HENNEPIN COUNTY
MINNESOTA
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Agenda

- Hennepin County Context
- Hennepin Health ACO Model
- Increasing Understanding of Social Complexity
- Clinical Approaches to Improve Care
- Taking Population Health Efforts to Scale
Hennepin County Profile

- Largest Minnesota county by population, includes Minneapolis
- 1.2 million residents
- Relatively favorable health outcomes on average
- Persistent and stark racial and ethnic health disparities
Hennepin Health Accountable Care Organization (ACO) - Structure

- Prospective enrollment in health plan
- Capitated reimbursement from State Medicaid Agency
- Shared electronic health record
- Collaborative decision-making
- Data and service integration
- Measuring impact
- Risk-sharing funding model
- Defining success in community health terms

Public Health, including Health Care for the Homeless
## Financial Model: Impact

<table>
<thead>
<tr>
<th></th>
<th>Before Hennepin Health / Traditional Health Care</th>
<th>With Hennepin Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Method of Paying Providers for Care</strong></td>
<td>Fee-for-Service <em>(Volume)</em></td>
<td>Total-Cost-of-Care <em>(Value)</em></td>
</tr>
<tr>
<td><strong>Health Plan &lt;---&gt; Provider Financial Incentives</strong></td>
<td>Opposed</td>
<td>Aligned</td>
</tr>
<tr>
<td><strong>Remaining Funds if Financially Successful</strong></td>
<td>Health Plan Margin</td>
<td>Reinvestment to Further Improve the System</td>
</tr>
<tr>
<td><strong>Services Offered to Patients</strong></td>
<td>Medicaid Benefit Set <em>(Rigid)</em></td>
<td>Medicaid Benefit Set + Care Coordination + Targeted Social Service Interventions <em>(Flexible)</em></td>
</tr>
</tbody>
</table>
Opportunities for Improvement

Health plan

- Optimal management
- Proactive and preventive care
- Acute exacerbation of chronic conditions
- Basic needs: shelter, food, transportation, income

Hospital/Clinic

Human Services
Evolution of the ACO

Then (2012 – 2015)

• Health reform demonstration model
• Average of ~10,000 members
• Serving exclusively Medicaid expansion (adults without children) members

Now (2016 – present)

• “Mainstream” Medicaid insurance offering in Hennepin County through competitive procurement
• Over 25,000 members
• Increasing proportion of Medicaid families and children

Hennepin County
Multiple Systems, Aligned Opportunities
A Broader Role in Community Health
Medicaid Expansion Data

All data limited to March 2011 to December 2014

**Minnesota Health Care Programs**
- Medical Assistance (Medicaid)
- MinnesotaCare
- Other programs

**Human Services**
- Food support
- Cash support
- Case management

**Criminal Justice**
- Court
- Jails and Detention Centers
- Supervision
- Adult Corrections Facilities
- State Prison

**Housing**
- Emergency Shelter
- Group Residential Housing
- Permanent Supportive Housing
Involvement Across Sectors

- 93% had contact with at least one sector
- 21% were involved in health care only
- 30% were involved in health care and human services, but not criminal justice or housing
- 19% were involved in health care, human services and criminal justice, but not housing
- 8% were involved in all four sectors
- 4% were involved in health care, human services and housing, but not criminal justice
Involvement Across Sectors

- **Hennepin Emergency shelter**: 58% of emergency shelter bed days
- **Hennepin ADC (Jail)**: 50% of Adult Detention Center (jail) bed days
- **Hennepin ACF**: 57% of Adult Corrections Facility bed days
Medicaid Expansion Public Costs Per Person by Diagnosis

Hennepin County

Cost per person

- MN health care programs
- Human services
- Criminal justice
- Housing

53% of public costs

Diagnosed with both SUD and MI (n=20,291)

Only SUD diagnosis (n=5,786)

Only MI diagnosis (n=20,474)

No SUD or MI (n=51,731)
Six Medicaid Expansion Sub-populations

**Group 1**
Low involvement in all sectors

**Group 2**
Managed chronic conditions
High primary care use
Majority women

**Group 3**
Health care high utilizers, long-term MA, older, supportive housing

**Group 4**
Low-level criminal justice involvement

**Group 5**
High utilizers in all sectors
High ED
Long-term MA
Low/Mid-level CJ
MI and SUD

**Group 6**
Serious CJ involvement
Evolving health care delivery

• Identifying social factors
• Application of data to drive change
• Reinvestment
• Expanded Medicaid benefits
Identifying housing status (then what?)
Housing status capture & use in EHR

- Individual patient – inconsistent
- Population level (internal)

Hospital discharges
- 9.4% medical/surgical discharges
- 23% psychiatry discharges
- 32% more likely to be readmitted (30d)
- >2x expected excess days

“Homelessness is the equivalent of another diagnosis” (ICD10 – Z59.0)
Population level (external)

- Many tables → Shared buffet
  - “Homeless Consult”
  - “Priority” populations for housing
- Medical Respite
- Adding to knowledge base
- Policy & advocacy

<table>
<thead>
<tr>
<th>Social Risk Factor</th>
<th>Hennepin Healthcare System, Inc</th>
<th>Minnesota Medicaid</th>
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</thead>
<tbody>
<tr>
<td>Substance use disorder</td>
<td>29.11%</td>
<td>13.84%</td>
</tr>
<tr>
<td>Serious and persistent mental illness (subset of individuals with SMI)</td>
<td>7.79%</td>
<td>4.40%</td>
</tr>
<tr>
<td>Serious mental illness (SMI)</td>
<td>35.27%</td>
<td>21.18%</td>
</tr>
<tr>
<td>Deep poverty (≤50% FPL)</td>
<td>32.67%</td>
<td>26.77%</td>
</tr>
<tr>
<td>Homelessness</td>
<td>19.87%</td>
<td>8.50%</td>
</tr>
<tr>
<td>Past prison incarceration</td>
<td>7.18%</td>
<td>3.95%</td>
</tr>
</tbody>
</table>
Jim & Beth

- Jim – late 40s, sleeps “all over” (outside, friends/family, various shelters)
  - Active substance use disorder, untreated mental health
  - Frequent ED, detox & jail visitor
  - Intermittent clinic visits (HCH)
  - **Goal:** “be a role model for my kids and grandkids so they want to see me”

- Beth – late 20s, in overnight shelter > 1 year
  - Untreated severe & persistent mental health, active substance use disorder
  - Frequent psychiatric hospitalizations
  - Rare clinic visits (HCH)
  - **Goal:** “just be stable”
Hennepin Health Access (HHA) Clinic
Reinvestment initiative 2014

- Coordinated Care Center – “Ambulatory ICU”
  - What if you met these patients earlier??

- HHA target population - high impactable ED (and hospital) utilization
  - Homeless
  - Chemically dependent
  - Mentally ill

- Health Care for the Homeless model
  - Integrated, coordinated, multidisciplinary team
  - Strong partnerships
  - Enabling services & flexible access
  - Transitional - stabilize and warm hand-off

- Tracking systems – dashboards, reports

![Graph showing Total Cost of Care/1000 with a decrease of 36%]

Pre-Access Clinic Encounter
Post-Access Clinic Encounter
Social Services Navigation Team

- County-employed social workers working in the community
- Linked to clinic and health plan-based teams
- Addressing social needs and barriers, often housing, employment, or behavioral health-related
- Paid with Medicaid health plan funds
Jim and Beth?

• Jim – enrolled in Hennepin Health
  • Connected with HH ED In-Reach → HHA Clinic, HH Social Service Navigators
  • Completed CD treatment, connected to mental health care, moved into housing
  • Job training & placement (HH Vocational Services)
  • Connected with children & grandchildren

• Beth – enrolled in Hennepin Health
  • Connected with HCH respite team → out-patient psychiatry, methadone program, HHA Clinic
  • Applied & approved for long-term disability (income, housing support & services)
  • Clean without hospitalizations > 9 months
  • Moving into her own apartment with services next month
Questions and Discussion
Health care for the Homeless: Social Determinants of Health and Minnesota’s Medicaid Program

Marie Zimmerman, Medicaid Director
Topics to cover today

+ Minnesota Medicaid Snapshot
+ Medicaid and homelessness
+ Strategies on Social Determinants
+ Medicaid Housing Stabilization Services
+ Integrated Health Partnerships
+ Medicaid Tomorrow
+ Medicaid Directors
Medicaid in Minnesota

1.2 million ENROLLEES

1 in 5 MINNESOTANS
$11.4 billion, annually

60 percent covers seniors and people with disabilities
Medicaid enrollment and spending by eligibility category
Medicaid spending by category of service for adults

Snapshot:

2016 spending

$1.7 billion

200,000 adults enrolled
Minnesota Medicaid & Homelessness

- **120,000** Minnesotans experience housing instability
- **15,000** Minnesotans experience homelessness on any given night

**Health and housing strategies intersect**
- Hennepin Health/Health Care for the Homeless

**New Medicaid Housing Stabilization Service**

**Accountable Care Partnerships**
- Building social determinants, like homelessness, into payment incentives
- Requiring formal partnerships
**MN Medicaid Housing Stabilization Service**

**GOALS**

1. Support an individual's **transition** to housing in the community
2. Increase **long-term stability** in housing
3. **Avoid** future periods of homelessness or institutionalization
4. Target population about 50,000

**PROCESS**

Disability or disabling condition + Housing instability

- Homeless or at risk of homelessness
- Transitioning from an institution or segregated setting
- At-risk of institutionalization

Assessed need for services due to limitations caused by the individual's disability

Leveraging Medicaid to transition and maintain housing
Integrated Health Partnerships (IHPs)

$213 million in savings

14 percent drop in hospital stays

460,000 people served
Improving Outcomes Through New Provider Incentives

• Health care providers work together across service settings to meet patient needs.

• These providers share in savings they help create and in losses when goals are not met.

• They look for innovations to improve the health of their communities.

Paying for value and good health outcomes instead of the number of visits or procedures through our Integrated Health Partnerships (IHPs).
Moving forward quality, IHP 2

Relevant, partnerships and measurable quality improvement activity

Social Risk Factors

Population-Based Payment
## Risk Factors

<table>
<thead>
<tr>
<th>Adult Population</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deep poverty</td>
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</tr>
<tr>
<td>Homelessness</td>
<td>Homelessness</td>
</tr>
<tr>
<td>SPMI</td>
<td>Parental SPMI</td>
</tr>
<tr>
<td>SUD</td>
<td>Parental SUD</td>
</tr>
<tr>
<td>Prison History</td>
<td>Parental Prison History</td>
</tr>
<tr>
<td></td>
<td>Child Protection Involvement</td>
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A drive toward whole-person care, lower-cost and better health outcomes

+ The acknowledgement that provider reach is only so deep, housing, income, justice-involved, food security are unaddressed

= A desire to integrate the health care system and social services
SDOH in Medicaid, Opportunities and Challenges

**Opportunities**

- Largest single health insurer in most states
- Promote and incentivize health outcomes
- Bring system-wide transformation
- Find partnerships and new business models, don’t reinvent the wheel of social services
- Determining what it means to incorporate SDOH into payment

**Challenges**

- Sustainability: federal and state budget pressures and economic conditions
- Medicaid is health insurance, it can’t pay for everything
- Gaps and disparities to address can be overwhelming
- Determining what it means to incorporate SDOH into payment
1) Come with:
   - A Specific ask (not just money)
   - Business model or proof of concept
   - Useable data, consumable info that helps tell a story

2) Demonstrate partnerships and plans for coming together

3) Offer to be a convener
Thank you

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DISCUSSION