



Hennepin County **Medical Center**

**Hennepin Healthcare System, Inc.  
Health Services Plan**

**2009**

(Draft for review & comment)

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## **I. Executive Summary**

The Health Services Plan describes the role Hennepin County Medical Center/Hennepin Healthcare System, Inc. (HCMC/HHS) plays in service to the community. This includes affirmation of our continued commitment to the historic mission of HCMC/HHS and our responsiveness to selected health challenges faced by our community and region.

This year's Plan addresses the health challenges identified as priorities by the Health Services Plan Advisory Council last year and affirmed by the Governance and Mission Effectiveness Committee, the Hennepin Healthcare System, Inc. Board, and the Hennepin County Board. Those priorities:

- **Access** to primary care
- Reduction of **health disparities** (including native-born minorities and with particular sensitivity to immigrant populations)
- **Mental health services**
- (Health care) **work force development** and promotion of a diverse and **culturally sensitive** HCMC/HHS environment

Plan development for this year included a review of the available community needs assessment documents assembled for Hennepin County and our region, while also emphasizing stakeholder coordination, i.e. working in collaboration with other health care partners and public health to enhance the effectiveness of our efforts. The formal update of the community needs assessment will now occur every two years (recognizing that except for extraordinary occurrences, the health status of the population and the incidence of illness and injury varies little from one year to the next), enabling us to place more emphasis on implementation and stakeholder coordination every other year.

The economic downturn and resulting impact on financing safety net services (based on the outcomes of the 2009 Minnesota Legislative Session) has altered the trajectory for health service planning and severely threatened our ability to meet our health services objectives. At this writing, HCMC/HHS is now confronted with the loss of \$43 million in annual payments with the termination of the General Assistance Medical Care program. Historically, HCMC/HHS has operated on razor-thin margins. To have the State withdraw the financing for these patients – who will continue to seek services at HCMC/HHS – has created a budgeting conundrum and potentially an operational crisis.

Consequently, our stakeholder coordination work this year has become three-fold. As we anticipated, HCMC/HHS has been involved with state departments, other providers, health plan companies and contractors in crafting the parameters with the State of Minnesota for the implementation of health care reform legislation that has been passed in the last three legislative sessions. And, again as anticipated, we have also had discussions with community stakeholders to address the priority health issue areas cited by the Health Services Plan Advisory Council and the HHS Governance and Mission Effectiveness Committee. The third area of stakeholder coordination has been a series of meetings with elected officials, representatives of State of Minnesota administrative departments, other providers and the public at large as we have attempted to bring forward public policy perspectives that are consistent with our approved legislative program. That program speaks to the importance of expansion of health care coverage and support for organizations that provide care to those who would otherwise be denied accessible, patient focused care.

It is not yet clear to what extent alternative funding resources will be made available to mitigate the loss of \$43 million in payments for General Assistance Medical Care patients. HCMC/HHS has accelerated work on internal performance improvement initiatives with respect to productivity, revenue cycle and supply chain. The Hennepin County Board has recognized the peril faced by HCMC/HHS, and has expressed intent to cover a portion of the impending shortfall. A final piece of the puzzle is the program review planning process currently underway at HCMC/HHS, necessitated by our need to reduce expenses to match our anticipated reduction in revenue. To the extent that process identifies mission-oriented programs for reduction or elimination, the scope or capacity of HCMC/HHS' programs and services may need to be curtailed.

With this context in mind, HCMC/HHS plans for the coming year will be calibrated to respond to the loss of public program funding, first, through performance improvement/expense reductions and, as needed, alterations in our programs and services.

Our intention is to continue to provide the same high quality care, (as exemplified by our *U.S. News and World Report* recognition and our observed-to-expected mortality scores) for approximately the same volume of patients: an inpatient census of 350 and more than 1,000 clinic visits, and 325 emergency room visits each day. Each year as many as 150,000 unique individuals seek services at HCMC/HHS, including persons from each Minnesota county.

With respect to the four specifically cited performance areas:

- Our year-to-date primary care clinic volume has increased by 6%, and our “likely to recommend” patient satisfaction has increased from 86% to 88% since 2007. In the coming year, **Primary care access** will be provided through continued expansion of our capacity, improved throughput achieved

- by “leaning” our operation, and transformation of our care model to provide the health care home environment.
- The **health disparity** issue is pervasive among native-born minorities and immigrant populations. We acknowledge that the health care service sector is but one component of the determinants of health. We will continue to address our processes and care model as we embrace our role. Our year-to-date activity measures document a 15% increase in our interpreter use, and a 29% increase in our International Clinic volume. Going forward, we will continue to improve access to HCMC, collaborating with other provider and human service agencies, and building our knowledge management infrastructure and clinical decision support to identify and execute on opportunities for effective intervention.
  - **Mental health** services continue to operate at capacity at HCMC/HHS. We hope to continue the current scope of services, and will continue to document the impact we are able to make on the quality of life of the patients we serve (as evidenced by our Programs Outcomes Status Report results documenting fewer homeless nights and incarcerations among our day treatment patients.)
  - **Workforce development** in the past year included a robust physician residency graduating class with a Board pass rate of 95%; 67% of our graduates will establish practice in Minnesota. 125 of our residents are in primary care specialties. The economic downturn has enabled HCMC/HHS to generally fill open positions in recent months. Therefore, in the coming year, **workforce development** activity will focus on the public policy agenda and the long-term needs that are projected. Meanwhile, our work on **diversity and inclusion** will continue on our current and successful path. Year-to-date, more than one-third of our emerging and engaged leader program attendees are of minority race or cultures.

## **II. Environmental Context for This Year's Plan**

The Health Services Plan describes the ways by which the Hennepin Healthcare System, Inc./Hennepin County Medical Center (HCMC) fulfills its mission and the role(s) that it plays in the community and region.

### **HCMC Mission Statement**

*We are committed:*

- *to provide the best possible care to every patient we serve today;*
- *to search for new ways to improve the care we will provide tomorrow;*
- *to educate health care providers for the future; and*
- *to ensure access to healthcare for all.*

The economic recession has had a substantial impact on our society, on state and local government, and to the health care industry. Demand for the services of the safety net health care system has continued to be strong, even as the private and not-for-profit health care providers are reporting a reduction in demand for their services. The State of Minnesota, facing budget deficits \$5 billion in the current biennium, has reduced Minnesota Health Care Program (MHCP) payment rates to providers. Furthermore, the Governor line-item vetoed funding for the General Assistance Medical Care (GAMC) program, which has been providing coverage for our poorest and most vulnerable population. Between the payment reduction and GAMC program termination, HCMC is looking at reduced revenue of \$73 million for the current biennium. To that end, HCMC has reviewed our portfolio of programs to ascertain the most appropriate balance of mission-oriented initiatives, recognizing sustainability must be derived from margin-producing efforts or alternative revenue sources. Given the impending termination of the GAMC program, HCMC/HHS has accelerated performance improvement efforts with regard to workforce productivity, revenue cycle, and supply chain.

Performance improvement efforts are not likely to yield the results necessary to respond to the loss of \$73 million in the current biennium. Therefore, to assure the viability of HCMC going forward, HCMC is having to consider:

- restricting access to some elective programs or services, based on geography and/or financial qualification;
- limiting capacity of programs that incur sizeable financial shortfalls, and
- terminating programs or sites of service.

A program review process is currently underway at the hospital. Among the criteria that being used in our deliberations are:

1. Magnitude of the number of persons impacted by program limits or termination.
2. Presence (or absence) of alternative programs or sites of service in the community.
3. The financial impact of the program on HCMC.
4. Consequences to other parts of the healthcare or human service systems.
5. Other community impacts, i.e. cost shifting, employment, etc.

The Health Services Plan public meeting on October 28 will be an opportunity for HCMC to solicit feedback from the community at large with respect to the criteria we are using in our deliberations, and the degree to which each or any of our programs are deemed essential. A comprehensive list of our programs is shown in the appendix (page 43).

The dynamic environment includes discussion of health care reform at the Federal level. More relevant at this time to our region and HCMC/HHS is health care reform enacted within the State of Minnesota. Reform in Minnesota is to be transformational with formally stated goals to “simultaneously:

- Improve the health of the population;
- Improve the patient/consumer experience; and
- Improve the affordability of health care”

The framework of reform includes:

- Population Health and the Statewide Health Improvement Program
- Market transparency and enhanced information (which includes Statewide Quality Reporting System and Provider Peer Grouping)
- Care Redesign and Payment Reform (which includes Health Care Homes, Baskets of Care, and Quality Incentive Payment System)
- Consumer engagement

Representatives of HCMC/HHS and Hennepin Faculty Associates (HFA) have been engaged participants in collaborative work by stakeholder as plans, practices and regulations are being crafted to guide the implementation of legislation.

The focus of this year’s Plan continues to be those areas that were identified by the Health Services Plan Advisory Council and affirmed by the HHS Governance and Mission Effectiveness Committee: enhanced mental health services; expanding primary care access; reducing health disparities with sensitivity to native-born minorities and immigrants and enhanced workforce training and diversity. In addition, we provide a greater description of selected partnership endeavors with organizations who also serve vulnerable populations as we work collaboratively to address our community’s health needs.

### **III. Plan Process and Development**

#### **A. Purpose of the Health Services Plan**

Hennepin County Medical Center/Hennepin Healthcare System is required by law to produce an annual “Health Services Plan” for the review and approval of the Hennepin County Board of Commissioners.

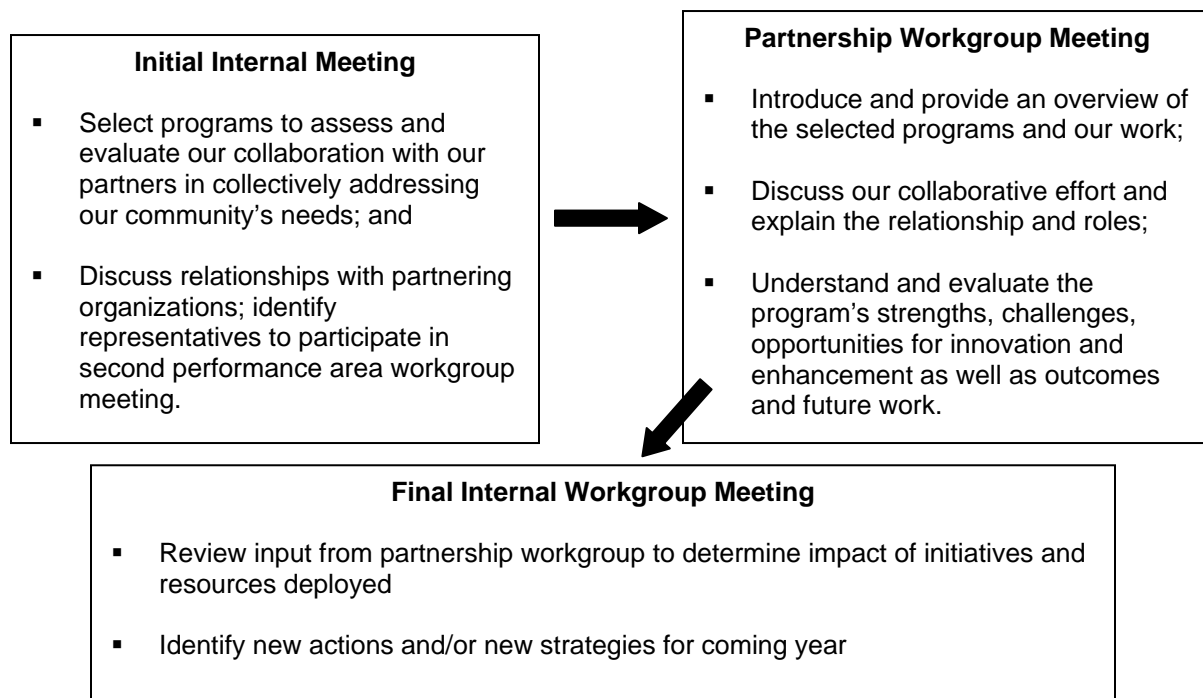
As stated in the bylaws, the Health Services Plan “will draw from a population needs assessment, and will delineate the Corporation’s role in the community, including education, research and services to improve the health status of the community, including indigent populations.” The Plan must also describe:

- Continued coordination with the County;
- The principal health services to be provided;
- Significant changes in the patterns of community health needs;
- Significant plans for changes in deployment of resources or sites;
- The primary thrust of workforce plans; and
- The operation and effect of the indigent care formula.

This year, pursuant to HHS Board’s Governance and Mission Effectiveness Committee directive, internal stakeholders worked to fashion the Health Services Plan highlighting efforts undertaken in partnership with State, County, and other partnering organizations to address our population’s needs. The objective was to design and facilitate actions that are continuous over time, measurable and that both leverage and complement our relationships with our partnering organizations. Our work in the coming year will also include embedding our initiatives deeply into our day-to-day operations.

## **B. Process and Development**

Last year concluded the second year of the inaugural Health Services Plan’s Advisory Council during which the Plan emphasized community assessment. To develop this year’s Plan, small workgroups met focusing on the identified health issue/performance areas. Comprised of a mix of HCMC content experts and representatives from the Planning Department the internal workgroups met on three occasions over a two-month period, including a partnership workgroup meeting in which the internal workgroup hosted two – five representatives from our partnering organizations.



The Plan’s development amidst a backdrop of a confluence of complex forces – reform, rising costs, economic recession, and budget cuts - has caused us to recognize that the breadth and depth of our programs must be calibrated to the funding resources available to us.

## **IV. HCMC/HHS Overview**

Hennepin County Medical Center/Hennepin Health Care System, Inc. has a proud history of service, and today maintains excellence and quality that is recognized nationally. It is a public teaching hospital that is an important statewide resource, and the linchpin of the health care safety net in our region.

A safety net hospital is defined as: *“A hospital or health system that provides a significant level of care to low-income, uninsured, and vulnerable populations. It is distinguished by its commitment to provide access to care for people with limited or no access to health care due to their financial or insurance status or health condition.”*  
(National Association of Public Hospitals)

HCMC/HHS exemplifies the best public teaching hospitals in the nation: responsibility for care of the indigent; a strong educational emphasis; an extensive highly developed ambulatory care system; a large number of severely ill patients; an urban setting; commitment to clinical research and innovative program development. Our Mission, Vision and Values statements:

### **Our Mission**

We are committed:

- to provide the best possible care to every patient we serve today;
- to search for new ways to improve the care we will provide tomorrow;
- to educate health care providers for the future; and
- to ensure access to healthcare for all.

### **Our Vision**

We are committed to being:

- The best place to receive care;
- The best place to give care; and
- The best place to work and learn.

### **Our Values, Beliefs, and Promises**

We believe every person has dignity and worth; therefore  
*we treat our patients, their families and each other with integrity, compassion, and courtesy, and respect.*

We believe affordable health care should be available to everyone; therefore  
*we work efficiently, minimize waste, and take personal responsibility for the stewardship of our limited health care resources.*

We believe we are at our best when we work as a team; therefore  
*we work in collaboration to provide safe, effective, timely and equitable care, always keeping the patients needs our highest priority.*

We believe our future will be secured by investing in the potential of our staff; therefore  
*we support learning that leads to personal growth, opportunities for advancement, and improvement in our organization.*

## **A. Comprehensive Array of Services**

Hennepin County Medical Center/Hennepin Healthcare System, Inc. (HCMC/HHS) provides access to a full range of health services while striving to assure no one is denied care for lack of financial resources. This accessibility regardless of the patient's ability to pay is achieved through the use of a sliding-fee charge schedule and charity care policy.

HCMC/HHS is a comprehensive health system, providing trauma and emergency care, critical care, maternity and pediatric care, chronic disease management, mental health services, rehabilitation, and other primary care.

Sites of service include pre-hospital transport and inpatient and outpatient settings. The scope of services HCMC/HHS has been developed based on:

- a) needs of the community,
- b) abilities and capacities of the health professionals in our system,
- c) volume of demand that facilitates proficiency and efficient use of resources, and
- d) awareness of the roles and programs of other health care service organizations.

The Twin Cities today are host to several large not-for-profit hospital systems and other independent hospitals. Although there are similarities among the hospitals, there are mission, clinical service, and geographical distinctions that make Hennepin County Medical Center unique, including:

- A Level 1 Trauma Center providing 24/7 emergency services and the State's busiest emergency room;
- A comprehensive array of inpatient services, including critical care medicine: medical, surgical, burn, pediatric, and newborn intensive care units;
- The largest volume of hospital services provided to persons who are uninsured or enrolled in Minnesota Public Health Care Programs, i.e. more than 20% of the statewide total;
- As a function of its "treat-first" policy, Hennepin County Medical Center sees more than 40,000 uninsured persons for more than 140,000 occasions of service each year;

- An extensive array of primary care and specialty clinics, with more than 350,000 encounters annually;
- Culture-specific sensitivity, including support services such as interpreters, care coordinators, social workers, etc.

A listing of services provided at Hennepin County Medical Center is included in Appendix. During 2008 and 2009, HCMC/HHS provided service to patients from each of the State's 87 counties.

The HCMC/HHS active medical staff is comprised primarily of the physicians of Hennepin Faculty Associates (HFA). HFA is an independent, nonprofit corporation of 300 physicians and dentists who provide professional services at Hennepin County Medical Center. HFA physicians and dentists (many of whom are known at a national level through their professional affiliations) provide and oversee care, teach physicians and dentists during their training, and pursue clinical and other health-related research through the Minneapolis Medical Research Foundation (MMRF).

## **B. Emergency Services, Critical Care and Disaster Preparedness**

Hennepin County Medical Center/Hennepin Healthcare System plays an essential role in providing for our region's capacity and capability to respond to day-to-day emergencies and preparation for potential disasters.

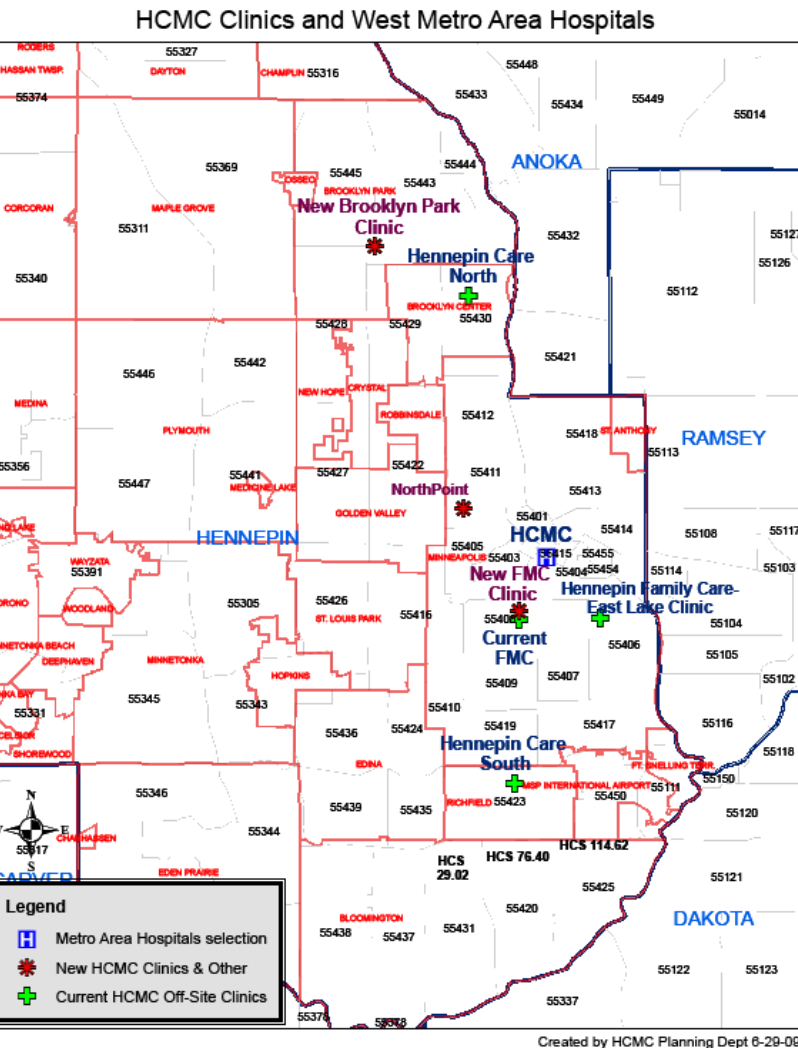
As a Level 1 Trauma Center, HCMC is equipped to handle any level of severity of trauma, with staff and services onsite and ready at all times for trauma and other acute care needs. HCMC was the State's first Level 1 facility, and is celebrating its 20<sup>th</sup> anniversary of formal designation.

Emergency Department and Express Care patient visits numbered more than 101,658 in 2008, and there were 57,000 ambulance runs. Board certified Emergency Medicine physicians provide 24-hour coverage and out-state emergency consultation. Nurses receive and participate in teaching specialized training in handling trauma and medical emergencies.

Hennepin County Medical Center is an integral part of Minnesota's Statewide Trauma System providing service and education emergency trauma care including the training of hundreds of police, sheriff, and fire department "first responders," ambulance and air-link crews, and emergency department health personnel from throughout Hennepin

County and all across Minnesota. HCMC/HHS also conducts on-site training at the request of rural hospitals and clinics. HCMC/HHS has established relationships with other designated trauma centers and emergency departments in Greater Minnesota. The goal is to provide services and equip healthcare professionals with resources and educational opportunities to assure that all patients receive state-of-the-art trauma care.

HCMC/HHS' central role in disaster preparedness is also vital to the community. As a Regional Hospital Resource Center, HCMC/HHS leads the state-wide coordination of hospital responses to emergency events. As a Global Migration and Quarantine Facility, HCMC will treat the first cases of any unknown infectious



disease that may arrive in the Twin Cities area. Together with local public safety agencies and other public and private health organizations, HCMC/HHS is part of the Metropolitan Response System, prepared to respond in a coordinated, highly effective way to any incident in which there are a large number of casualties to be treated. This year HCMC/HHS has participated with the Minnesota Department of Health and other provider organizations to anticipate, inhibit, and respond to the H1N1 influenza outbreak we have seen this fall.

## **C. Education of Health Professionals**

Public hospitals are special places that help the underserved and provide comprehensive and unique services for the general population. In addition to primary care and routine patient services, teaching hospitals also are centers for innovative and technically sophisticated services. Thus, these teaching hospitals are essential not only because they are the “classrooms” for physicians, nurses, and other health professionals, but also because they are the sites from which new therapies, surgeries, and technologies to treat and cure patients often emerge.

Hennepin County Medical Center/Hennepin Healthcare System, Inc. is a premier teaching hospital and clinic system. From the training of tomorrow’s doctors, to ensuring physicians throughout Minnesota remain current on the latest medical advances, HCMC/HHS has long been and continues to be a nationally recognized public health system and medical education resource.

The U.S. health care system relies on public teaching hospitals and their clinics and emergency departments, free-standing ambulatory care centers, chronic care facilities, hospices, and individual or group practices for service to vulnerable populations and the clinical education of physicians and other health care professionals. Thus, medical schools and teaching hospitals have formed a dynamic partnership for health care, clinical education, and research application. The medical school is the intellectual home for these professionals, but the teaching hospitals like HCMC are the setting for interaction with patients and the transformation of laboratory findings to patient therapies.

In concrete terms, at HCMC/HHS, our faculty and staff:

- Provides more care to Minnesota Health Care Program (MHCP) recipients and the uninsured than do our non-teaching hospital counterparts; nearly 50% of HCMC/HHS’ volume is provided to low-income populations. HCMC/HHS is the State’s largest provider of service to the poor – by a substantial margin;
- Treats the counties and regions more severely ill patients – such as those referred from other hospitals and those requiring extensive support services;
- HCMC/HHS physicians and alumni are integral to the region’s emergency preparedness and stand-by capacity;
- Provide many specialized inpatient and outpatient services such as organ transplantation, intensive neonatal care, oncology services, and sophisticated reconstructive surgery to the region’s population; and
- Facilitates the transition of new services and technologies into the mainstream and raise our regional standards.

As a major provider HCMC/HHS helps to meet the health care needs of the state and region as well as Hennepin County. A majority of HCMC/HHS's newly graduating physicians have chosen to establish their medical practice in the State of Minnesota. This ongoing retention of HCMC trained physicians in Minnesota helps to ensure that the state's increasingly diverse and growing population is able to draw upon highly qualified physicians who are well trained in diagnosing and appropriately treating people of varied backgrounds and cultures.

We estimate more than half of the practicing physicians in Minnesota have received graduate or post-graduate training at HCMC/HHS. Currently, there are 290 resident and fellow physicians and approximately 90 medical students in training at HCMC. In 2008, 758 residents trained in whole or part (clinical rotations) at Hennepin County Medical Center. Sixty to Sixty-five percent of physicians graduating from HCMC/HHS' residency programs establish practice in Minnesota.

In addition to physicians, HCMC/HHS educates students in a multitude of allied health professions, including nursing, laboratory and imaging technicians, emergency medical technicians, paramedics, and other first responders. With more than 100 education contracts in place, and affiliations with more than 60 Minnesota schools and colleges, HCMC/HHS annually trains over 1,800 students in any given year in over 50 health professions.

## **D. Safety Quality and Outcomes**

Health care should be safe, timely, effective, efficient, equitable and patient-centered, thus improvement efforts should support these six aims as identified by the Institute of Medicine. In an effort to support these aims fully, the Institute of Medicine has identified new principles and rules or features of healthcare including:

- Safety is a system property versus an individual's responsibility
- Transparency versus secrecy
- Anticipation of needs versus system reacts to needs
- Decrease waste versus cost reductions sought
- Cooperation among practitioners versus preferences given to professional roles

Performance improvement is supported by a culture of continuously measuring, assessing and initiating changes to improve outcomes.

The oversight and infrastructure to assure performance includes:

- Hennepin County Board of Commissioners
- Hennepin Healthcare System, Inc. Board of Directors
- Interdisciplinary Quality and Safety Committee
- Medical Executive Committee
- Medical Staff Quality Committee
- Performance Measurement and Improvement

HCMC/HHS again received 3-year Joint Commission accreditation last year. We continue to achieve clinical excellence, as demonstrated by our consistently superior risk-adjusted observed-to-expected mortality rates and many clinical service specific measures (e.g. door-to-balloon time for cardiac intervention). Our dashboard of quality indicators is reported each month to the Hennepin Healthcare System, Inc. Board. Overall performance improvement goals and objectives are widely distributed and available to our leadership to assure continued focus on the most vital of our imperatives.

## E. Community Benefit

Hennepin County Medical Center plays a vital role in the overall health status, health service, and stand-ready capacity for the community and region. This role is comprised of a wide and varied range of far-reaching benefits to the community that include the cost of uncompensated care, health outreach, education, research, and government underfunding.

Hennepin County Medical Center is a vitally important economic entity in the region, as an employer and purchaser of goods and services:

- Full-time equivalents (2008) 3,917
- Wages – benefits (2008) \$338 million



**Hennepin County Medical Center/Hennepin Healthcare System, Inc.  
Benefit and Contributions to the Community**

	<b>2008</b>
Charity care and discounts offered to uninsured	\$18.3 million
Costs in excess of Minnesota Health Care Program payments	\$40.1 million
Education and Workforce Development	\$11.3 million
Community subsidized health services, community building and other community benefit costs	\$1.7 million
Medicaid surcharge and MinnesotaCare taxes	\$9.5 million
<b>Total Cost of Community Benefit</b>	<b>\$81.0 million</b>
Costs in Excess of Medicare Payments	\$42.5 million
Other Care Provided Without Compensation (e.g. bad debt)	\$56.1 million
<b>Total Cost of Contributions to the Community</b>	<b>\$179.6 million</b>
<b>HCMC/HHS Community Contribution as Percent of Total Expenses</b>	<b>33%</b>

In recognition of the transition from governance by the Hennepin County Board in 2007, the operating agreement between Hennepin County and the Hennepin Healthcare System, Inc. includes a volume-driven formula wherein the County will provide payments to HCMC/HHS to help cover a portion of the indigent care costs for Hennepin County residents. The principles underlying the agreement have been observed in 2008 and 2009 and will continue to be applied in 2010.

**V. Public Policy and Advocacy**

The ability of HCMC/HHS to fulfill its historic mission is a function of not only the commitment of the staff, but also the willingness of policy makers and funders to support our mission. While the direction of health care reform includes a commitment to expand the eligibility for those on public programs, the State of Minnesota has actually embarked on a different course with the elimination of funding for the General Assistance Medical Care (GAMC) program.

The efforts of HCMC/HHS' leadership and health service planning staff has therefore been adjusted to spend more time on the public policy agenda. The principles and potential consequences that reflect our experience and perspective:

- Uninsurance is a fatal disease

- The termination of the GAMC program has created a crisis for at-risk Minnesotans and the provider organizations that will be asked to serve them
- Without health care coverage, hospital emergency departments (particularly at HCMC/HHS') become the default coverage plan
- An underfunded safety net is the pathway to cost shifting to employers and property tax payers
- A crisis at the safety net institutions will immediately impact the poor, but will also impact access to health care for the middle class as the scope and capacity of services become more limited and fewer health professionals are trained to meet growing demand
- HCMC/HHS is on-board with reform movements to transform our health care system, but without relief will have to focus on preservation strategies

In advocating for our public policy perspective, we have had a series of meetings with elected officials, representative of State of Minnesota administrative departments, other providers and the public at large as we have attempted to bring forward public policy perspectives that are consistent with our approved legislative program. We believe it is important to expand coverage (universal coverage is the ultimate goal) and support organizations that provide care to those who would otherwise be denied accessible, patient focused care. Based on these interactions, and in view of the peril that HCMC/HHS faces, we have ventured the following concepts:

- GAMC/MinnesotaCare redesign
- Risk-gain sharing arrangements as accountable care organizations/partnerships for those currently or about to become uninsured
- Demonstration projects to develop innovative care models for specific patient populations. For example, we have engaged Hennepin County's Human Services and Public Health Department for evaluation of concepts for a next-generation Assured Access Program for Hennepin County's uninsured residents

If health care coverage is not restored, of necessity we will advocate for funding mechanisms that can be broadly applied and would offer sustainability for safety net providers. Our development of these concepts has been in concert with other health care provider organizations (such as Regions and Minneapolis Children's), the Minnesota Hospital Association, the Minnesota Departments of Health and Human Services, the Safety Net Coalition (which includes the United Way, the Minnesota Association of Community Health Centers, the Minnesota Association of Mental Health Centers, the Minnesota Visiting Nurses Association, Portico, Hennepin Faculty Associates, Neighborhood Health Care Network, Regions Hospital, St. Mary's-Duluth (clinic), and others).

Concerned stakeholders include those outside the health care industry. The GAMC Alliance (which includes the Association of Minnesota Counties, Minnesota Coalition for the Homeless, National Alliance on Mental Illness, faith-based organizations, organized labor, Take Action Minnesota, and others) has been formed as a means to expand the awareness and educate the public at large as to the likely consequences if there is no reversal to the GAMC coverage termination.

## **VI. Health/Performance Areas Priorities**

The Governance and Mission Effectiveness Committee of the Hennepin Healthcare System, Inc. confirmed that this year's Plan should continue to focus on the areas identified and prioritized by the work of the Health Services Plan Advisory Council in 2008.

These issues or performance areas are:

- Primary Care Access
- Health Disparities (with sensitivity to native-born minorities and immigrant populations)
- Mental Health
- Workforce Development and Diversity

### **A. Primary Care Access**

#### **1. Access: Issue Summary**

Access to health care is important to increase the quality and years of life for everyone, and to help reduce health disparities. Primary care is an important part of the health services continuum which can address part health promotion, preventive care, and a medical home that patients can use as an ongoing resource to maintain their health and mitigate against the onset of more serious conditions. 14.46% of Hennepin County's population is residing in designated Medically Underserved Areas (a Federal designation for areas that have low rates of providers per capita, high infant mortality, high poverty and/or high elderly populations).

#### **2. Causal/Contributing Factors**

Access to primary care is problematic for a number of reasons, including:

- A national and statewide shortage of primary care providers.
- Geographic distribution of providers, relative to the population.

- Lack of affordability for many persons due to inadequate financial resources or health care coverage.
- The challenge for some individuals and population segments to navigate in a timely and effective manner to primary care delivery sites and/or a medical home.

### 3. Actions and Implementation, 2009

The actions proposed in last year’s plan were directed toward the goals of (1) expanding and improving access to our system, (2) improving the efficiency and effectiveness of our system, and (3) transforming our care model, in step with the interests of our patients and the trajectories of health care reform. We can report accomplishments toward these goals.

#### a) Expand Primary Care Capacity

HCMC/HHS is building primary care capacity. This includes work on improving throughput in our existing operations, and expansion of our clinic space at our Hennepin Care East, Hennepin Care North, and Hennepin Care South community clinic sites. Staff is being recruited to enable HCMC/HHS to achieve 8% year-over-year growth in primary care visits. Hours of operation have been extended at the HCMC Pediatrics Clinics (evenings and Saturdays). HCMC/Hennepin County has also committed to and broken ground on a replacement facility for the Family Medical Center and a new clinic in Brooklyn Park.

Our clinic visits at primary care sites:

<b>Clinic Visits</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009 YTD</b>	<b>2009 Annualized</b>
<b>Downtown Primary Care:</b>		106,425	107,188	77,046	107,738
▪ Medicine					
▪ Pediatrics					
▪ Ob-Gyn					
<b>Family Medical Center</b>	49,153	50,092	46,261	33,520	44,693
<b>Hennepin Care East</b>	n/a	10,288	13,601	12,231	16,308
<b>Hennepin Care North</b>	15,934	16,937	14,787	15,740	20,987
<b>Hennepin Care South</b>	13,268	14,501	15,215	14,446	19,261

HCMC/HHS' walk-in capacity includes our Walk-In and Direct Access Clinics. In addition, we offer scheduled patient appointments, and have reduced the time to "3<sup>rd</sup> Next Available" scheduled appointment:

<b>3<sup>rd</sup> Next Available Appointment</b> <i>(Measured in days—3<sup>rd</sup> next available deemed the appropriate measure, so that any one appointment cancellation is not able to distort the measure)</i>	<b>2008</b>	<b>2009 Q1</b>	<b>2009 Q2</b>
▪ Medicine	45	33	33
▪ Primary Care	13	9	10

In addition to building physical capacity, HCMC/HHS' Contact Center, now in its second year of operation, is enabling scheduling to run more effectively than ever before. Our Contact Center performance measures have slipped only minimally while our call volume has increased by 61%.

<b>Call Volume</b>	<b>2008</b>	<b>2009 Q1 – Q3</b>	<b>2009 Annualized</b>
▪ Total Calls	250,500	303,395	404,527

<b>Calls answered within 60 seconds</b>	<b>2008</b>	<b>2009 Q1</b>	<b>2009 Q2</b>
▪ Medicine	87.4%	86.6%	83.3%
▪ Primary Care	81.5%	83.3%	81.8%

<b>Call Abandon Rate</b>	<b>2008</b>	<b>2009 Q1</b>	<b>2009 Q2</b>
▪ Medicine	2.5%	5.0%	5.2%
▪ Primary Care	4.6%	6.2%	6.4%

Recognizing that access is also a function of patients' willingness to pay, HCMC/HHS continues its sliding fee admission policy. HCMC/HHS is the largest provider for Hennepin County's Assured Access network, which has grown from 9,000 enrollees in 2004 to more than 24,000 currently. And, HCMC/HHS has become a sponsor of the Portico program, which provides enrollees primary and preventive health for uninsured.

b) Improved Efficiency

HCMC/HHS has been engaged in extensive "Leaning" to enhance the efficiency of the clinic operation. "Lean" is a process improvement philosophy that engages and teaches

staff across all areas and levels of an organization to use a standard set of tools to identify and remove systems inefficiencies with the ultimate goal of increasing value for the customer, our patients. Lean process improvement teams use these tools to identify and illuminate waste in an organization; the tools also provide a foundation for continuous process improvement.

Several of our Lean Rapid Process Improvement Workshops (RPIWs) have resulted in sustained improvements to our efficiency (and subsequently improve primary care access). Representative samples include:

**Hennepin Care South Clinic – Optimizing Provider Time**

Two RPIWs at Hennepin Care South Clinic examined opportunities to increase capacity, reduce patient wait time and reduce failed/cancelled patient appointments. Improvements included:

- Optimization of patient flow through implementing a standard rooming process (vitals, height/weight, medication updates, etc.)
- Development and testing of a personalized template for provider schedules based on demand calculations

**Appointment Scheduling**

Efficiencies flowed from a project focused on improving the scheduling process.

- The RPIW Team streamlined scheduling guidelines and standardized them for use across our services
- Preliminary sampling suggests opportunity to achieve 12% reduction in appointment scheduling time and a reduction in the error rate by 27%
- These efficiencies will achieve up to a 50% increase in capacity for our Contact Center to schedule patient appointments

**Eliminate Waste and Create Process Improvements Around Interpreter, Social Work, and Financial Services**

Access to Interpreter Services: Approaches to eliminate inefficiencies in excessive wait times for patients, providers and interpreters when a patient is in need of interpretive services. The Lean Team discovered that interpreters wait up to 53% of their time waiting to interpret. Among the changes implemented:

- Creation of a “Waterfall” schedule which matches up patient demand with the appropriate number of interpreters
- Trials on the use of a mix of face-to-face and phone interpreting to cut down on both interpreter wait time and patient/provider wait time

Social Work and Financial Counseling Departments:

- The Lean Team identified 14 patient needs and created standard work to use to direct patients to the appropriate service
- The Lean Team improved access to social workers through the creation and piloting of a new communication “Social Worker Pool” in Epic that enables clinics to indicate the need for a social worker

c) Care Model Redesign

Care model ideology is perpetually evolving at HCMC/HHS. One major initiative at HCMC/HCMC has been preparation for the Primary Care Coordination project, launched in 2009 wherein we provide a health care home to an enrolled population. Patients eligible are those in the Medical Assistance fee-for-service program with five or more chronic conditions. HCMC/HHS is a certified “Health Care Home” provider at three of our primary care sites: Medicine Clinic, Pediatrics Clinic, and Hennepin Care East.

A second focus of our work has been to improve the care of diabetic patients. Diabetes patients are seen throughout our system, in primary care and specialty care sites of service.

**HCMC examined the delivery of Diabetic Care, which has resulted in standard work in four areas of diabetic care:**

- Created enhanced role definitions for each member of the care team
- Created pre-visit planning standards including a pre-visit questionnaire and a process for completing all tests before the patient’s appointment with his/her provider
- Optimized Epic tools to support providers in diabetic care
- Determined a need to add 8 elements to the community standard (recognizes 5 (D5)) for assessment to effectively care for diabetic patients

Ultimately, by standardizing our practice, we anticipate improvement in the quality of care for diabetic patients (see appendix for selected indicators for diabetic patients, by cultural/ethnic background).

A key indicator in our assessment of our effectiveness is our patient satisfaction scores. Our results for our patients in all of our primary care clinics show a high degree of satisfaction, though we continue to strive for continuous improvement:

<b>Patient Satisfaction Metrics: Primary Care</b>	<b>2007</b>	<b>2008</b>	<b>2009 TYD</b>
▪ Likely to Recommend	86.2%	88.5%	88.3%
▪ Overall Score (“Very Good” and “Good”)	86.3%	86.2%	86.4%

**d) Collaborations**

The 2009 Plan cited proposed actions that are directed toward improving the public’s health through collaborations with other human service and public health entities. Collaborative endeavors have generally focused on work dedicated toward improving the health of all Hennepin County residents, rather than targeted specifically to remedy disparities within particular segments. These include:

- Continuing engagement with the Hennepin County Public Health Advisory Committee which has successfully secured a grant from the State Health Improvement Program, as part of the State’s health care reform implementation.

- Preparation for seasonal and H1N1 influenza collaboration with Hennepin County's Public Health, the Minnesota Department of Health, and the Minnesota Hospital Association.
- Primary Care Access Initiative: Process to find primary care homes for patients receiving care in the HCMC/HHS Emergency Room, in concert with the Indian Health Board, Community University Health Care Center, Fremont Clinic, and North Point
- Coordinated Care Network: Diabetes patient management, with North Point
- Epic (electronic health record) roll-out to: Hennepin County Human Services and Public Health Department, North Point, and Cedar-Riverside People's Center, with implementation at other sites underway
- HCMC/HHS has devised and continues to expand and improves systems to address the root causes of disparities, particularly those related to communications – through the use of interpreter services and training in cross-cultural communications for providers and staff
- Engagement in the Heading Home Hennepin initiative, which will include dedicated resources for discharge planning for the homeless.
- Participation in Hennepin County efforts to explore the feasibility of a medical respite service site for the homeless.
- Engagement with Hennepin County's Human Services and Public Health Departments for evaluation of concepts for a next-generation Assured Access program, as might be necessitated by the termination of the General Assistance Medical Care program.

#### 4. Proposed Actions for 2010

We aspire to provide increased access to primary care and continue to improve the patient experience. Our ability to do so will be defined in part by the public policy and legislative developments that have occurred in recent years. The termination of the General Assistance Medical Care program and other revenue reductions suffered by HCMC/HHS will require HCMC/HHS to calibrate the breadth and depth of our clinical programs – including primary care – to our financial wherewithal. Among the issues we will address is restricting the access to our primary care system for patients who reside in other counties, as a means to preserve access for Hennepin County residents.

Our current staffing plans include the addition of physicians, nurse practitioners, and physician assistants to accommodate year-over-year growth of 8% in primary care visits. This will enable us to maintain all current sites and staff the Family Medical

Center replacement clinic in South Minneapolis and the Brooklyn Park Clinic, both of which will open in late 2010.

Our goals and actions for the coming year include:

- Year-over-year growth of 8% in primary care clinics
- Conduct study to determine value and opportunity of conversion of HCMC/HHS' primary care clinics to Federal Qualified Health Center (FQHC) status
- Continue our "Lean" work to achieve greater efficiency and patient satisfaction, including:
  - Reduce the gap relative to benchmark by 10% on the 3<sup>rd</sup> next available appointment
  - Standardize the patient rooming process and make other patient flow improvements to achieve standard of 10 patient visits per session and achieve 10% improvement in "very good" lobby and exam room wait time scores
  - Modify scheduling system to better match access and demand and leverage the effectiveness and efficiency to the Contact Center
- Continue care model transformation
  - Identify preferred practices and staff models through Primary Care Coordination pilot sites for system-wide Health Care Home roll-out
  - Implement *MyChart*, an Epic enhancement that will enable patients to view clinic appointment availability, their care plan, etc.
- Performance/Quality Improvement
  - Formalize the agenda for newly implemented Ambulatory Quality Committee
  - Develop infrastructure to improve reporting and identify patient conditions for focused improvement (i.e. replicate current efforts in diabetes care)

## **B. Disparities and Minority & Immigrant Populations**

### **1. Health Disparities: Issue Summary**

Health disparities among persons of varying socioeconomic status (e.g. income, education, race, and ethnicity) are a well-documented phenomenon in most countries of the world. Data show that profound health disparities exist in Minnesota.

Much of the work to redress health inequities lies beyond the health care service sector. Genetics, behavior, and the classic social determinants of health are all fundamental to the disparities reflected among the cultural/ethnic groups that we serve.

With this context in mind, HCMC is committed to do its part to address the issue.

Racial and ethnic minorities continue to lag behind Caucasians in health status in Minnesota. Racial and ethnic minorities in general experience a greater incidence of chronic disease and higher mortality than Caucasian Americans in younger age cohorts. At HCMC/HHS, 60-65% of services are provided to persons belonging to racial and ethnic minorities. These disparities exist among our American-born racial segments, and the magnitude of the disparities issue becomes even more pronounced as our immigrant population increases.

The number of immigrants in Minnesota continues to increase. During the 1990s, there were 118,700 foreign-born, documented immigrants. From 2000-2006, the pace of immigration increased, as there were 112,300 new immigrants. The health status of the immigrant population is a major concern. Many immigrants arrive in Minnesota with one or more health problems, and both the stress of immigration itself and exposure to new risks in Minnesota (e.g. diet, isolation) can threaten health status.

### **2. Causal/Contributing Factors**

Among the factors cited nationally and regionally that contribute to racial and ethnic disparities, among native-born minorities and immigrant populations include:

- Unequal access to health care services
- Poverty
- Health care seeking behaviors (e.g. delays because of reluctance to approach the health care system)
- Cultural and linguistic barriers and isolation
- Clinical uncertainty and limited information available to health providers that result in disparities in treatment
- Unequal access to health care services

Factors that are impediments to securing care particularly for the international population include difficulty knowing how to approach and navigate the health care system, challenges in literacy and the English language, fear of institutions (perhaps due to experience in their homelands), clinical uncertainty and limited information available to providers that result in disparities in treatment.

### 3. Actions and Implementations, 2009

HCMC/HHS is the community's most essential health care provider in the quest to remedy disparities among racial/ethnic/cultural populations. The thread of health disparity reduction and immigrant health runs through all performance areas – it influences our approach to the delivery of culturally sensitive primary care, initiatives to recruit and retain a diverse workforce that reflects and understands our patient population, efforts to meet the unique and often complex mental and behavioral health needs of the newly arrived immigrants, our active engagement with the broader community and our efforts to educate and develop the state's future physicians and allied health workers. Hennepin recognizes addressing health equity as not only a social justice and moral issue but as an essential component of quality care and our community benefit principles.

Approximately 20% of our patients were born in other countries. Over 140,000 times a year, HCMC/HHS calls on interpreters, fluent in 50 languages, to help patients at a cost of over \$3 million a year. Latinos, both documented and undocumented, make up the largest immigrant group in the state, as well as in the nation. But since the late 1970s, Minneapolis has also been taking waves of legal refugees from such diverse countries as: Vietnam, Cambodia, Laos, Thailand, Burma, Belarus, Bosnia and Herzegovina, Liberia, Ethiopia, Nigeria, Ghana, Somalia, Myanmar and others.

The very existence of HCMC/HHS, with its mix of clinical programs, social and support services and its dedicated staff are all testimony to the commitment to enhance the status of any/all cultural and ethnic segments of our population. To that end, while health disparities continue, we believe those gaps would be undoubtedly be greater if not for HCMC/HHS.

Shown below are two of the proxy measures of activity that reflect our work with the immigrant community we serve. Interpreter visits, year-to-date have increased by 15%, and visits to our International Clinic by 29%.

	2006	2007	2008	2009 Q1-Q3	2009 Annualized
Interpreter Services, Visits	121,450	118,427	126,949	109,097	145,463
International Clinic, Visits	1,927	1,653	1,694	1,643	2,191

The 2009 Plan cited the intent to develop an infrastructure to enable us to track patients and track quality measures by race and ethnicity. We anticipated leveraging the work conducted by the Center for Urban Health and the evolving Knowledge Management infrastructure at HCMC/HHS. Circumstances have slowed infrastructure development, though we have established a framework and are specifically monitoring our performance on diabetes measures across ethnic groups (Appendix). HCMC/HHS administers Press Ganey patient satisfaction surveys in five languages and has begun to stratify results by race and ethnicity thus allowing for greater awareness and the opportunity for focused intervention.

Much of the work cited in the “Access’ performance area is intended to improve the health of all Hennepin County residents, rather than to be targeted specifically to remedy disparities within particular segments.

Focused initiatives, with sensitivity to the disparity challenges, include the Sage Screening Program at HCMC/HHS (described in the Appendix). In addition, our stakeholder engagement work included meetings with staff supporting the Centering Pregnancy and Aqui Para Ti programs.

Aqui Para Ti (Here for You) (APT) is located at Hennepin Family Care East Lake Clinic, one of our community – based clinics. APT essentially functions as a health care home for comprehensive and systematic, integrated, culturally competent primary care. The program has as its objective, “to provide comprehensive care in a safe and confidential environment for youth (ages 11-24) and their families, simultaneously helping teens and parents address their individual and common needs.” The underlying premise is that incorporating the core values of the (Latino) population served into organizational practices will improve health care outcomes. Aqui Para Ti offers a continuum of medical services throughout a teen’s life including health education, mental health assessments and referrals to therapy, counseling, education for parents, coordination of services and referrals to community resources as needed. The APT interdisciplinary team is comprised of a physician, health educator, social worker/therapist and coordinator of services. Through an intake questionnaire, the APT team identifies protective and risk factors to determine the need level of the patient and to define a plan for prevention and intervention. Utilizing the patient care plan, APT focuses on providing care, connecting the patient with culturally appropriate resources and assisting family in navigating the system. HCMC/HHS has provided in-kind support for the program and is assisting in the quest for the continued grant funding from a variety of sources.

#### 4. Proposed Actions for 2010

HCMC/HHS’ goals and actions for 2010:

- Data collection and reporting:

Implementation of HCMC/HHS' Knowledge Management strategy is already underway. Optimization of the benefits of the strategy requires work process modification through the full continuum from data collection at initial patient contact through data reporting to permit evaluation of demographics, health outcomes, and patient satisfaction by race, ethnicity, and cultural heritage. We anticipate maintaining current levels of support for Knowledge Management in the HCMC/HHS 2010 operating budget.

- Care model transformation and the development of HCMC/HHS' primary care sites as health care homes.

We will provide patient-centered by "home" teams, including providers, care navigators/community health workers and other staff as needed. HCMC/HHS' work in health care home development will include development of strategies to address cultural and linguistic barriers to care. Scheduling for the roll-out for health care homes, and enrollment targets, is a work in process, building upon our learnings from the Primary Care Coordination (PCC) pilot sites.

- Coordination with other health care and human service provider organizations

To date, HCMC/HHS has worked with community partners in enabling the continuity of care through communication (Epic, Contact Center, Hennepin Connect) and the advocacy agenda. As we continue to see reduced funding streams, HCMC/HHS will resume formal activities to build on the Urban Health Network framework (referenced in HCMC/HHS' Strategic Plan and last year's Health Services Plan) as the financing trajectories have created an imperative for a more rational system of care. Sites of services and program offerings will be developed with sensitivity to patient needs and also acknowledgement that reduced services will necessitate "partnering" relationships that optimize stewardship of scarce resources.

## **C. Mental Health**

### **1. Mental Health: Issue Summary**

Mental health is defined as a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity.

Mental illness refers to all mental disorders: conditions that are characterized by alternations in thinking, mood or behavior associated with stress and/or impaired functioning. Mental illness can be serious and persistent or episodic.

Both mental health and illness are inextricably linked with social and economic forces and trends within the community, as well as with individual and family physical health status.

### **2. Causal/Contributing Factors**

Mental illness continues to be a pervasive detriment to the overall health of our region – among the reasons:

- Mental health status is the outcome of an extremely complex assortment of factors, both individual and communal. Mental health is partly an individually-based experience, but is also intimately impacted by family, community, and economic factors.
- Within the current care paradigm, mental illness is treated differently than other health conditions. It is administered as a special service, resulting in stigma and underfunding compared to health care services.
- Public mental illness services are often fragmented into many different programs, and funding streams and services vary by locality, making it difficult to understand and navigate the system.
- Roles and accountability of the state, counties, health plans, non-profit agencies and mental health providers are not clearly defined.
- Shortages of mental health professionals and gaps in the service continuum.
- Few incentives for prevention, early intervention, and effective management of mental illness, with access/funding often not available until mental illness becomes serious and persistent.

### 3. Actions and Implementation, 2009

HCMC/HHS and our physician partner (Hennepin Faculty Associates) provide a comprehensive continuum of care for acute and ongoing care for mental illness. HCMC/HHS' program includes round-the-clock Acute Psychiatric Services (i.e. crisis), inpatient care (102 beds) partial hospitalization, day treatment, and clinics (adolescent at HCMC; adult at HFA).

HCMC/HHS is recognized for its ability to diagnose and treat the most complex disorders and the capability to diagnose and treat patients that have severe medical co-morbidities.

The HCMC/HFA providers are known to be leading-edge educators and health service educators and researchers as well as excellent, compassionate clinicians.

This year's Plan cited our intent to continue to provide the full spectrum of services. We have historically been able to do so while retaining similar capacity levels.

#### **Volume of Service**

	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009 Q1-Q3</b>	<b>2009 Annualized</b>
Inpatient psychiatry discharges	1,775	1,514	2,101	1,935	2,580
Inpatient beds available	87	87	102	102	102
Psychiatry Residents (trainees)	20	23	26	27	27
Child/Adolescent clinic visits	2,992	2,849	3,049	2,520	3,360
Adult clinic visits (HFA)	26,193	24,114	25,999	19,752	27,337
Service Units, Day Treatment	33,873	34,084	35,889	26,169	34,892
Service Units, Partial Hospitalization	10,414	11,376	11,889	8,509	11,345
Acute Psychiatric Services, visits	11,082	10,148	10,474	7,765	10,353

HCMC/HHS has historically reported information to the Minnesota Department of Human Services (DHS) through the Community Mental Health Reporting System. HCMC/HHS began to also report information through the Program Outcomes Status Report in the 4<sup>th</sup> quarter of 2008. The objective of the Program Outcomes Status Report is to provide the provider institution feedback with respect to how patients/clients are doing through their episode of treatment. The Program Outcomes Status Report program provides data that is able to provide information to provider sites with respect to the efficacy of the day treatment program.

Preliminary findings are very encouraging:

	<b>Frequency (in preceding 90 days)</b>	
	<b>Before Treatment</b>	<b>After Treatment</b>
<b>Number of times homeless</b>	62	35
<b>Homeless nights</b>	3,859	2,360
<b>Number of times incarcerated</b>	12	6
<b>Number of incarcerated days</b>	281	49
<b>Inpatient admissions</b>	146	64
<b>Inpatient days</b>	3,100	1,418

We have continued to participate in the state-wide inpatient bed tracking system (through the Minnesota Hospital Association).

HCMC/HHS has been a voice in the media and at the Capitol with respect to the growing need for mental health services. This includes recognition of the efforts to develop and subsequent approval of the Prairie St. John's facility for adolescent and child psychiatry care.

The Legislative session ended with reduced funding for State Operated Services. This has given rise to stakeholder engagement by the Department of Human Services (DHS); HCMC/HHS is participating in the process including the DHS sponsored meeting on October 6, 2009.

Our participation in Hennepin County's Metropolitan Health Plan (MHP) Preferred Integrated Network (PIN) pilot has been inhibited, in that the State has not awarded the contract to MHP; negotiations are continuing as of October 1, 2009.

Our pursuit of dedicated funding to ascertain outcomes/health status one year after discharge from the inpatient program did not survive the 2009 HCMC/HHS budget reduction process.

Our work in stakeholder coordination included intentional dialogue with Hennepin County's Mental Health Division and the Department of Human Services. The 2009 legislative session included reallocations in funding within State Operated Services, which has given rise to State Operated Services seeking to make modifications to the mental health system and enhances its efficiency. HCMC/HHS is participating in

Stakeholder Group meetings (e.g. October 6, 2009) to provide important perspective from HCMC/HHS as the front-line site of service most often sought for acute care intervention.

A second collaboration is the development of Integrated Dual Disorders Treatment Program. HCMC/HHS has launched the Integrated Dual Disorders Treatment (IDDT) program. The IDDT model is an evidence-based practice that improves the quality of life for person with co-recurring severe mental health services. The program, catalyzed by the Department of Human Services and committed providers, is being implemented with five goals in mind:

- Standardized screening and assessment
- Clinician training
- Promote and support provider collaboration
- Evaluate funding gaps
- Data collection

#### **4. Proposed Actions for 2010**

HCMC/HHS' plans for the coming year will be influenced by environmental factors, including demand for service, role(s), and programs of other providers, and health care program existence (and eligibility).

Of concern is the loss of the General Assistance Medical Care program (GAMC). It is estimated that 60% or more of the GAMC population are afflicted with mental illness, chemical dependency, or both. The termination of that program will likely increase the need for services at HCMC/HHS. The willingness and ability of the rest of the community to respond to this additional increment of the uncovered behavioral health afflicted population will impact the delivery modes and volume capacity at HCMC/HHS.

HCMC/HHS' mental health service goals for the coming year include:

- Maintain service volumes that parallel our system's capacity
- Implementation and documentation of the impact of the Integrated Dual Disorder Treatment program
- Implementation of telepsychiatry, as a means to provide 24/7 access to mental health providers and their patients via telemedicine
- Engage in the State Operated Services planning process to assure the perspectives of HCMC/HHS and its staff are incorporated as the State Operated Services staff engages in system redesign
- Refinement of outcomes reporting, e.g. Program Outcome Status Report, Global Assessment of Function

- Develop care model demonstration projects that will address coordinating care for the mentally ill with chronic medical conditions who are frequent users of hospital emergency rooms and in the absence of care coordination, often require inpatient hospitalization as their site of treatment

## **D. Workforce Development & Diversity**

### **1. Workforce Development & Diversity: Issue Summary**

The difficult economy has provided a brief respite for HCMC's staffing challenges, with applicants generally available for most open position. We expect this phenomenon to be short-lived, however, reverting to the longer term patterns we see.

The workforce is constantly changing as older people retire and younger people enter the workforce. Minnesota's health care industry is experiencing particular pressure in that: (1) as the baby-boom generation leaves the workforce between now and 2020, the health care industry will be competing with all other sectors of the economy for a smaller workforce generation, and (2) the aging of the entire population will increase demand for health care services, creating a need for more health professionals than ever before.

Health care service delivery is facilitated when patients and providers share backgrounds and values. Racial and ethnical similarity between patients and providers is associated with greater patient satisfaction, and greater compliance with treatment regimen.

### **2. Causal Contributing Factors**

The dilemma we face by the demographic trends cited above are further compounded by the following:

- At the national level, though U.S. medical schools are expanding their enrollments, little expansion is called for in Graduate Medical Education (GME) positions. Caps on the number of resident trainees imposed by Medicare (still the largest single funding agency for GME) restrict any expansion in the number of physicians.
- Given the high costs of medical education, there is a tremendous bias among new trainees to gravitate to procedural subspecialty oriented practices, which afford greater income opportunity than primary care specialties.
- Diversity in the employee and medical staff of HCMC/HHS tends to parallel that seen in our society as a whole and in health care enterprises:

- Leadership positions are often held by Caucasians with greater proportions of persons of color employed in positions available for the less skilled.
- Leadership positions typically require extensive formal education, which is a severe challenge to persons of color who are less likely to have the economic resources and support systems to obtain the necessary education.
- The high cost of education and the necessity to maintain paid positions often make it difficult for minority populations to train for health professional careers.

### 3. Actions and Implementation, 2009

HCMC/HHS is one of the State’s most essential institutions for graduate and clinical training for physicians and more than 50 other health care professions. A particular source of pride at HCMC/HHS is that a majority of the physicians and other health professionals trained at Hennepin continue to practice or are employed within the State of Minnesota. Sixty-seven percent of the 2008 graduating trainees have established practice in Minnesota. HCMC/HHS’ training programs include recognition of the need for more primary care providers. There are more than 125 physician trainees in primary care specialties at Hennepin County Medical Center/Hennepin Healthcare System, Inc. HCMC/HHS also has affiliations as the clinical site for nurse practitioner and physician assistant trainees.

The excellence of our teaching program continues. Virtually all of our residencies receive the maximum accreditation teams available. The Board Pass Rate for our program is 95%, compared to the national rate of 85%.

Our residency training program is providing opportunity to persons with diverse cultural backgrounds:

<b>Workforce – Physician Trainees</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
HCMC/HHS Resident – FTEs	271	274	290	TBD
Percent Female			38%	37%
Percent Non-Caucasian			43%	46%

The actions in last year’s plan with respect to our work in developing health professionals and establishing a diverse and inclusive work environment included policy objectives and operational endeavors.

Our policy work included ongoing collaborative discussions with the Metropolitan Minnesota Council on Graduate Medical Education (MMCGME). The MMCGME sponsored a visioning and strategic planning session conducted by the Association of American Medical Colleges that provides a framework for the MMCGME to develop its

multi-year graduate medical education plan. One of this year's MMCGME efforts is the establishment of a Legislative Advocacy Committee to bring knowledge and influence to federal and policy discussions regarding health professional training.

The scope of professional practice conversation during the past year included a focus on oral health, and has resulted in pilot studies to ascertain the efficacy of mid-level practitioners as a means to improve access to dental services.

We were able to obtain federal support for the development of the Hennepin Health Sciences Education Center as part of the 2009 Federal appropriations.

At HCMC/HHS there is a genuine commitment to building a workforce that identifies with our patients and their cultural heritage. HCMC/HHS also embraces "inclusion" which includes all elements of diversity and cultural competence and commits the hospital to create a culture that serves to unite and celebrate all employees rather than differentiate among groups.

Our overall employed staff has remained at comparable levels: 3,817 FTEs in 2008; 3,867 FTEs YTD in 2009. We continue to increase the relative proportion of minority employees:

<b>Workforce – HCMC Employees</b>	<b>2007</b>	<b>2008</b>	<b>2009 YTD</b>
Percent, Female	74%	74%	74%
Percent, Non-Caucasian	23%	24%	26%

HCMC/HHS' Organizational Development and Learning Department has provided a wide range of opportunities for employees' learning and growth. This includes our Emerging Leader and Leadership Academy (with the University of St. Thomas) programs that provide our emerging leaders (many of whom represent divergent cultural backgrounds) with knowledge, leadership tools and practical skills.

**Learning and Leadership Program**

*(includes Emerging Leader, Engaged Leader, and Leadership Academy)*

	<b>2009 Q1</b>	<b>2009 Q2</b>	<b>2009 Q3</b>
Attendance	363	260	190
Percentages:			
▪ Male	21%	21%	28%
▪ Non-Caucasian	31%	26%	35%

**Diversity Offerings**

*(includes language and cultural competence training)*

	<b>2009 Q1</b>	<b>2009 Q2</b>	<b>2009 Q3</b>
Offerings	105	22	35
Attendance	2,097	342	422

In general, the past year has not been one where vacant positions went unfilled for lack of candidates. That circumstance enabled us to direct our stakeholder coordination focus to two local efforts that speak to developing the health professional workforce with populations from diverse cultural backgrounds.

Our stakeholder coordination efforts include engagement with the Roosevelt High School Health Careers Program. Its mission is to provide educational opportunities to a diverse body of students interested in preparing for careers in health. Graduation rates for the program are between 90-95% compared to 60-70% for the overall student population. This year, HCMC/HHS identified 30 different topics and content experts, many of which became didactic and interactive sessions with the Roosevelt High School students. More than 50 Roosevelt students were employed at hospitals this summer.

A second endeavor to facilitate the development of tomorrow's diverse workforce occurs through our collaboration with Health Force Minnesota, a collaborative partnership sponsored by education, health care, and the private sector. Scrubs Camp is a program, held at Winona State University, introducing high school-aged campers to health-related fields including electroneuro-diagnostics, clinical laboratory science, nursing, emergency medical services, imaging and dental careers. A total of 112

campers attended Scrubs Camp this year. Seventy were sponsored by industry or community partners. Nearly half of the students were persons of color and nearly half were urban, with substantial representation from greater Minnesota. The camp experience included over 30 speakers and presenters, classroom learning with Winona State faculty, hands-on simulation experiences, and a hospital tours. HCMC/HHS sponsored six campers and provided one counselor. The camp, only in its second year, has been extremely successful in engaging young people with an interest in health careers as they explore their potential options in a college setting.

#### 4. Proposed Actions for 2010

HCMC/HHS' mission in education will continue through our collaborations with educational partner institutions and other health care providers. These relationships include our affiliation with the University of Minnesota, formal contractual relationships with approximately 60 other educational institutions and collaborations with the Healthcare Education Industry Partnership and Health Force Minnesota. Our work for the coming year will include:

- Continuation of our current scope of formal affiliations
- Execution of the HCMC/HHS Graduate Medical Education Work Plan for the coming year
- Assert our public policy perspective regarding the need to increase the health care professional workforce, particularly in the areas of primary care, mental health, and dental care providers, enabled in part by the Legislative Advisory Committee of the Metropolitan Minnesota Council on Graduate Medical Education
- Propose legislation to restore funding for our Family Medicine residency training program
- Finalize facility and financing plan for the Hennepin Health Sciences Education Center

HCMC/HHS is committed to creating a culturally competent and inclusive work and care environment where all employees and patients are treated with fairness, dignity and respect. Diversity and inclusion is a key initiative and integral part of the care we provide. We have identified the following four goals as we move forward with our work:

- Expand Leadership Diversity
- Provide culturally proficient patient care
- Strengthen workforce diversity
- Reflect the community we serve

Proposed initiatives include:

- Building in mentor/mentee into the current Emerging Leaders program
- Expand Diversity Council membership to include employees at all levels of the organization
- Create Career Pathways Program to allow employees to gain knowledge, skills and credentials necessary to move up in the organization
- Partner with external healthcare training programs to identify potential future diverse leaders in health care
- Continue diversity/inclusion training sessions
- Exploring Diversity E-learning module(s) implementation in 2010
- Establish measures to explore patient satisfaction in terms of culturally competent care provided by HCMC/HHS employees (this may be done via assessments or focus groups)

**APPENDIX**

- Hennepin County Medical Center/Hennepin Healthcare System, Inc. Services, 2009
- Diabetes Outcome Indicators and Data Stratified by Race
- Sage at Hennepin County Medical Center/Hennepin Healthcare System, Inc.

## **Hennepin County Medical Center/ Hennepin Healthcare System, Inc.**

### **Services – 2009**

*(\*Services often categorized as “safety net” services)*

- Acute Psychiatric Services\*
- Ambulance Service\*
- Anesthesiology
- Battered Women’s and Men’s Advocacy Services\*
- Birth Center
- Brain Injury Services
- Burn and Wound Clinic
- Burn Center\*
- Cancer Center
- Cardiology
- Cardiothoracic Surgery
- Center for Senior Care
- Chaplaincy\*
- Child/Adolescent Psychiatry Clinic
- Clinics
- Continence Center
- Continuing Medical Education (CME)
- Cytogenetics Lab
- Dentistry\*
- Dermatology
- Diabetes and Endocrinology Center
- Disaster Preparedness\*
- Diversity Program
- Donations, Organ and Tissue
- Education Department
- Emergency Department\*
- EMS Education
- Extended Care Department
- Family Medicine\*
- Graduate Medical Education\*
- Health Sciences Library
- Heart Center
- Hennepin Regional Poison Center\*
- Hennepin Women’s Mental Health Program
- Hospitalist Program
- Huntington’s Disease Center for Excellence at HMC
- Hyperbaric Medicine\*
- Indian Health Advocate\*
- Internal Medicine
- Interpreters\*
- Knapp Rehabilitation Center
- Laboratories, Clinical and Anatomic
- Library and Media Services
- Lung Infections and Diseases
- Medical Technology School
- Medicine Specialty Clinics
- Midwife Service
- Minnesota Regional Sleep Disorders Center
- Neurodiagnostics Lab
- Neurology
- Newborn Intensive Care Unit\*
- Nutrition Services
- Obesity Program
- Obstetrical Testing Unit
- Obstetrics/Gynecology Clinic
- Occupational Therapy
- Operating Room
- Ophthalmology
- Orthopaedics
- Otolaryngology
- Partial Hospital Program
- Pathology
- Patient Education Resources
- Patient Representative’s Office
- Pediatrics Clinic
- Pediatric Inpatient Care
- Pediatric Emergency Department\*
- Pharmacy
- Physical Medicine and Rehabilitation Clinic
- Physical Therapy
- Positive Care at Hennepin County Medical Center\*
- Prenatal Classes
- Prevention Programs
- Primary Care Clinics\* and Specialty Centers
- Psychiatry\*
- Public program enrollment assistance\*
- Pulmonary Function Lab
- Radiation Oncology
- Radiology
- Renal Care Unit
- Respiratory Care
- Same-Day Surgery
- Sexual Assault Resource Service (SARS)\*
- Social Services\*
- Speech-Language Pathology
- Sports Medicine
- Surgery Subspecialty Clinics
- Transplant Services
- Trauma Services\*
- Urgent Care
- Vascular Access
- Weight Loss Surgery

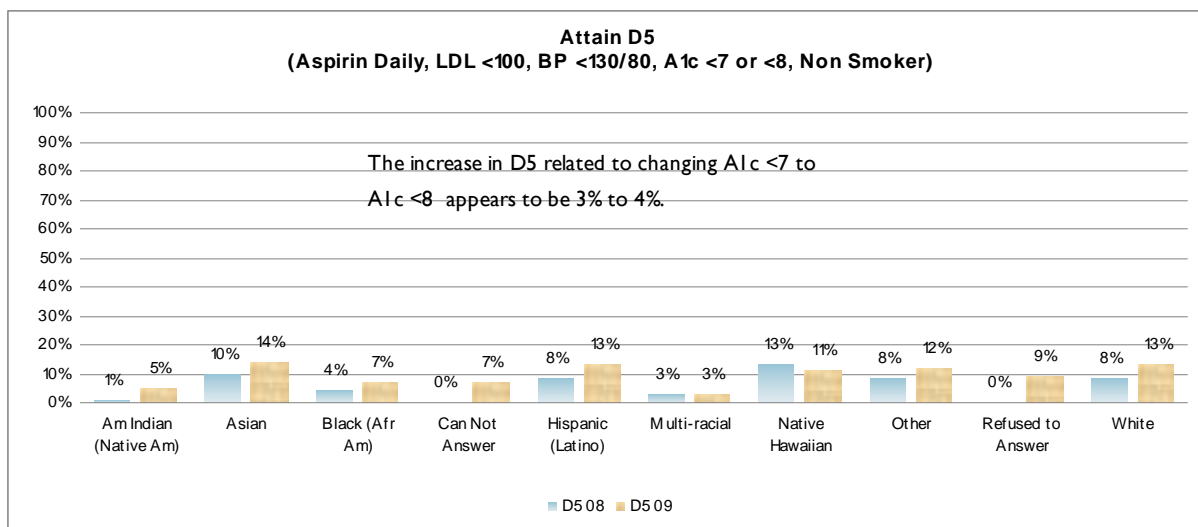
## Diabetes Outcome Indicators and Data Stratified by Race

Diabetes is a complex chronic condition that has afflicted many of HCMC/HHS' patients. HCMC/HHS is creating standard work to improve efficiencies and effectiveness in the delivery of quality diabetic care. We have created, tested and implemented standard work in five areas of diabetic care:

- Created enhanced role definitions for each member of the care team
- Developed and implemented a standard process for patients to arrive prior to their visit to obtain necessary lab. Having the results available allowed for care plan discussions and appropriate changes to be made at the time of the visit
- Successfully piloted the use of a Self-Management Goal Contract between the patient and discharging nurse
- Optimized Epic tools to support the providers in diabetic care
- Determined a need to add eight elements to the community standard (recognizes 5 (D5)) for assessment to effectively care for diabetic patients

Below is an example of the disparities among certain indicators arrayed by race/culture for the aggregate D5 scores<sup>1)</sup> for patients in our clinic system in 2008 and 2009. For example, in 2009, 5% of the American Indian population obtained D5, 14% of the Asian population; etc.

1) Control Blood Pressure less than 130/80; LDL "bad cholesterol" less than 100 mg/dl; maintain blood sugar so A1C is <7%; don't smoke; daily aspirin for those age 40 and above.



## **Sage at HCMC/HHS**

### *A Cancer Screening Collaboration with the Minnesota Department of Health*

The Sage Screening Program at HCMC/HHS provides free breast and cervical cancer screening exams to women who are over 40 years of age and are uninsured or underinsured. The program also serves women under 40 for breast health concerns only, if they have a first degree relative who was diagnosed with breast cancer.

An outreach grant has enabled HCMC/HHS to effectively reach out to our Latino community. The goal this year is to increase the number of women receiving screening not just in the Latino community, but in our African and African American communities as well. Outreach staff go into the communities to educate women about breast and cervical health, the importance of being screened and how to conduct breast self-exams. A dedicated patient navigator helps our patients overcome obstacles that have historically functioned as barriers to their appointments:

- Work schedule barrier
  - Clinics are designed to include a visit and the mammogram at the same time, a “one-stop-shop” experience for its working population
  - The program offers bi-monthly clinics/screening events extending to as late as 7:30 pm
- Transportation barrier
  - The program provides bus tokens and taxi rides at no charge to the patient
- Language barrier
  - Staff is bi-lingual and bi-cultural where possible
  - HCMC Interpreter Services provides interpreter services in 50 languages
- Cultural sensitivity
  - We are currently working with outside organizations to arrange a Somali women’s screening event to include food and social time
  - We hope to hold culturally centered screening events for several populations in the year to come