right to privacy
- Providing a right to participate and make decisions with practitioners about their health care
- Providing a right to voice complaints verbally or in writing about the organization and their care and appeal the decision if not satisfied

Hennepin Health expects all enrollees to abide by the following Enrollee Responsibilities:

- A responsibility to provide all information, to the extent possible, that will enable practitioners and providers to provide appropriate care
- A responsibility to follow plans and instructions for care that they have agreed to with the practitioner
- A responsibility to participate in developing and carrying out a care management plan
- A responsibility to comply with data sharing among partners
- A responsibility to comply with appointments, treatments and service agreements

Appeals and Grievances

MHP can provide appeals and grievance services with a centralized entry point; consultations; assistance with preparation of appeals; and assistance with hearings as necessary.

Enrollee Incentives

It is our experience that enrollees who are not personally motivated by improved wellness and/or have other priorities can be incentivized to engage in healthy behaviors and improve the outcomes of health care initiatives. Hennepin Health will identify appropriate methods for encouraging desired behaviors by beginning with manageable goals.

Enrollee Meetings and Councils

There is a benefit to connecting enrollees to peers to facilitate community supports, learning from others' experiences, and providing feedback to the program regarding what is working and not working. There is also a benefit in having enrollees as members in the development team. It is anticipated that meetings with enrollees will be set up during and after implementation as a means to provide on-going enrollee supports, as well as program and policy development.

Privacy

As a part of the education process, the enrollee will be requested to sign a release of information for access to their records for providers engaged in their care across the continuum of health care. These enrollees will have the same privacy and enrollee rights as others, but it is imperative that information can be shared across the health care system in order to provide rapid linkage to auxiliary services, as well as to ensure quality health care throughout the system.

Appendix J

Hennepin County Details

Demographic Data

Hennepin County is a County located in the United States, state of Minnesota. As of 2010, the population was 1,152,425, up 3.2% from 2000. Its county seat is Minneapolis, which makes up 33.20 percent of Hennepin County. More than one in five Minnesotans lives in Hennepin County.

Hennepin is governed by an elected Board of seven Commissioners. The county government's headquarters are in downtown Minneapolis in the Hennepin County Government Center.

Foreign languages spoken by major immigrant groups in Hennepin County include Arabic, Hmong, Khmer, Lao, Russian, Somali, Spanish, and Vietnamese.

Commissioners and Key Staff

Commissioners as of February 2011:

District	Commissioner	In office since	Current term expires in January
1st	Mike Opat (chair)	1993	2015
2nd	Mark Stenglein	1997	2015
3rd	Gail Dorfman	1999	2015
4th	Peter McLaughlin	1991	2015
5th	Randy Johnson	1979	2013
6th	Jan Callison	2009	2013
7th	Jeff Johnson	2009	2013

Key Staff:

Hennepin County's normal operations are coordinated by the County Administrator, Richard Johnson; Deputy County Administrator, David Hough; Assistant County Administrator for Human Services and Public Health, Dan Engstrom; and, Assistant County Administrator for Public Works, Marthand Nookala.

Hennepin County: Mission and Vision

Mission

The mission of Hennepin County is to enhance the health, safety and quality of life of our residents and communities in a respectful, efficient and fiscally responsible way.

Vision

We envision a future where residents are healthy and successful and where our communities are safe and vibrant. We will strive to meet and exceed expectations by engaging people and communities in developing innovative solutions to challenges. We will be a diverse, learning organization. We will partner with others to enhance the quality of life in Hennepin County and the region.

Appendix K

Human Services Measures for Minnesota, of which Hennepin County HSPHD represents more than 20% of the service provision.

Minnesota ranks at or near the top in key human services measures

DHS-5106-ENG 04-11

Health and human services in Minnesota compare favorably to other states in a number of national surveys. Minnesota ranks:

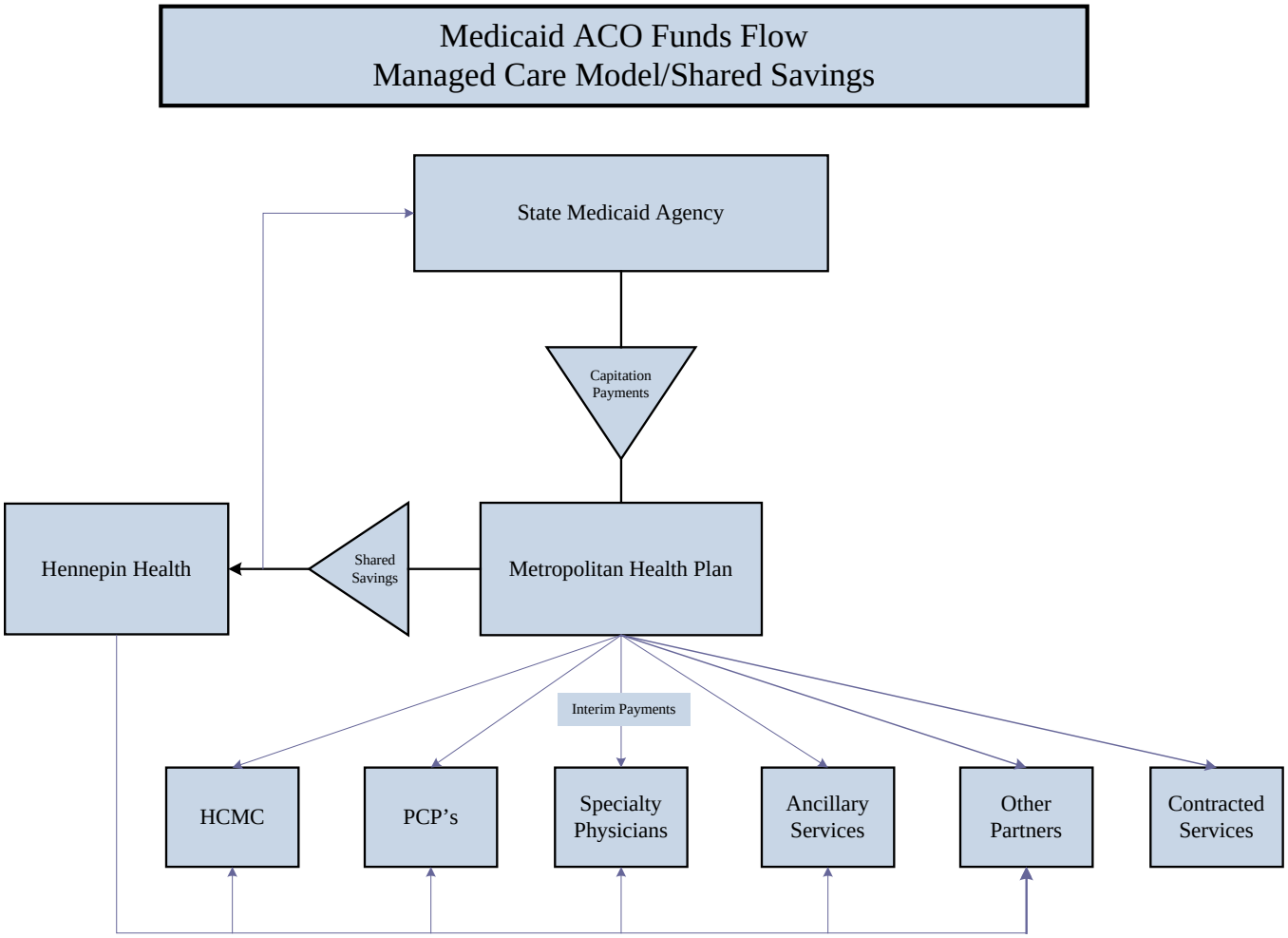
- First for health status outcomes. Minnesota ranked first in two key outcome measures: low rate of deaths from heart disease and a low rate of premature death. (America's Health Rankings®, 2010)
- Second in health care among states based on 21 health-related factors, including access to health-care providers, affordability of health care and the general health of the population. (Health Care State Rankings 2010: Health Care Across America)
- Second in the nation in child welfare based on a composite of 10 measures of children's well-being including: number of children in poverty, teen birth rate, infant mortality rate, high school dropout rate and number of low birth-weight babies. (Annie E. Casey Foundation's 21st annual Kids Count Data Book, 2010)
- Third in the nation in the amount of child support collections per case. (U.S. Department of Health and Human Services, 2009)
- Third in the nation for overall health care quality. The 2009 National Healthcare Quality report includes 18 measures of health care quality, including maternal and child health, enrollee safety and cancer care. (Agency for Healthcare Research and Quality, 2009)
- Fourth (tied with two other states) for the lowest percentage of children living in poverty. Eleven percent of Minnesota children lived in poverty, compared to 18 percent nationally. (Annie E. Casey Foundation's 21st annual Kids Count Data Book, 2010)
- Sixth in overall health among states, based on health-related factors, including uninsurance rate, infant mortality and early prenatal care. Minnesota is among the top 10 states on 13 of the 22 measures. (America's Health Rankings®, 2010)
- Sixth in the rate of health insurance coverage with 90.9 percent of Minnesotans covered. (U.S. Census Bureau, 2009 American Community Survey)
- Eleventh among the states with 11 percent of Minnesotans living in poverty. The national poverty rate was 14.3 percent. (U.S. Census Bureau's 2009 American Community Survey)

www.dhs.state.mn.us .

For more information, call the Minnesota Department of Human Services at (651) 297-4124. This information is available in other forms to people with disabilities by contacting us at (651) 282-5329. TTY/TDD users can call the Minnesota Relay Service at 711 or (800) 627-3529. For the Speech-to-Speech Relay, call (877) 627-3848.

Appendix L

Finance Modeling



Appendix M

References and Additional Resources

References

1. Atul Gawande, "The Hot Spotters," The New Yorker January 24, 2011.

2. United States Census 2010, U.S. Census Bureau

3. Commonwealth Fund "Organizing for Higher Performance: Case Studies of Organized Delivery Systems", Douglas McCarthy and Kimberly Mueller, Issues Research, 7/09.

Additional Resources

1. HHS Strategic Plan Goals and Objectives- FY 2007-2012

2. CMS Strategic Plan

3. Patient Protection and Affordable Care Act

4. *National Healthcare Quality Report* (NHQR) and the *National Healthcare Disparities Report* (NHDR)

5. HHS Action Plan to Reduce Racial and Ethnic Health Disparities FY 2007-2012

6. Evolving Models of Behavioral Health Integration in Primary Care Chris Collins, Denise Levis Hewson, Richard Munger and Torlen Wade, May 2010, Milbank Memorial Fund

7. *Launching Accountable Care Organizations — The Proposed Rule for the Medicare Shared Savings Program*, a New England Journal of Medicine article by Don Berwick, published March 31, 2011 (http://www.nejm.org/doi/full/10.1056/NEJMp1103602).