Hennepin Health
People.Care.Respect

Super Utilizer Summit
February 2013
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Hennepin County, MN
What is Hennepin Health?

Minnesota Department of Human Services (DHS)
&
Hennepin County
Collaborative for Healthcare Innovation

**Hennepin County Partners:**

Hennepin County Medical Center (HCMC)
NorthPoint Health & Wellness
Human Services and Public Health Department (HSPHD)
Metropolitan Health Plan (MHP)
Population Served

- MA Expansion in Hennepin County
- 21 - 64 year-old Adults, without dependent children in the home
- At or below 75% federal poverty level ($677/month for one person)
- Targeting ~10,000 members/month
- Start date: January 2012 (two year demonstration project)
Premise

- Need to meet individual’s 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
The 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
Population Characteristics

- ~68% Minority status
- ~45% Chemical Use
- ~42% Mental health needs
- ~30% Chronic Pain Management
- ~32% Unstable housing
- ~30% 1+ Chronic diseases
Goals: Years 1 and 2

Improve Residents Health Outcomes, Reduce Overall Costs

- Decrease admissions/readmits by >10%
- Reduce emergency department visits by >10%
- Increase primary care “touches” by >5%
- Reduce churn. Maintain coverage by >95%
Finance model

- 100% at risk contract
- Partners share risk/gains
- Tiering approach
- Fee for Service → “pmpm” with outcome contracts
Top 200 Utilizers- Focused Report

• Created report of top utilizers
• Review team identified trends

Individual Interventions  System Changes
Virtual Teams

**Individual Team**
Clinic connected
Plus central team
Radar report driven

**System Team**
Health Plan
Clinic
Hospital
Human Services
Community Providers

- Care Coordinator
- MD/NP
- CHW
- Community Providers
- Human Services

individual connected
Plus central team
Radar report driven

working for you
Technology (examples)

• One Patient Record
  – Health plan
  – Inpatient
  – Outpatient
  – Community providers
  – Social Services

• Radar Reports
  – Provider specific
  – System alerts

• Data Warehouse
  – Medication fills
  – Pharm/Clinic hopping
System Opportunities (sample)

- 5% utilizing 64% of health care funds
- Individuals “stuck” in hospital beds
- Individuals failing transitions between programs
- Individuals misusing crisis care venues
- System fragmentation and duplication
- Low medical literacy
System Investments Year 1 (sample)

Initiative
- Same day dental care
- Care Coordination
- Data Warehouse
- Patient Radar Reports

Outcome
- >30% average cost reductions
- >50% hospital reduction - Tier 3
- Ability to see across systems
- Work prioritization
## System Investments Year 1 (sample)

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy MTM</td>
<td>Reduce medication costs &gt;50%</td>
</tr>
<tr>
<td>Health Plan/Provider record</td>
<td>Near real time data, reduced duplication of efforts</td>
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<tr>
<td>Same day access to primary care</td>
<td>Reduction of ED - crisis care</td>
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</tbody>
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Outcomes Year 1 (as of Oct 2012)

• **Admissions:** 17/1000 (Jan) to 12/1000 (Aug)
  - Length of stay and total cost of admission analysis end of year

• **Readmissions:** Decreased 2%-5% (Jan - July)

• **Emergency Dept:** Decreased 35% (includes Urgent Care change)

• **Primary Care:** Increased 23% (Jan - Aug)

• **Patient Satisfaction:** 87% “likely to recommend”
  (Press-Ganey)
System Investments Year 2

**Project**
- Sobering Center
- Transitional Housing
- Behavioral Health Continuum
- Psychiatric Consult model
- Intensive primary care - clinic expansion
- Vocational services

**Return on Investment**
- 80% cost reduction ED to sobering center
- One month of housing < 2 days of hospitalization
- 30 - 50% cost reduction expected
Critical to Success - 3 Elements

• **Flexible funding**
  – to meet individual and system needs (motivation and solutions)

• **Data sharing**
  – capability across systems (welfare and healthcare)

• **Leadership**
  – alignment, business case motivation
  – neutral, convener role
  – barrier busting
Unsolved Challenges

- Reducing Medicaid churn
- Seamless provider information sharing
- Caseload complexity - algorithm
- “Big Data” - comparisons healthcare to welfare
- 50% system change remains to be built
- 1% to 100% - population and provider spread
Hennepin Health
Bringing systems and people together

Video and more information: www.hennepin.us/healthcare