

Health Services Plan

2017



Hennepin Healthcare System, Inc.

Approved by Hennepin County Board - 11/29/2016

Approved by Hennepin Healthcare System Board - 11/16/2016

Contents

Overview | Hennepin County Medical Center..... 2

Community Needs and the Health Services Plan..... 3

2016 Top Priority Health Needs and HCMC Program and Projects
that Align with each Health Need..... 4

 Mental Health 4

 Social Determinants of Health..... 6

 Maternal Child Health..... 9

Measurements for 2017 Activities..... 10

Longer-view Planning 11

Overview | Hennepin County Medical Center

Hennepin County Medical Center (HCMC) is a mission-driven health system and academic medical center with a focus on improving health and wellness in the community through expert patient care, innovation, research and teaching. HCMC is a nationally renowned Level I Adult and Pediatric Trauma Center with the largest emergency department in Minnesota and is recognized nationally for leadership in medical education, emergency preparedness, research, and compassionate care in many medical specialties.

HCMC is a comprehensive clinic system which includes a 486-bed acute care hospital, primary care and specialty clinics located on our downtown campus, as well as neighborhood clinics in Minneapolis, Brooklyn Center, Brooklyn Park, Richfield, St. Anthony Village, and Golden Valley and an employee clinic in downtown Minneapolis that serves downtown businesses. HCMC specializes in trauma, emergency medicine, acute care, hyperbaric medicine, traumatic brain injury, burn, and more. MVNA is the community connections care division for HCMC providing over 20 community-based safety-net programs spanning care needs from prenatal and birth, to chronic disease management, to end-of-life and bereavement. Programs include home health, hospice, and family health home visiting. MVNA's role is prevention, hospital follow-up, transitional care, supportive services, public health, and community health initiatives.

As a public teaching hospital, HCMC provides students and medical professionals with access to innovative and comprehensive resources that are unique to the organization, drawing over 20,000 providers to our campus each year for clinical training. We also train providers across Minnesota and the region through our outreach efforts. HHS is the largest Continuing Medical Education (CME) provider accredited by the Minnesota Medical Association. HCMC is the largest offsite teaching hospital for the University of Minnesota School of Medicine and operates 14 HCMC-based residency and fellowship programs. Within the medical center, there are multiple educational areas to enhance student and provider education such as the Interdisciplinary Simulation and Education Center, the Center for Learning Integration, and the Advanced Practice Provider Professional Center.

HCMC prides itself in being an industry leader for innovative and technically-sophisticated services. This is essential not only because of the training provided to physicians, nurses, and other health professionals, but also because it is often the genesis of new therapies, surgeries, and technologies to treat and cure patients.

Because of HCMC's focus on innovation, *Upstream* Health Innovations was launched in 2015. Using human-centered design, *Upstream* Health Innovations seeks to empower patients to lead healthy lives, partners with the community to build capacity and fosters the health innovations that create equity and improve outcomes. *Upstream* Health Innovations is focused on HHS's safety net mission of creating and delivering health for all patients—regardless of economic or social circumstances. Its mission is to move healthcare upstream and transform the current healthcare model into one that is truly people-centered.

Another area of recognition for HCMC is its commitment to advancing the field of medicine through progressive research. Minneapolis Medical Research Foundation (MMRF), the third largest medical research non-profit in Minnesota, has a deliberate and distinguishing emphasis on the health care problems and needs prevalent in the HHS patient population and surrounding community. Research conducted at HCMC and through MMRF includes trauma, emergency medicine, and traumatic brain injury fields of study.

HCMC's mission is "We partner with our community, our patients, and their families to ensure access to outstanding care for everyone, while improving health and wellness through teaching, patient and community education, and research." HCMC strives to provide the best possible care to every patient; to search for new ways to improve the care that will be provided tomorrow; to educate health care providers for the future; and to ensure access to healthcare for all.

Community Needs and the Health Services Plan

On January 1, 2007, Hennepin County Medical Center's (HCMC) operational oversight transitioned from Hennepin County to a separate Public Benefit Corporation, Hennepin Healthcare System (HHS). As a part of this transition, Minnesota Statute 383B.918 required HCMC to:

Prepare, and submit to the county board for review and approval, a health services plan that draws from a population health needs assessment and delineates the corporation's role in the community, including education, research, and services to improve the health status of the community including indigent populations. The health services plan shall contain a description of how the corporation shall continue to coordinate with the county to provide health-related services to the residents of Hennepin County, including the indigent as defined by state and federal law and as determined by the Hennepin County Board of Commissioners.

HCMC has completed a Health Services Plan (HSP) annually since 2006. Starting in tax years beginning after March 23, 2012, the Affordable Care Act required 501(c)(3) non-profit hospitals to conduct a community health needs assessment (CHNA) and adopt an implementation strategy at least once every three years. The format and requirements of the CHNA vary slightly from the HSP, but the two efforts are closely related.

HCMC completed a new CHNA in 2016. Through considerable input from a broad group of community stakeholders, the CHNA identified three priority needs:

- Mental health
- Social determinants of health
- Maternal child health

These priority needs are in alignment with two of the needs identified in 2013:

- Maternal and child health
- Social and emotional well-being

Nutrition, obesity, and physical activity—the third need from the 2013 Community Health Needs Assessment—was a need considered within the Healthy Behaviors category in the 2016 process but did not rise to the level of priority of the selected top health needs. To learn more about the process and findings, visit the 2016 HCMC Community Health Needs Assessment report on the HCMC website.

This document serves as a reflection of work aligned with the newly identified community health priorities. In addition, a multi-year community health implementation plan will take shape into early 2017 and inform future Health Services Plans over the next three years.

2016 Top Priority Health Needs and HCMC Program and Projects that Align with each Health Need:

Mental Health:

Through the 2016 CHNA process, mental health was identified as one of the three top priority health needs in the HCMC community. Mental health itself encompasses a wide range of issues, from promoting mental, emotional, and spiritual wellbeing to diagnosing and treating serious long-term mental illness.

HCMC programs and projects for 2017 aligned with Mental Health include:

Crisis Residential Facility

There is a well-known crisis in the mental health system, and many efforts are underway to help improve the quality and capacity of services offered. In early 2017, HCMC will open a new offering: a 16-bed crisis residential facility in south Minneapolis. Crisis stabilization will play a large role in improving access and a unique opportunity to better coordinate care. HCMC's facility will be the first program of its type in the state offered under the umbrella of a hospital system. Crisis stabilization provides intensive treatment, skills building and safety planning for those stepping down from the hospital or people who need assistance but do not meet the hospitalization level of care. A patient's average length of stay will be seven days.

Psychiatry Family Resource Center

Family members often feel isolated and closed off from their loved one with mental illness. Education and support can provide hope for the future and effective ways to cope with mental health diagnosis. HCMC is opening a new Psychiatry Family Resource Center on the downtown campus. The space is open to all people interested in learning about mental health and the support available to them. The goal of the new center is to provide support and resources to anyone connected to mental health concerns, and a space for people experiencing similar situations to connect and find support.

First Episode Psychosis Program

Early support and access to treatment is essential for adolescents and young adults (ages 15 to 30) who have recently experienced an onset of psychotic symptoms. The new First Episode

Psychosis Program is an innovative grant-funded program addressing early intervention needs of individuals experiencing a first episode of psychosis. This program will work closely with other areas of HCMC including acute psychiatric services, emergency department, inpatient psychiatry, and outpatient psychiatry to improve speed and ease of access to care and decrease the long-term, negative consequences of untreated psychosis. With engagement in the program, patients will receive comprehensive outpatient care that will reduce the need for hospitalization. Further, this program aims to reach individuals in the community who might otherwise struggle to access appropriate medical care.

The program has a focus on improving quality of life, not just symptom reduction. It also aims to work with the families of patients to help support these young men and women to better health.

Mother-Baby Program

The Mother-Baby Program, offering a range of psychiatric services to support women and families, expanded to include an Intensive Outpatient Program. The first of its kind in our community, the program is available to pregnant or postpartum women with moderate to severe mental health symptoms. It is a step-down level of care from the Mother- Baby Day Hospital and consists of three days of treatment each week with three hours of group psychotherapy each day. Most women attend for 8-12 weeks.

Other Mother-Baby service options include a partial hospitalization program, outpatient groups and a Mother-Baby HopeLine, a free mental health telephone support service for pregnant women, families with children ages 0-5 years old, and providers. Call 612-873-HOPE and leave a message requesting assistance. Mental health staff members will call back in 2-3 business days to provide mental health triage and connection with resources.

Members Give Back

HCMC *Upstream* Health Innovations team is partnering with Life Track (a vocational rehab community organization), U.S. Bank, and the HCMC Day Treatment Program, which serves adults living with serious mental illness, to pilot a new concept called Members Give Back. The program support clients to secure meaningful employment or volunteer roles in the community to fulfill their sense of “giving back.” A 2016 prototype was tested with a cohort of nine clients or recent graduates of the Day Treatment Program. The program was a 10-week series of group and 1:1 sessions, followed by ongoing support for up to six months. The program contributes to clients’ rehabilitation treatment plans by helping them reintegrate into daily life through a structured role and meets an often-unfilled need for employment services. Clients completed the program with an updated resume, cover letter, thank you note, and interview preparation, as well as increased familiarity with additional financial and work-related skills.

To date, nine of nine pilot group members have successfully entered or are about to enter an employment or volunteer opportunity. Critical learnings from the pilot will inform next steps and further curriculum development.

Group Visits

Upstream Health Innovations is partnering with HCMC clinical teams to pilot group visits in several care settings. The HCMC Psychiatry Clinic and *Upstream* Health Innovations piloted a bi-monthly group visit for medication management with two different patient populations. The group visit is led by the patients' psychiatrist. The goal is to meet with the patients more frequently (every two months). Per current medication guidelines, patients need to meet with providers every three months. Teams are evaluating the model to determine medication adherence, impact and potential to scale.

Another series of group visits aim to engage cohorts of patients with diabetes, depression and anxiety. Focused on rest and renewal, the group visits have been offered to English and Spanish speaking patients in partnership between *Upstream* Health Innovations and a functional medicine physician from Whittier Clinic. Early results have proved this to be a successful program both medically and personally. Patients have reported lower A1C scores, lower medication needs and weight loss, as well as lower stress and anxiety. Future cohorts are in the planning stages for diabetic African American males and pain management.

Social Determinants of Health:

The 2016 Community Health Needs Assessment also identified social determinants of health as one of the three priority health needs in the HCMC Community. The Centers for Disease Control defines determinants of health as *"factors that contribute to a person's current state of health."* Additionally, CDC says: *"Social determinants are the complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities."* Several community stakeholders observed, "It's hard to think about healthy eating or getting exercise, when you don't know where you're going to sleep tonight." Addressing social determinants of health was seen as foundational to addressing other health issues such as health behaviors and chronic diseases.

HCMC programs and projects for 2017 that align with Social Determinants of Health include:

The Food Shelf at HCMC

The Food Shelf at HCMC addresses hunger and food insecurity among patients and families, with a long term vision of hunger-free patients and a community where all families have the healthful food they need every day. One of only two food shelves in the nation located in a hospital setting, The Food Shelf provides services in thirty hospital-based clinics and eight community clinics. Staff provide nutrient-rich foods on-site, often coupled with health and diet education, and also help patients connect to more sustained assistance programs such as SNAP (Supplemental Nutrition Assistance Program, formerly known as Food Stamps) and WIC (Women, Infants, and Children). The program actively recruits and engages multi-lingual community volunteers and staff to assist and support this work. The program serves approximately 40,000 households and 100,000 people a year.

Food Insecurity Screenings

Routine food security screening and referral in primary care practice is one avenue to identify and address food insecurity. HCMC's Senior Care Clinics at Parkside and Augustana implemented a pilot food security screening and referral process in spring 2016 as a joint effort between HCMC and Second Harvest Heartland Food Bank. Patients visiting the clinic answered the two-item food security screening tool. Individuals with food needs are offered a referral to Second Harvest Heartland where a dedicated team assesses and connects people to food support program options like Supplemental Nutrition Assistance Program (SNAP). During the pilot, approximately 25% of Senior Care Clinic patients were food insecure. The pilot will now expand to additional clinics.

Priorities Conversation

HCMC *Upstream* Health Innovations is trying to tackle this question: How can we address a patient's social determinants so that patients feel empowered, listened to, and engaged? After completing the first prototype in the Priorities Conversation project, the Innovation team is testing a patient self-assessment visual tool to better understand and address our patients' social services concerns. There is an opportunity to start to engage all of our patients in a meaningful priorities conversation with the goal of working with low and rising-risk patients to prevent them from becoming high risk and better aligning services with patient's wants and needs.

Resource Engine (Community Resource Network Collaborative)

HCMC *Upstream* Health Innovations is piloting a technology platform to connect individuals with community partner resources to meet social needs. They have collaborated with NowPow, a technology startup, to prototype a resource engine to help HCMC staff find and connect people to resources based on the patient's medical diagnosis and social unmet needs. In addition, the technology tool has the potential to allow for efficient information exchange between health systems and social/community service providers. HCMC is exploring the potential of the platform with other health systems and a myriad community partners. *Upstream* Health Innovations will pilot the tool, and then develop a project road map accordingly.

Hitch Health

How could we improve the patient transportation system for health care services so that patients can maintain their appointments and improve health outcomes? Hitch Health addresses the challenges that patients experience related to medical care transportation. Following a successful initial pilot, *Upstream* Health Innovations is partnering with both Lyft and iHail to explore two dispatch systems to understand the specific needs of a safety net healthcare system. The goal is to build a technology product that will help ensure more consistent transportation to services for patients, thereby enhancing access and ensuring individuals receive needed care while also reducing waste and improving productivity.

Accountable Health Communities Model

In partnership with Hennepin County, HCMC submitted an application to the Accountable Health Communities (AHC) model, an innovative program sponsored by the Centers for Medicare and Medicaid Innovation (CMMI). The AHC model aims to implement widespread consistent screening for health-related social needs and, when needs are identified, to connect individuals to resources. Screenings would occur at the time individuals seek care at access points across HCMC and Hennepin County clinical services locations. CMMI will announce selected participants in 2017. If selected, the HCMC/Hennepin County teams will begin widespread planning and implementation readiness efforts in 2017.

Housing-related initiatives

As a key social determinant, housing insecurity takes many different forms. HCMC is involved in housing-related projects at various levels of development. These efforts include:

- **Medical Respite for Persons Experiencing Homelessness:** Through a Bush Foundation Community Innovation Grant, HCMC has convened a group of community stakeholders to explore the need for medical respite care in the community. The one-year effort will review the current state, identify gaps and, if need is validated, develop a business plan.
- **Micro Housing:** After convening a community forum on the potential of micro housing to address homelessness in the downtown area, a team from *Upstream Health Innovations* is assessing next steps.
- **Health-Supported Housing:** HCMC is a participant in ongoing planning efforts led by Aeon to create a new model of housing and care called Health-Supported Housing. Aeon is working toward a capital and operating funding model for new housing in downtown Minneapolis.

Next Step

A new program is aiming to break the cycle of violence for young people who are themselves victims of violence and come to HCMC for care. Launched in 2016, Next Steps uses guidelines for hospital-based interventions that builds trust with victims to put them on a path way from future violence. Two Youth Development Workers, grant-funded staffers, visit patients in the ER and inpatient units to introduce the program which offers face-to-face service and support. The program serves individuals after they leave the hospital to help them develop and adhere to their individualized safety plan. The effort is supported by HCMC ER, Security, Spiritual Services, and Social Work and receives external funding from City of Minneapolis Health Department and Minnesota Office of Justice.

Maternal Child Health:

The 2016 CHNA also identified maternal child health as one of the three top priority health needs in the HCMC Community. There were three specific aspects of need that were identified by a broad group of community stakeholders participating in the assessment process: prenatal services, early childhood development and care for high-risk teenagers.

HCMC programs and projects for 2017 that align with Maternal Child Health include:

Nurse-Family Partnership expansion

Nurse-Family Partnership (NFP) is a maternal child health program that engages the most at-risk families (medical and socially complex) to help improve pregnancy and early childhood health and developmental outcomes. Specifically, the program aims to serve first time moms and engage them in care prior to their 29th week of pregnancy.

MVNA has been providing NFP for City of Minneapolis families since 2010. This expansion is based on a 2016 grant in partnership with Hennepin County Public Health department to expand services to provide the long-term home visiting program to at risk, low-income families living in suburban Hennepin County.

Between Us

Between Us (formerly called Henne-Teen) is a program aimed at individuals between the ages of 11-26 needing confidential sexual and reproductive health care. Launching the new name of the initiative and beginning a new marketing campaign will raise awareness of these services among existing patients and their parents, as well as potential patients in the community. The website, www.betweenushealth.com features tips for parenting teens and information for teens on how to access confidential care at HCMC. A newly established Nurse Clinic Coordinator offers targeted case management for teens at high risk of pregnancy or Sexually Transmitted Infections. Preventing STIs and teen pregnancies influences the health and well-being of the current and next generation of children, thus having a strong impact on maternal and child health.

Mother / Baby Support Group

The Mother/Baby Support Group is a free weekly gathering for any new mother and her infant who would like to participate in a support group setting. An experienced childbirth educator facilitates this program, and much like an Early Childhood and Family Education (ECFE) infant class, mothers are encouraged to share, support one another and seek out parenting information. Infants can be weighed if a mother chooses, and informal lactation support is offered. This services aligns with HCMC's commitment as a Baby Friendly Hospital. The trained eye of the facilitator can also help identify new moms in need and get them directed to the right services.

Measurements for 2017 activities

The activities highlighted in this report build on the base of activities happening across HCMC every day to serve the needs of our patients, families and the community. The following measurements are associated with key activities aligned with the newly identified priority community health needs:

Priority Need Area	Activity	Measurement
Mental Health	Crisis Stabilization facility	<ul style="list-style-type: none"> • # of patients served • Average length of stay • # of inpatient days averted
	Family resource center	<ul style="list-style-type: none"> • # of individuals served
	First Episode program	<ul style="list-style-type: none"> • # of individuals served
	Mother-Baby Program	<ul style="list-style-type: none"> • # of participants in Intensive Outpatient Program
	Members Give Back	<ul style="list-style-type: none"> • Improvement in Financial Health Assessment scores • Improvement in WHOQOL-BREF scores • Improvement in PQH9 scores • Attendance to program • Successful Volunteer / Job placement • Pre and post assessments
	Group Visits	<ul style="list-style-type: none"> • Resiliency: PQH9 decrease • Diabetes: <ul style="list-style-type: none"> • A1C scores decrease • Weight loss • Blood pressure decrease • Medication Management—TBD
Social Determinants	The Food Shelf	<ul style="list-style-type: none"> • # of individuals and households served
	Food Insecurity Screenings	<ul style="list-style-type: none"> • % of patients with food insecurity in target clinics • % of patients referred for food program assessment that receive assistance
	Resource Engine	<ul style="list-style-type: none"> • # of community partners involved by zip code and service category • # of referrals provided to patients • # of referrals by social determinant category • # of patients who initiated / completed a referral (closed loop)
	Accountable Health Communities (AHC) model	<ul style="list-style-type: none"> • Our acceptance into the AHC program

Social Determinants (<i>cont.</i>)	Next Step	<ul style="list-style-type: none"> • # of participants • # of participants who do not have repeat violence-related returns to HCMC ER • % of participants with individualized safety plan
Maternal Child Health	Nurse Family Partnership	<ul style="list-style-type: none"> • # of families served
	Between Us	<ul style="list-style-type: none"> • # of teens served by care coordinator • # of teens on long-term birth control measurements
	Mother and Baby Support Groups	# of participants

Longer-view planning

HCMC has a long-standing commitment to address the health needs of our community. In addition to the 2017 activities already noted in this document, HCMC will undertake a planning process to build a multi-year implementation strategy to address the priority health needs identified in the 2016 Community Health Needs Assessment process. In compliance with IRS requirements, the 2017-2019 Community Health Implementation Plan will be completed by May 2017. Health Services Plans will be drawn from the multi-year implementation plan.

HCMC actively engaged community stakeholders in the identification and prioritization of priority health needs. Many community stakeholders expressed strong interest in continued involvement in determining approaches to address those needs. Likewise, internal HCMC stakeholders are a key contributor to further understanding needs and possible solutions.

Recognizing that collaborative efforts involving HCMC stakeholders and community partners are the most likely to yield positive impacts, HCMC CHNA Implementation Planning will be directed from the Population Health department and under executive leadership of the Community Care Ring. HCMC will employ the following community engagement model:

- Implementation Steering Committee:

HCMC will form an Implementation Steering Committee. Engaging both HCMC and community stakeholders, the committee will guide the implementation planning process. This will encompass helping determine key strategies, programs and initiatives to address each of the three identified priority health needs as well as monitoring progress of efforts.

- Community Listening Sessions

The sessions will allow for more dialogue about the priority need areas and where more focus and attention is needed. The sessions will be held in the community and in partnership with community partners.

- Potential collaborative solution forums

All community stakeholders involved in the CHNA plus additional stakeholders will be invited to help identify possible collaborative solutions to priority need areas.

- Workgroups focused on specific implementation strategies, programs, and initiatives (as applicable).

If applicable, HCMC will convene need-focused workgroups to ensure engagement.