Health+Human Services Special Report

A RESEARCH REPORT FROM THE **GOVERNING INSTITUTE** AND **CENTER FOR DIGITAL GOVERNMENT**

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Health Care Policies and Practices that Work

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e.Republic SMART MEDIA FOR PUBLIC SECTOR INNOVATION

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Investing Now for **Better Outcomes Later**

For the past few years, health care legislation and its mandates have dominated the HHS space as agencies prepared for and then implemented the Affordable Care Act (ACA). As Edward Fowler, Medicaid program manager of the Louisiana Department of Health and Hospitals told us last year, "We spend all day, every day preparing for the ACA. I can't imagine how anyone does anything else."[1]

However, a year has made a significant difference. Days of only focusing on the ACA are hopefully behind most HHS leaders; health insurance exchanges are (mostly) up and running and, while health care will always demand a major chunk of workloads, agencies are now able to give human services some much-deserved attention. At the same time, the once-dire economic environment has improved, and state and local governments have more capacity to consider strategies for improving health and human services for the long term rather than simply treading water.

One of the results of this contemplation is the concept of paying for success, an initiative already implemented by Illinois, Massachusetts and New York, and being considered by several other states. Paying for success programs operate exactly how they sound: Government sets specific goals around areas like homelessness or preventative health care, while private investors help finance nonprofits and other organizations to provide social services on behalf of the state. The investors are only paid if success is achieved.

> "For too long, the U.S. government has funded programs based upon metrics that tell us how many people we are serving, but little about how we are improving their lives."
>
> — The White House

The model is getting support from the White House, which has said, "For too long, the U.S. government has funded programs based upon metrics that tell us how many people we are serving, but little about how we are improving their lives. ... Pay for Success is an innovative way of partnering with philanthropic and private sector investors to create incentives for service providers to deliver better outcomes at lower cost — producing the highest return on taxpayer investments. The concept is simple: Pay providers after they have demonstrated success, not based on the promise of success, as is done now."[2]

Why is this model important? It represents a greater trend — some would say a much-needed one — of measuring results against efforts and costs, and the use of data-driven decision-making and analytics to address problems and ensure success. While HHS agencies have never had an overwhelming amount of resources to deliver needed services, the recession, followed by incredibly tight timelines to implement portions of the ACA, put a particularly harsh strain at the state and local level. This strain has spawned a focus on providing the best outcomes with the least resources.

This HHS Special Report details the current state of health and human services at the state and municipal levels and takes a closer look at initiatives like Pay for Success that attempt to improve outcomes with strategies that buck the status quo — including investing in technology, implementing unique initiatives, going further to promote advanced collaboration, reducing waste, and focusing on coordinated care and patient integration.

This Special Report will also highlight states, cities, counties and agencies leading the way by investing in innovative programs and solutions that help people in need while bending the cost curve in their favor.

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The State of Health Care:
The Time for Transformative Change is Now

Kentucky's HIX program, Kynect, was one of the most successful in the country. As of December 2013, the state had registered more people for private insurance and Medicaid per capita than any other state.

CARLO KELLEM/KYNECT

When looking at the current state of health care, it is important to consider the payment model that has been the status quo for years. Fee for Service (FFS), like Pay for Success, means just what it says: Doctors and health care providers are paid for each service performed.

This model has created its fair share of problems — so much so, in fact, that it has often been dubbed "fend for self" by those least capable of doing so.[3] Unfortunately, FFS has proven to be inefficient, evidenced by the fact that the United States has the most expensive health care system in the world, but continues to finish last or near last in access, efficiency and equity ratings, according to a 2014 Commonwealth Fund study of 11 nations.[4]

Its ineffectiveness brings us back to cost and outcome. Consider the 2013 report from the federal Agency for Healthcare Research and Quality, which found that 1 percent of the population accounted for 21 percent of the nearly $1.3 trillion Americans spent on health care in 2010, at a cost of nearly $88,000 per person. Five percent of patients accounted for 50 percent of all health care expenditures. By contrast, the bottom 50 percent of patients accounted for just 2.8 percent of spending that year.[5]

Cost and outcome are misaligned and changes need to be made. Part of that change will be technological, as both health insurance and health information move online through improved exchanges. The other part

is financial, as new payment models attempt to shift the system from FFS to outcomes-based practices. The following sections detail the ways in which states and municipalities are finding success in both areas.

Successfully Implementing Health Insurance Exchanges

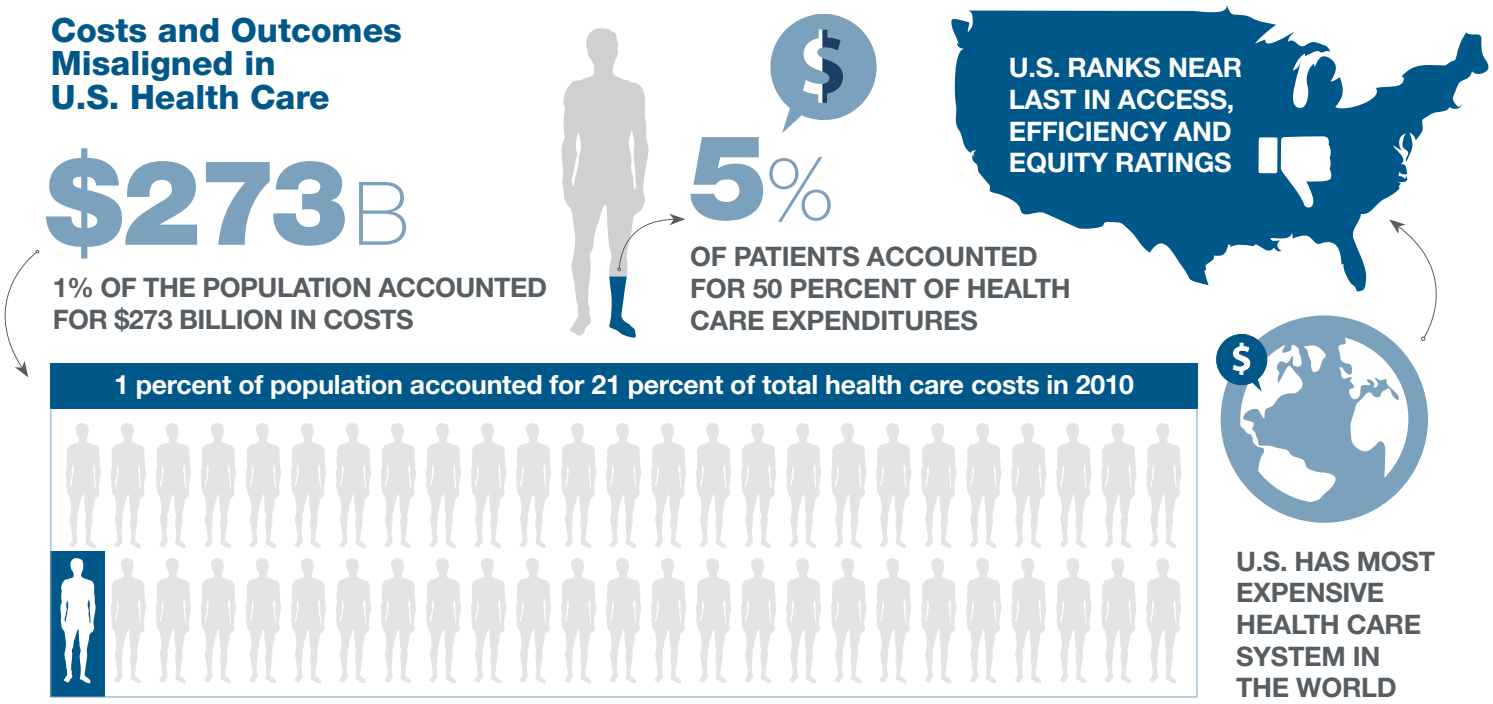
Health insurance exchanges (HIXs), part of the ACA, were intended to ensure every American had access to affordable health care — but there were problems. Along with Healthcare.gov's well-publicized challenges, many state-based HIXs also stumbled out of the gate. The technology itself was sometimes to blame, but far more often, many felt that unrealistic expectations and poor project management were the real culprits.

Given the scope of the project and the time constraints, many likened even the most basic HIX rollout to landing a 767 on a country airstrip. There was a tendency to overreach, and those states that tried to do too much, in terms of custom-built technology or implementing more than the simplest solutions, ran into the most severe deadline and cost pressures.

However, several states took a more conservative approach, and met the business problem of simply getting people coverage — no more, no less. Kentucky and Connecticut were early examples. Kentucky and other successful states avoided overloading their HIX by allowing consumers to browse different options before setting up an account and filing an application. The result: The state registered about 1,400 consumers per week for private insurance and enrolled 29,000 people in Medicaid during the first month. As of December 2013, Kentucky had registered more people for private insurance and Medicaid per capita than any other state.[6]

Connecticut was also successful. "Our rollout went pretty well, given the caveat that this is a 3- to 5-year project done in 10 months," says Jim Wadleigh, Connecticut CIO. "Our goal was set to stay up for the first day and help people enroll, and those things occurred."

As of July 2014, less than 1 percent of all customers were experiencing problems with the Connecticut HIX. Initial glitches came from unforeseen issues, including customers who applied 10 times or more and difficulties interacting with the



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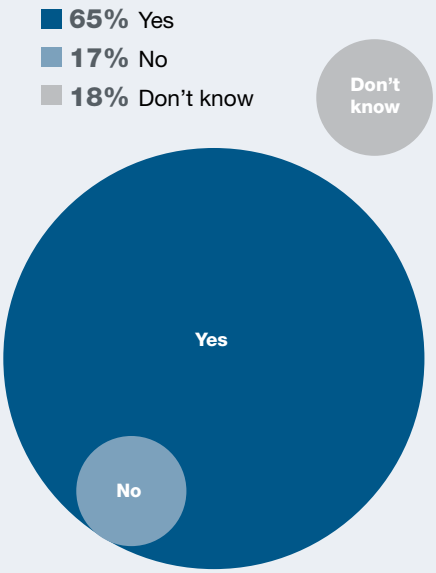


Source: Governing Health and Human Services Survey, 2014

Federal Data Services Hub, especially with hyphenated or otherwise punctuated names like O'Neill.

Wadleigh attributes the HIX success to three things: simplicity, outsourcing and entrepreneurial spirit. "Focusing on mission-critical items was one of the most important things we did. We deferred anything that wasn't needed to go live," he says. "We also applied private sector practices in the public sector space; our leadership team came from health care organizations or had that background, and we could build business principles like outsourcing — we outsourced everything we could — and created strong governance over all of our projects."

Having met the minimum go-live requirements, Wadleigh now envisions changes that can meet the new, post-October 1 federal guidance and provide better outcomes. He wants to improve customer service with a call center portal and better support tools to increase the health literacy of the many customers for whom health care and its jargon — copays, deductibles, primary care — are new concepts. "I am looking to create an avatar on the website so customers can interact with it and ask questions. It has the potential to really help customers," he says.

Connecticut's long-term vision is to integrate other HHS programs into the HIX. Improved dental coverage is up first in fall 2014, and the state hopes to integrate with the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) enrollment by the end of 2015, creating a no-wrong-door entry point for all HHS services.

"Clearly, I would have liked more time to test, but with projects like this, more time doesn't always mean more success," he says. "At this point we have had no real catastrophic issues, and having that short timeframe allowed us to move mountains to get where we needed to be. I feel comfortable that the way we have gotten to this point is the right way to go."[7]

Collaborating and Sharing Data

While collaboration and data sharing are important in all government endeavors, it is particularly critical in health care. Collaboration enables HHS agencies to not only be more efficient, reduce duplication of work and often decrease costs, but also provide improved outcomes and better care for constituents, particularly those most in need. To improve collaboration and data sharing, governments are looking to enhance their health information exchanges and implement other innovative programs and strategies.

Health Information Exchanges

Health information exchanges (HIEs) — systems that enable the electronic sharing of health-related information — are not new to health care. Early HIE efforts began more than a decade ago with the U.S. Departments of Defense and Veteran Affairs, which needed to exchange electronic health records of military personnel. However, HIE initiatives have routinely faced challenges in many states as providers express distrust and uncertainty and stakeholders question the governance, sustainability and financial feasibility of such undertakings.

But there have been successes. Indiana founded one of the first HIEs, a state-led initiative in 2004. Also in 2004, Massachusetts implemented a provider-led model. By 2011, 255 state, regional and metropolitan HIEs existed.

Most recently, the Texas HIE (HIETexas) announced that Healthcare Access San Antonio (HASA), the health exchange organization for 22 counties in south central Texas, became the fourth accredited HIE in the nation. Accreditation comes from the two entities that run the state HIE — the Electronic Healthcare Network Accreditation Commission (EHNAC) and the Texas Health Services Authority (THSA). HASA was the first HIE to receive Texas accreditation and the fourth to receive recognition from EHNAC. The

Brooks Daverman says Tennessee rewards providers for coordinating care across the system and helping ensure good outcomes for their patients.

SHERI ONEAL

accreditation was awarded as proof of successful, secure interoperability with state and federal programs.

With the functioning accreditation program in place, the state is hopeful that others will model their HIEs after successful exchanges. "Increasing confidence and trust in organizations involved in exchanging and maintaining electronic health information will not only foster greater participation in HIEs, but also support sustainability of HIE efforts in Texas and across the United States," says Tony Gilman, CEO of the THSA.[8]

HIEs are becoming increasingly important as they not only help guarantee better care on an individual basis, but also provide critical data across programs to gain insights into what is working and what is not, which helps support the Pay for Success model.

Innovative Programs and Projects

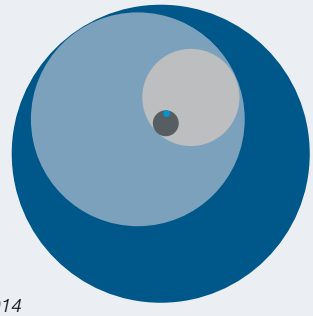
In addition to implementing technologies to increase collaboration and data sharing, states and municipalities can focus on programs that encourage various stakeholders to come together to solve common challenges.

For example, the Tennessee Health Care Innovation Initiative, TennCare, is designed to bring quality care to acute and long-term services. The initiative highlights the principles of collaboration and paying for success. "We reward the provider for coordinating care across the system and for the outcomes for their patients, so that providers are paying attention to what is happening to their patients with outside providers," says Brooks Daverman, director of strategic planning and innovation at the Tennessee Division of Health Care Finance and Administration.

The state will also work with its commercial payers and managed care organizations to create a framework that supports the sharing of actionable

Regional collaboration is a key success factor in HHS delivery.

- **46%** Agree completely
- **33%** Agree somewhat
- **15%** Neither agree nor disagree
- **4%** Disagree somewhat
- **1%** Disagree completely



Source: Governing Health and Human Services Survey, 2014

information like episodes of care. An episode is the collection of care provided to treat a particular condition for a given length of time. The state has incorporated three episodes of care into the framework — perinatal, total knee and hip replacement, and asthma exacerbation — and 520 providers now get reports on patients regarding utilization, cost and quality measures. "We plan to implement 75 episodes of care in 5 years," says Daverman.

The state has more collaboration-related goals. "First we have to create alignment in the payer systems — commercial, Medicare, Medicaid and managed care organizations (MCOs). Second, we are working on a system for every primary care provider to be able to know when their patient goes to a Tennessee hospital or emergency department," says Daverman. "We have a lot of small providers and we need to support them with information that helps them know what their patients experience outside of their office that creates financial rewards for high value coordinated care."[9]

In another example, the Pennsylvania Department of Public Welfare (DPW) Office of Medical Assistance and 12 other state Medicaid programs utilized a vendor-supplied software application to administer the Medicare and Medicaid Electronic Health Records (EHR) Incentive Payment Program. This application, the Medical Assistance Provider Incentive Repository (MAPIR), which embodies the Centers for Medicare & Medicaid Services' (CMS) vision for collaboration, cost sharing and coordination in administering the EHR incentive program, has issued more than $1.4 billion in incentive payments to providers across the country.

Additional benefits of this collaborative effort include:

- Sharing of knowledge and best practices
- Coordination among partners to monitor statutory and regulatory requirements while reducing fraud, waste and abuse
- Reduced expenses
- The ability to engage with representatives from state Medicaid agencies to discuss and review operational issues and program strategies[12]

Innovative solutions can also be seen in direct communication between patients and care providers. For example, the Mississippi Department of Mental Health (DMH) implemented a mobile application to help community members with intellectual and developmental challenges living in residential care lead an independent lifestyle and improve communication.

Where verbal communication is challenging — or sometimes impossible — the app helps residents communicate their health needs and better engage in social activities or daily interactions with staff. DMH staff can easily access resident information from any one of the dozen state programs DMH operates, which helps them to better

SIM GRANTS ARE SPURRING TRANSFORMATION

CMS' State Innovation Models (SIM) initiative has already awarded nearly $300 million in grants to 25 states to design or test improvements to public and private health payment and delivery systems for people enrolled in Medicare, Medicaid and the Children's Health Insurance Program (CHIP).[10] The grants help fund innovations that include development of advanced primary care networks supported by statewide health information technology (HIT) systems and models that coordinate care seamlessly across providers.[11] The goal is to speed the move to outcomes-based and performance-based delivery, and to promote Pay for Success financial models.

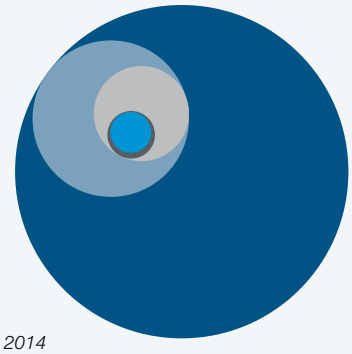
Some believe that SIM grants "flew under the radar" because of the workload associated with the ACA and Medicaid expansion. But SIM grants will light up radar screens this fall. Round two of the grants, totaling another $730 million, are expected to be awarded in October. Up to 12 states will receive state-sponsored Model Testing awards ($700 million available) and up to 15 states will be chosen for state-sponsored Model Design work ($30 million available).

One state looking for a Model Test grant is New York, which received a 2013 grant for its State Health Innovation Plan (SHIP). SHIP is "a roadmap to coordinate and integrate all payers and all providers and to better align incentives and resources to promote systemic reform." SHIP's major initiatives include improving access to care, integrating primary care and behavioral health with commensurate reimbursement reform, working to align its prevention agenda with reimbursement and delivery system reform, incentivizing and supporting primary care to assure effective geographic distribution of care, and enhancing transparency and HIT.

understand the needs, wants and feelings of those who otherwise couldn't express these things themselves.

"We feel we are at the forefront of health care engagement — linking patients, providers and families," says James Dunaway, chief information officer at Mississippi DMH. "Our residents not only communicate more easily with our staff on symptoms and treatments, but may also interact more effectively with their primary caregiver and other health care professionals."[13]

In your opinion, is the move to managed health care working?



- **49%** It's too early to tell
- **23%** No
- **14%** Yes
- **7%** Don't know
- **6%** We have not moved to a managed health care model

Source: Governing Health and Human Services Survey, 2014

Addressing Medicaid and Medicare

Given that Medicare and Medicaid spending totaled $572.5 billion and $421.2 billion, respectively, in 2012 alone, it's impossible to keep them out of an HHS conversation focusing on reducing costs and improving outcomes — they represent a significant portion of spending.

The ACA has sparked significant changes in Medicaid. Although the Medicaid expansion, first proposed under the ACA, did not go as planned, the resulting confusion has created a cauldron of innovation in programs, especially as the federal government offers special waivers to states trying to align services with outcomes and incentives.

For example, Maryland, with the blessing of the CMS, is modernizing its already unique all-payer rate-setting system for hospital services, with the aim of improving patient health and reducing costs by paying for successful results, not services rendered.

Under the new model, Maryland hospitals commit to achieving significant quality improvements, including reductions in 30-day hospital re-admissions and hospital-acquired condition rates. Maryland will limit all-payer annual per capita hospital growth, including inpatient and outpatient care, to 3.58 percent below historical trends.

Maryland will also limit annual Medicare per capita hospital cost growth to a rate lower than the national annual per capita growth rate per year for 2015-2018. This model, available through the authority of the CMS Innovation Center, which was created by the ACA to test payment and service delivery models, is estimated to save at least $330 million over the next 5 years.[14]

"The exciting thing is that intense work is being done in practically every state to improve delivery systems and re-align payment incentives," says Matt Salo, executive director of the National Association of Medicaid Directors.[15] Every state has different political and economic realities, he says, "but they are trying to get to the same place. For example, Arkansas pioneered an innovative approach to Medicaid expansion that other states are now modeling, called the private option, which allows the state to use federal Medicaid dollars to help low-income individuals buy private health insurance."

Managed Care and Dual Eligibles

One of the biggest areas of experimentation is in moving Medicaid and Medicare toward managed care organizations. In a managed care program, one company oversees all of a patient's health care needs and is paid on a per-person basis, rather than the traditional FFS model.

Managed care isn't new — Tennessee and Arizona have been doing this for some time — but it is an increasingly viable option. Illinois also recently announced it will move hundreds of thousands of low-income patients into managed care health plans after a 2011 state law required expanding managed care to half the state's Medicaid patients by 2015. The Illinois Medicaid program now covers 3 million people, and 1.7 million people will be notified by the end of 2014 of their new health plan choices. Patients who don't choose a plan will be assigned to one, and can switch within the first 90 days of coverage.[16]

Managed care is also an increasingly popular solution to handle the duplicate work created by dual eligibles, or individuals who qualify for and use the services of both Medicaid and Medicare. Although dual eligible beneficiaries comprised just 14 percent of Medicaid enrollment in 2010, 36 percent of all Medicaid expenditures for medical services were made on their behalf, according to a Kaiser Family Foundation report, and dual eligibles accounted for 33 percent of Medicare spending in 2009.[17]

Massachusetts became the first state to take advantage of $1 million in planning grants from the Medicare-Medicaid Coordination Office, an ACA initiative designed to give dual eligibles better care at a lower cost. Dual eligibles in Massachusetts who are enrolled in the One Care program will have a single health plan and a case manager to coordinate their care. According to the Pew Charitable Trusts, California began participating in the program in May 2014, and Colorado, Connecticut, Idaho, Illinois, Iowa, Michigan, Minnesota, Missouri, New York, North Carolina, Ohio, Oklahoma, Rhode Island, South Carolina, Texas, Virginia and Washington joined or will join soon.[18]

However, the Medicare-Medicaid relationship remains fractious, Salo says. "With the dual eligibles office, states can now move the ball forward, but the takeaway is that the challenges, from macro to micro, to fully integrating two very different programs are significant. Medicaid is really 50 different programs, and each state has 50 years of running its own program. Similarly, the federal government has 50 years of experience running Medicare. Neither side particularly likes the idea of giving authority away. Resistance to change is very deep and there are very deep-seated distrusts here."

Despite these challenges, the ball, as he says, is moving forward. And the concept of paying for success is often at the heart of it. "The clear trend is moving away from Fee for Service, away from paying for volume and toward paying for value," Salo says. "Some are doing it without managed care, some with managed care, but however you do it you have to change the financial incentives inherent in the system."

Better Coordinating Mental Health Care

Medicaid pays for 27 percent of all expenditures for mental health services — the largest single payer in the United States. Individuals diagnosed with a mental illness represent almost 11 percent of the individuals enrolled in Medicaid and account for almost 30 percent of all Medicaid expenditures. In addition, those with a behavioral health disorder often use other health care services.[20]

The Pay for Success model and overall health care transformation requires attention be paid to mental health services. Especially now, with Medicaid expansion of the 25 million people estimated to gain health insurance, 20 percent will have a mental illness and 14 percent will have a substance abuse problem.[21]

CMS has released new policies and programs to support states' efforts to rebalance and reform service delivery systems for individuals with behavioral health issues. This gives states the opportunity to invest in services — not only within behavioral health clinics, but beyond the clinic walls as well — including employment programs, inpatient and residential services, prevention and other wraparound services.

WHAT IS PATIENT-CENTERED PRACTICE?

In patient-centered care, health insurance companies provide incentives to doctors to meet certain clinical quality, patient satisfaction and efficiency benchmarks. Unlike the traditional FFS model, patient-centered practices are another form of paying for success in that financial rewards are provided to improve the patient experience and care based upon national clinical guidelines.

Data suggests they work. A 2013 study of claims data for more than 200,000 members of a large New Jersey insurance plan found that patient-centered practices performed better than traditional practices in a number of clinical metrics:

- 14 percent higher rate in improved diabetes control
- 12 percent higher rate in cholesterol management
- 8 percent higher rate in breast cancer screenings
- 6 percent higher rate in colorectal cancer screenings

Cost savings were significant. Members under the care of a patient-centered practice avoided more than 1,200 emergency room visits and 260 inpatient hospitals admissions, a savings of approximately $4.5 million.[19]

Massachusetts Gov. Deval Patrick created the Opioid Task Force to improve coordination of opioid abuse prevention with other HHS programs.

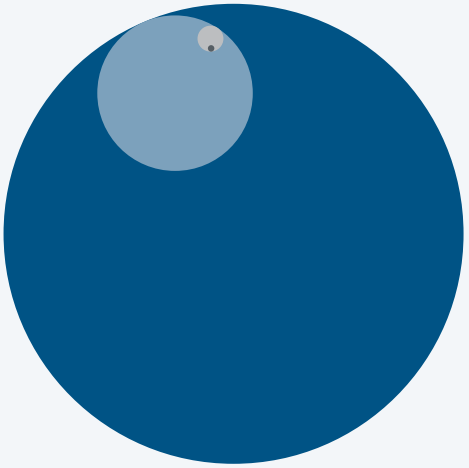
FLICKR/DEVAL PATRICK

Coordination, as always, is key. And it can come from the top, as Massachusetts Gov. Deval Patrick demonstrated with the Opioid Task Force, which convened families, stakeholders and the Department of Public Health to develop a set of findings and recommendations, released June 2014, to improve opioid abuse prevention and treatment systems, prevent opioid misuse and addiction, increase the numbers of persons seeking treatment and support persons recovering from addiction in local communities.[22]

As with any other program, for mental health programs to succeed they need to be measured. To help with this, CMS created the Measure and Instrument Development and Support (MIDS) program to create and promote strategies for developing, testing, refining, revising, maintaining, implementing and publicly reporting quality health care-specific measures.[23] One example of this is in Minnesota. Minnesota Community Measurement (MNCM) is a nonprofit organization working with partners statewide and nationally to create and refine measures in all areas of health, including mental health. MNCM also supports patient-reported outcome measures (PROMs) to engage patients and their families to improve their own care.[24]

How important are prevention and early intervention services to avoid more costly interventions in the future?

- **71%** Very important
- **24%** Important
- **4%** Neutral
- **1%** Not important



Source: Governing Health and Human Services Survey, 2014

Moving from Reaction to Prevention

"An ounce of prevention is worth a pound of cure," said Benjamin Franklin. More than 250 years ago, Franklin knew the best way to solve a problem — particularly in health care — was preventing it from occurring in the first place.

The Robert Wood Johnson Foundation agrees, stating that investing $10 a year per person on

FLICKR/ NATALIEMAYNOR

The Florida Literacy Coalition provides resources to help adults make informed decisions about their health. Activities like planting community gardens provide educational, sustainable opportunities to learn about nutrition.

prevention would save the country's health care system billions of dollars. Investing in proven, community-based prevention programs, the foundation says, "could offer a substantial savings over traditional medical treatments for illnesses such as diabetes and cardiovascular disease, lowering health care costs and improving people's quality of life."[25]

Prevention and early intervention programs can be seen as a different approach to paying for success. Unlike direct service and care, prevention and early intervention is about investing in individuals now, often in the form of education programs, to avoid costly health care needs down the road.

As more localities understand the connection between prevention and cost savings — not to mention better health outcomes — new initiatives are giving patients and providers the tools they need to prevent both physical and mental illness before it strikes.

Due to the ACA, millions of people with previously limited access to health care are entering the system. The complicated, jargon-filled world of health care can be a shock to someone who has never before engaged with it. To ensure individuals are empowered to make educated decisions about their care, several organizations across the U.S. have developed community-based health literacy programs as a prevention effort.

For example, the Florida Literacy Coalition and a large regional health insurance company partnered to offer targeted grants to promote health literacy. The goal is to provide health education resources and family literacy programs to local individuals so participants can make informed choices about their health and nutrition. The coalition also develops and distributes health curricula for adult education students.

Over the last year, the public-private partnership provided 2,829 Floridians with health literacy instruction. Since 2009, the initiative has served more than 9,900 individuals in the state of Florida, surpassing the initial goal of serving 2,200 adults and families over a three-year period.

The coalition achieved some notable results, as shown in its 2014 mid-year survey:

- 71 percent of participants demonstrated improvement in health literacy knowledge.
- 73 percent of participants shared the information learned with family or friends.
- 93 percent of survey respondents indicated the health information learned in class helped in everyday life.[26]

In Texas, the state employee health insurance program, managed by the Employees Retirement System (ERS), moved to a Patient-Centered Medical Home (PCMH) model in 2011 when it was faced with an aging workforce. The PCMH model focuses on primary

care and prevention, in hopes of reducing chronic disease rates and costly hospitalizations.

Over the next three years, the state realized net savings of $31.4 million. The PCMH provider practices received a total of $7.3 million in shared savings payments between 2011 and 2013, in addition to their reimbursements for medical care.

Patients reduced their visits to the emergency room and inpatient hospital stays and increased generic drug use. Doctors performed more cholesterol and diabetes testing. Overall drug therapy costs increased — but that is seen as a good thing, indicating that patients were taking their medication as prescribed and receiving better coordination of care.[27]

"The primary care provider (PCP) is responsible for the entire cost of care, including hospitals, specialists, durable medical equipment, drugs — whatever it is, the PCP coordinates care among providers," says Rob Kukla, director of benefit contracts for the Texas ERS.

Kukla, armed with years of private sector group benefits experience, was quite familiar with the medical home approach. He started with three regional clinics — Austin, Houston and Tyler, Texas — and devised a monthly capitation fee. "On the back end, we said we will reward you if you can improve on quality targets we established," he says. But there were no penalties if the clinic failed. "We wanted to encourage providers to take a chance, so that from their financial perspective there was no risk to them. If they can't control cost of care, they are compensated as if the program didn't exist. There was a significant desire on physicians' part to make this work," says Kukla.[28]

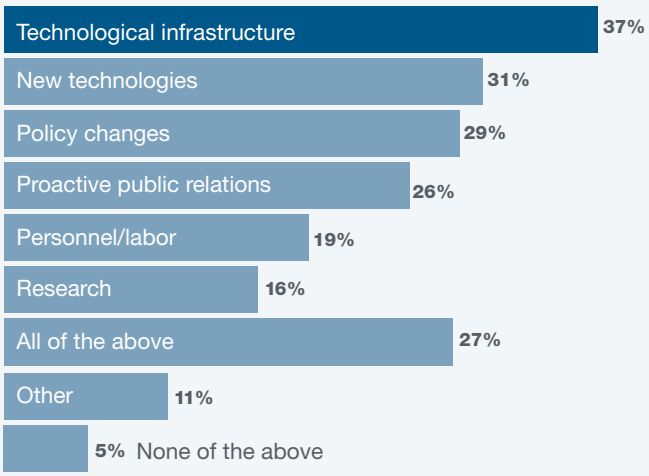
ACCORDING TO THE ROBERT WOOD JOHNSON FOUNDATION, INVESTING $10 A YEAR PER PERSON ON PREVENTION WOULD SAVE THE COUNTRY'S HEALTH CARE SYSTEM BILLIONS OF DOLLARS.

By the end of 2014 there will be a total of five provider groups in the program. ERS members are free to choose any network provider, even one outside this program. About 12 percent of all state employees are taking part, mainly because "the biggest challenge is finding provider organizations that are big enough to manage this program," Kukla says.

According to Kukla, to get the program up and running, the most utilized resource was time. The plan's third-party administrator did much of the heavy lifting. "We are spending on care management, which is not typically part of our pay structure. It's about $90,000 extra a month in payments for care coordination units and capitation fees. But that is the upfront cost, and we recover all those costs before we share the savings," says Kukla.

To successfully shift the health care dynamic, organizations need provider buy-in and patient and community engagement. Transformation has to move slowly to bring providers along as they adopt new ideas and adapt to new technology, giving them ownership of the solution — and incentives to do so — along the way. Patients should be taught how health care works and trained how to think anew about their role in staying healthy. +

Strategic investments in which of the following areas would have mitigated many of the issues associated with the ACA?



Source: Governing Health and Human Services Survey, 2014

DAVID KIDD

Poverty and the need for service remain consistent challenges. Many people turn to HHS agencies seeking basic needs such as food and shelter.

The State of Human Services:
Bridging the Great Divide

As the ACA dominated political rhetoric and captured the public's attention, the "HS" in HHS has seen — and continues to encounter — its own set of challenges. State social services programs and initiatives — including early childhood education programs, aid to individuals with disabilities and assistance to the elderly — faced substantial cuts as leaders tried to balance budgets. At the federal level, the 2014 farm bill cut funding to reduce SNAP expenditures by $8 billion over 10 years.

At the same time, the recession hit individuals and families who were already teetering on the edge of financial instability hard and placed many people who had never sought assistance before in the position to apply for help.

Poverty has become a persistent ill plaguing myriad populations — no one is immune, evidenced by *Governing* articles like "Poverty Comes to the Suburbs," "Poverty Among Seniors Harder to Ignore" and "Poverty Remains Stubbornly High in Big Cities." Rural Americans also face poverty, as do

> There's good evidence that when you invest in both parents and children together, there are, immediately, better outcomes in terms of stability for families, and down the road, better outcomes in health, achievement and connection to community."
>
> — Anne Mosle, Executive Director, Ascend at The Aspen Institute

children, indiscriminately. According to the National Center for Children in Poverty, children represent 24 percent of the population, but they comprise 34 percent of all people in poverty.[29]

Increased demand for services at the same time agencies face program cuts and staff reductions creates a conundrum for state and local governments. Like their health counterparts, human services agencies must find more efficient ways of doing effective work with increasingly positive outcomes. Human services agencies can also focus on a paying for success mentality that supports innovation and rewards programs and initiatives that accomplish what they set out to do and revises or ends efforts that are not achieving results.

Launching "Two Generations" Approaches to Fight Poverty

According to the National Human Services Assembly, more than 1.4 million youth between ages 15 and 24 are out of school and out of work, and are also raising dependent children.[30] When young parents are unable to go to school or find work, it makes it difficult — if not impossible — for them to support themselves and it tends to negatively impact their children's future success as well. Many times, this leaves these families trapped in poverty for generations.

To meet the needs of these families, many human services organizations have started creating so-called "two generations" approaches that address the needs of young adults and their children.

Education programs provide many examples of a two generations approach, and public community colleges are often the focus for such programs. More than 25 percent of all community college students are parents and 16 percent are single parents, so these colleges

THE EDUCATION-HEALTH CONNECTION

Those in need of social services typically have lower levels of educational attainment and have an increased risk of health problems. One in every eight children in the U.S. (12 percent) lives with a mother who has not graduated from high school, and these children experience especially large health disparities compared to children whose mothers have a bachelor's degree:

Children with Mothers Who Did Not Complete High School	Children with Mothers Who Earned Bachelor's Degree
LOW BIRTH WEIGHT	
9.0%	6.8%
CHILD MORTALITY RATE UNDER AGE 1 PER 1,000 LIVE BIRTHS	
8.2%	3.9%
OBESITY	
27.0%	13.0%
NOT IN EXCELLENT OR VERY GOOD HEALTH	
29.0%	8.0%
NOT COVERED BY HEALTH INSURANCE	
16.0%	4.0%

By focusing on educational programs and early intervention, smart communities are, in effect, paying for success and helping to solve health care-related issues. Not only are the parents and children healthier, they are able to get better jobs now and in the future, and thus are less likely to depend on Medicaid and other social programs.[31]

are providing on-site child care facilities and student housing that supports dual- and single-parent families in job training programs.

These approaches provide an excellent return on investment. According to the *Washington Post*, Nobel Prize-winning economist James Heckman has found that investing in quality early childhood education for low-income children can have a positive impact resulting in greater academic achievement, better jobs, higher incomes, reduced incarceration rates and lower health care costs. And new research shows that for families with very young children earning $25,000 a year, raising family income by just $3,000 can yield a 17 percent increase in earnings for these young children when they become adults.[32]

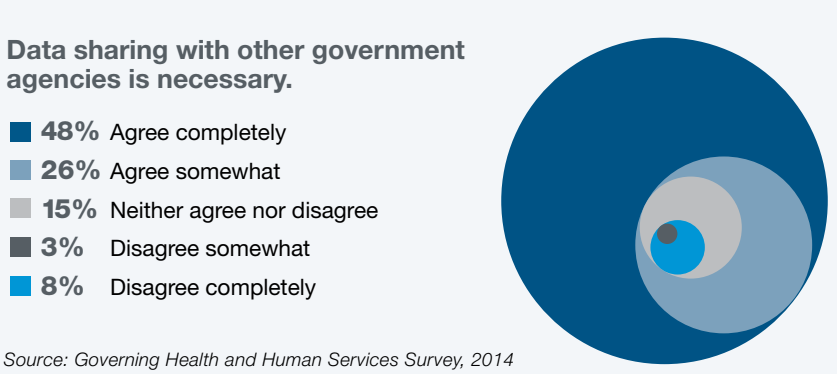
"There's good evidence that when you invest in both parents and children together, there are, immediately, better outcomes in terms of stability for families, and down the road, better outcomes in health, achievement and connection to community," writes Anne Mosle, executive director at Ascend, a policy program of the Aspen Institute striving to move vulnerable children and their parents toward educational success and economic security. Ascend recently invested $1.2 million in 57 organizations across the country working on two generations education approaches.[33]

Tulsa, Okla.'s experience can verify Mosle's statement. The city's ambitious program, CareerAdvance, is one of the first fully operational dual-generation programs with sector-based workforce development for low-income families. The program, with partners including Tulsa Community College, Tulsa Technology Center, Child and Family Services, and Union Public Schools, was initiated in 2009. It links Head Start/Early Head Start programs for children operated by the Community Action Project of Tulsa County with education and training for their parents in health care jobs such as nursing, health information technology, medical assistant and pharmacy technician.

The parents are grouped in cohorts of about 15 that serve as support networks. Each cohort has a mentor-coach. The parents learn basic life skills such as budgeting and tax filing, resumé writing and interview skills. They receive payments for tuition and other education and training expenses; adult basic education and tutoring services; and wraparound services, including before and after child care and transportation assistance.

Of the 203 parents who started the education program in the last four years while their children were in Head Start, 92 percent completed the program.[34]

Data sharing with other government agencies is necessary.



Source: Governing Health and Human Services Survey, 2014

Sharing Data and Using Analytics for a Holistic View of Human Services Needs

Just as education and health are connected, so too are every other aspect of human services. Individuals using one service — say, SNAP — are highly likely to be using at least one and often many other services, like temporary assistance, health care and housing support. This fact has led forward-thinking HHS leaders to take a holistic, 360-degree view of their clients to predict, prepare for and provide more effective and cost-efficient services.

This requires sophisticated technology, and advanced analytics and data management tools are emerging to help agencies collaborate and share information more effectively, gain powerful insights, and, ultimately, provide more streamlined and preventative services based on a complete view of an individual's human services needs.

When looking at data to support these programs, there is an opportunity to highlight patterns that provide greater value for citizens in one program and across all programs. With the emphasis shifting from FFS to outcome-oriented programs,

government agencies can eliminate redundant services and protocols that don't produce beneficial outcomes. One of the advantages of sharing data for integrated service is the ability to make data-driven decisions. In order to more effectively pursue population-based health outcomes, HHS departments need to do more than provide aid once something bad happens. Analytics allow agencies to take a holistic approach to providing an array of human services that help decrease the demand for long-term services. Linked or common client databases enable the identification of both at-risk clients (who would benefit from coordinated case management) and geographical "hotspots" (where greater resources are needed).

Many of the items on HHS leaders' wish lists could be addressed with data analytics:

"Ensure that all eligible individuals have the opportunity for health care coverage."

"Better target those in need."

"Reach otherwise ignored patients with truly urgent needs."

"(Have access to) new technology to make health care delivery and public health services more efficient."

Source: Governing Health and Human Services Survey, 2014

> "We can't extend every service to the entire population, but we can use technology and online instruments to detect who needs what services first."
>
> — Will Lightbourne, Director, California Department of Social Services

"We need to get good data on what works and with whom, and that is potentially one of the best things we can do in human services," says Will Lightbourne, director of the California Department of Social Services. "We can't extend every service to the entire population, but we can use technology and online instruments to detect who needs what services first. We can tease out critical path issues that are most useful, and then integrate those services across domains as realistically as possible."[35]

The Oklahoma Department of Human Services, for example, needed a solution to sort, summarize and present information about its clients to help caseworkers provide better services and enable agency directors to meet federal Child and Family Services Review (CFSR) mandates. Thus, the department implemented a new technology to create domain-specific data marts that house data from each program, and then used a business intelligence platform to present the data through specialized reports, which reveal current information about its programs and services. Now, caseworkers can make better decisions and directors can manage their programs and meet federal mandates, maximizing incentive payments.[36]

In addition, new frameworks, tools and technologies provide a common platform and enable agencies to interact and exchange information across different levels of government. For instance, the federal Administration for Children and Families launched its Interoperability Initiative in 2011, which included the National Human Services Interoperability Architecture (NHSIA) project to facilitate information sharing across federal, regional, state and local information systems. The project is aimed at supporting integrated eligibility assessments, helping detect fraud, improving case management and achieving efficiencies through the sharing of IT resources.

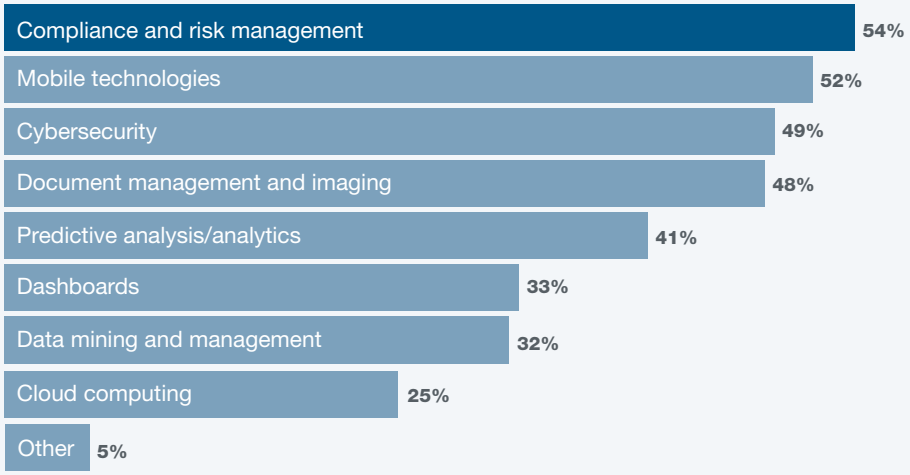
NHSIA is supporting states in initiating their own interoperability projects. New York, for instance, received support for developing a Children's Passport, an electronic tool that will integrate the data multiple federal, state and local agencies currently hold on young people who are under the guardianship of the

New York State Office of Children and Family Services. The ultimate goal is to improve the quality of support provided to youth in foster care.

Even within individual agencies, the growing complexity of datasets makes client patterns difficult to identify without sophisticated data analytics. The Washington Department of Social and Health Services found a way to distill information from complex data by using predictive modeling in chronic care management. It is bringing together medical and public health and human services data to direct resources to clients with complex needs. This approach is being extended to new areas, including child welfare.

The use of data to drive targeted care and human services can be seen worldwide. For example, Australia's federal government is analyzing data to understand intergenerational cycles of deprivation, where they begin under the current system and how the cycle can be broken.[37]

HHS leaders identified the following technologies as having the largest potential value in improving delivery of health and human services:



Source: Governing Health and Human Services Survey, 2014

Streamlining Case and Document Management for More Effective Delivery

Client documents are fundamental to every HHS delivery issue, and with caseloads rising and budgets not increasing fast enough, human services organizations are working to improve efficiency by eliminating redundant data entry and the need to manually transmit client information among agencies. Automating these processes helps to eliminate duplicative efforts and enables human services employees to more quickly identify and monitor at-risk situations, increasing their ability to prevent crises from occurring.

Recent advances in technology significantly improve case and document management, and provide state and local human services agencies with effective and affordable tools. By using Web-based platforms, state and local human services agencies can:

- ✔ Simultaneously track and communicate outcomes across programs and agencies
- ✔ Increase outcome visibility
- ✔ Improve coordinated delivery of services
- ✔ Reduce expenses
- ✔ Rapidly implement changes based on policy, evolving best practices, new reporting requirements and management needs

For instance, Our Kids, a government contractor in Florida, is using technology to increase efficiency and manage caseloads. Our Kids helps Miami-Dade and Monroe County's at-risk children grow up in safe, permanent families through its adoption and foster care services. With new program requirements and increasing workloads, Our Kids needed a central system to help its 100-person staff manage its cases. When evaluating possible technology solutions, Our Kids knew it needed to consolidate three systems into one. In addition, because of the sensitive nature of client information, Our Kids sought a solution that could offer integration with its existing technology and strong data security at a low cost.

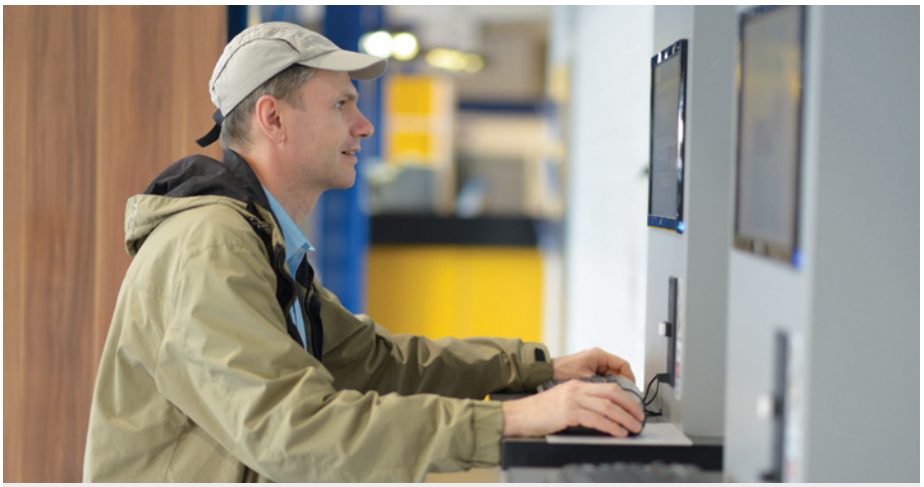
Now called Safe Haven, the customer relationship management (CRM) solution provides a cohesive, instant view of each child's information from a variety of portals, including schools, juvenile justice organizations,

and medical and legal entities. Moving forward, Our Kids plans to use the advanced data analytics to identify signs of potential child abuse earlier than its previous system allowed.

"With this CRM, processing time has been cut in half, helping us tackle urgent cases as they come in," says Dave Harland, director of Applications Development for Our Kids. "As we continue to collect data, we'll soon be able to identify those key dimensions that signify the potential for abuse in the home, enabling us to proactively flag those homes and act accordingly."[38]

The following examples highlight additional ways document and case management systems are helping to improve the delivery of human services:

- **Virginia.** The city of Norfolk's Department of Human Services Benefits Division used a new electronic content management (ECM) system to completely eliminate the four- to five-day backlog of documents from its TANF, SNAP and other public assistance programs, and is now able to maintain a one-day turnaround on cases.[39]
- **North Carolina.** Durham County's Department of Social Services automated its entire case management process, from initial paperwork to transferring the documents to court, as it prepares child welfare cases for trial.[40]
- **Minnesota.** Olmsted County approved budget money for a new document management system in an innovative way. The county's IT



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INTEGRATING SERVICES: A WIN-WIN FOR AGENCIES AND CONSTITUENTS

From an operational perspective, integrating human services and health care services delivery offers a more efficient and effective support system:

INCREASED CAPACITY. A reduction in duplicated administrative processes (e.g. identity verification and document authentication) means service delivery organizations can redistribute financial and staffing resources to activities that serve program goals.

IMPROVED STRATEGIC PLANNING AND SYSTEM INTEGRITY. The sharing of information among different agencies and program areas enables a better understanding of service usage patterns, system outcomes and client needs. With the aid of data analytics, it is easier to target resources more effectively, hold providers accountable, and detect fraud or procedural errors.

REDUCED DEMAND FOR CRISIS SERVICES. Swifter, more coordinated assistance and early intervention can help stabilize clients' conditions, and as a result, limit the need for high-cost crisis interventions (e.g. foster care and hospital services) at a later date.

From a citizen perspective, integrated services offer a more responsive support system:

SIMPLIFIED ACCESS. One-stop-shops, integrated online portals and formal networks of service delivery organizations using a "no wrong door" approach mean clients benefit from common entry points into the human and social services system. They no longer have to navigate a confusing array of services to locate the support they need.

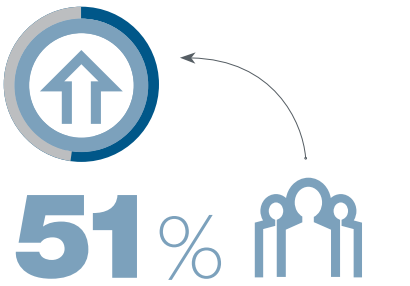
HOLISTIC AND CUSTOMIZED SUPPORT. As duplicated processes are phased out and case managers have access to client information via shared databases, a more holistic understanding of clients' needs emerges.

FASTER RESPONSE TIMES. Streamlined back-office systems (e.g. eligibility assessment) improve processing times, while case workers make quicker decisions through improved access to information.

IMPROVED OUTCOMES AND USER EXPERIENCE. Evaluations show that better sequencing and coordination of interventions can improve client outcomes over time. Equally, new working relationships between providers and citizens seeking support, and easier, timelier access to services increases client satisfaction.[41]

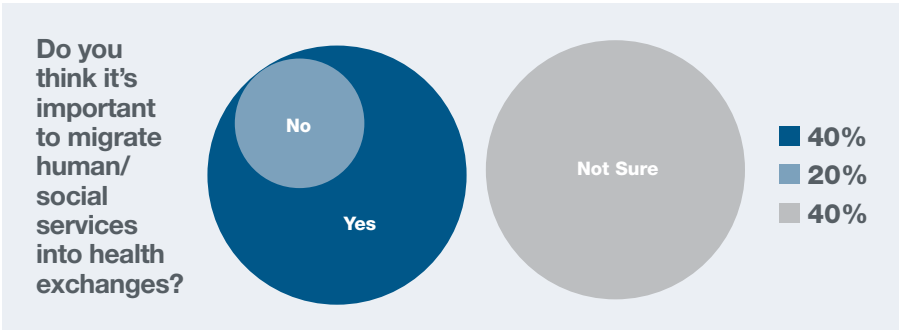
department used the ACA to argue the demand on public assistance would increase dramatically, and without a technological solution it would need to hire more people. It was able to expand the initial scope of the project by increasing federal matching funds.[42]

- **Michigan.** Recognizing a need to integrate child welfare data and move information out of silos, the Michigan Department of Technology, Management and Budget approved the adoption of a Statewide Automated Child Welfare Information System (SACWIS). The new platform provided an integrated database for use by Michigan Department of Human Services employees to track child welfare cases. The database houses all aspects of the child welfare process, including eligibility, adoption and financial management.[43]



OF HHS LEADERS BELIEVE THAT HEALTH AND HUMAN SERVICES DELIVERY IN THEIR JURISDICTION IS HEADED IN THE RIGHT DIRECTION.

Source: Governing Health and Human Services Survey, 2014



Source: Governing Health and Human Services Survey, 2014

Integrating Human Services into Health Exchanges

With the most important ACA deadlines passed, agencies are taking a larger view of HIX programs and looking to add more functionality, both in health and human services. Adding an entry point for clients to access human services through the same portal they find health insurance information creates a more efficient service delivery approach and allows HHS agencies to gain a more holistic view of citizens' needs, resulting in more successful outcomes.

The biggest change driving this integration is the ACA. Federal financial incentives such as the 90/10 matching grant and the cost allocation waiver push to modernize Medicaid front-end systems while including the potential for integrating human services within health exchanges.

California's Lightbourne says his department is "focusing on improving interaction between IT systems in programs that serve the same populations such as CalWORKs, CalFresh and Medi-Cal, with a goal of integrating human services access with the ACA databases and technology." His department has already completed and rolled out a replacement system for case management and payroll for Medicaid home care, which "moved us to a platform with real-time tracking of utilization and payroll," he says. "We can move cases between counties without having to dismember teams and put them back together, as our old legacy system did. And this will serve as the backbone for universal assessment."

ACA implementation has been the biggest reason for these changes, he says. "With Medicaid expansion, many of these people have income eligibility very close to or the same as SNAP. We look at this as a major opportunity."

Colorado is also showing how eligibility integration can be accomplished. With a mountainous acronym, PEAK (Program Eligibility and Application Kit) "is the front door to self-managing the eligibility process," says Sue Birch, executive director of the Colorado Department of Health Care Policy and Financing.

"We differentiated ourselves by saying this was going to be an

AP IMAGES

Sue Birch, executive director of the Colorado Department of Health Care Policy and Financing and Colorado Gov. John Hickenlooper speak with an attendee after announcing expanded Medicaid coverage for adults.

intra-operable health and human services system," she says. She likens it to a highway high-occupancy express lane, with off- and on-ramps from and to the various departments. Funded by the 90/10 federal match and integrated with the state HIX, "it has really supported intra-operability and more efficiencies in HHS," she says. "We believe we can drive a new consumerism and self-engagement for our clients."

Her department built a modular system out of standard platforms, and added custom code to address the state's rules and regulations. "We unbundled 8 million lines of code to allow more nimble movement throughout the system," says Birch. The portal is a cloud-based, front-end structure wrapped around the legacy system, a "surround strategy" that allows agencies to remove their legacy structures incrementally.

The system supplies real-time eligibility information about 82 percent of the time, she says. "If you have all your data ready, it can determine eligibility in about 40 minutes. Before, it took 45 days. That's an enormous boost to efficiency." During open enrollment, the system doubled capacity without the need for any added staff, she says. "That is a real, measurable outcome, and helps us re-purpose our workforce into coordinating case management. This helps increase self-sufficiency among our clients and ultimately be more successful at moving toward the middle class."[44]

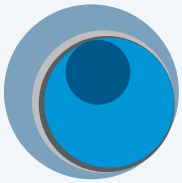
Mitigating Fraud and Security Threats in HHS

In order to ensure the federal paying for success initiative works, agencies must also eliminate paying for unnecessary fraud, waste, abuse and security breaches. State and local governments simply don't have the money to "pay and chase" fraudulent claims or address identity theft and other security breakdowns.

While it's difficult to tell how much money is lost to fraud, waste and improper payments for HHS each year, the number is estimated to be anywhere between $48 billion and $90 billion.[45] The good news is that investigations into fraud and abuse claims are paying off. In 2013, the Departments of Justice and Health and Human Services announced that for every $1 spent on investigations, the government recovered $7.90. The federal government's efforts to mitigate and investigate fraud and abuse crimes resulted in a record $4.2 billion in taxpayer dollars recovered in FY 2012, up from $4.1 billion in FY 2011.[46]

While this is certainly progress, the amount recovered each year is just a fraction of what is lost. The most effective way to save taxpayer money and protect client information is to prevent fraud, waste, abuse (FWA) and security failures from occurring. Investment in new technologies is helping to make this possible. Several state HHS agencies are investing in technology to prevent FWA and protect against data security breaches, potentially saving millions of dollars in the long term — and preserving citizen trust.

We have effective ways of monitoring and abating fraud with our current systems.



- **10%** Agree completely
- **27%** Agree somewhat
- **22%** Neither agree nor disagree
- **20%** Disagree somewhat
- **21%** Disagree completely

Source: Governing Health and Human Services Survey, 2014

Addressing Fraud, Waste and Abuse

FWA prevention isn't new. However, it is a lot more important now because of the sheer number of new people in the HHS system. With more accounts come more opportunities for gaming the process. Massachusetts, for example, estimated that it may be wasting between 21 percent and 39 percent of medical expenditures every year, to the tune of $27 billion.[47]

ELISA MORRIS PHOTOGRAPHY

In January 2014, Delaware Gov. Jack Markell announced plans for the Delaware Cyber Initiative to develop a skilled and innovative cybersecurity workforce.

Massachusetts is not alone and the move to Medicaid managed care may be compounding issues with FWA. Managed care organizations add a second level of payment that states oversee, which raises the complexity of maintaining system integrity.

There is increased focus on FWA, especially as agencies integrate siloed systems and implement platforms that combine data and analytics to address the problem.

At the federal level, CMS is working to strengthen provider and supplier enrollment screening provisions, and selected a fingerprint-based background check contractor to phase in fingerprint-based background checks in 2014.[48]

At the state level, the Florida Department of Children and Families (DCF) is the country's first and only social services agency to implement an automated customer authentication solution. With nearly 97 percent of all public assistance benefit applications received electronically, DCF began using technology that helps curtail identity fraud by verifying the identities of public assistance applicants. During the pilot phase and first five months of statewide operation, this technology produced more than $11 million in cost avoidance savings (from benefits not paid to unqualified individuals), efficiency savings (from reduced staffing time to process an online application), improved integrity of the public benefits programs and an expedited application process for Floridians in need.[49]

DCF employs a data analytics platform to verify and authenticate the identities of customers applying electronically for public assistance benefits. "We are extremely pleased with the savings we've already realized in the short time our program has been implemented," says Office of Public Benefits Integrity Director Andrew McClenahan. "We look forward to continuing to protect the identity of our clients and stopping fraud at the front door, making sure only those who truly need help receive it." The program has been so successful, DCF was named by Florida Gov. Rick Scott as a "Governor's Savings Award" recipient in March 2014.[50]

Enhancing Security

In 2013, cyber attacks rose 14 percent.[51] Since the launch of the ACA and increased federal reporting requirements, the U.S. Department of Health and Human Services has tracked nearly 950 data breach incidents affecting 30.1 million people. Most of these breaches are related to theft while others are related to data loss, hacking or unauthorized access of accounts. Smaller breaches, those affecting fewer than 500 people, occur as well. In 2012, there were 21,194 reports of smaller breaches affecting more than 160,000 people.[52]

Security is a paramount concern for all health and human services agencies. A centralized flow of personal information across agencies is a prime target for thieves. In fact, according to one astute security expert, personal health information is significantly more valuable on the black market than credit card information.

According to a recent report, HHS agencies have a long way to go in securing data. A March 2014 review of 10 state Medicaid agencies by the HHS Office of Inspector General discovered "pervasive high-risk vulnerabilities," which "raise concerns about the integrity of the systems used to process Medicaid claims." Without the proper security controls in place, it's nearly impossible for HHS agencies to protect sensitive personally identifiable information, including Medicaid data. Because the vulnerabilities were shared among the 10 agencies reviewed, the report suggests that other state Medicaid information might also be vulnerable.[53]

The Department of Homeland Security (DHS) created the Continuous Diagnostics and Mitigation (CDM) program, which is an important step for governments to improve their security posture. CDM supports

When asked about the greatest challenges in HHS, leaders reported:

"Ensuring that data and sensitive information is protected with a high level of security."

"Transparency, fraud and waste."

"Too many clients and not enough resources."

Source: Governing Health and Human Services Survey, 2014

civilian federal agencies in becoming more secure and deploying a cost-effective cybersecurity program.

The goal of the CDM program is to scan networks once every 72 hours to detect potential vulnerabilities or attacks. The program helps provide administrators with tools to know the state of their network at any given time, understand the risks and mitigate issues rapidly.

In many cases, state and local governments are unprepared to meet cyber threats and a fundamental reason is the lack of skilled cybersecurity personnel. The demand for cybersecurity employees is more than double the overall IT job market.[54] This need can also been seen at the federal level — in his 2015 budget, President Obama proposed a $35 million cybersecurity campus to house federal experts to respond to cyber threats. At the same time, states and localities are scrambling to find the tools and workers who can protect critically important government computer systems.

In Delaware, during his State of the State speech in January 2014, Gov. Jack Markell announced plans for the Delaware Cyber Initiative, which will bring together academia and the private sector to develop a skilled and innovative cybersecurity workforce. Markell proposed spending $3 million to create a partnership between the University of Delaware, Delaware State University, Delaware Technical Community College and private companies to create a collaborative learning and research network dedicated to cyber innovation. The initiative is part research lab, part workforce development and part business park.[55]

The office of the State of Nevada Public Employees' Benefits Program (PEBP) also relies on technology to increase security standards and comply with privacy laws. Being responsible for providing medical and dental benefits for all of the state's 77,000 employees and retirees, as well as their dependents, the office wanted to strengthen compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and encrypt email messages containing protected health information (PHI). It turned to an integrated data loss prevention, messaging security and encryption solution, and was able to process an escalating number of transactions without adding a single full-time employee.

PEBP utilizes technology to maintain its efficiency and security standards, as well as those mandated by government and industry regulations, without hiring additional staff. This is a full-time job in itself, and in 2011 required the launch of several technology projects, one of which focused on data security. This project involved identifying sensitive data, routing it properly and securing it with encryption.[56] ✚

WIKIPEDIA.ORG/SMALLBONES

As part of his cybersecurity initiative, Gov. Markell proposed spending $3 million to create partnerships with academic entities, including the University of Delaware.

Nick Macchione, Director, County of San Diego's Health and Human Services Agency

FLICKR/LEAD SAN DIEGO

Leading the Way:
Trend-Setting States and Municipalities

Forward-thinking localities are finding innovative ways to help the needy and bend the cost curve in their favor through innovative approaches aligned with the Pay for Success model. Along with those already mentioned in this report, here are some others worth highlighting.

San Diego. Many HHS thought leaders singled out the Live Well San Diego (LWSD) initiative for its community-driven, all-hands-on-deck approach to HHS challenges.

LWSD is a 10-year initiative with three basic components to improve the health and well-being of the county's 3.2 million residents: 1) building better health, 2) living safety and 3) thriving, according to Nick Macchione, director of the county of San Diego's Health and Human Services Agency. This public-private partnership invites government agencies, schools, libraries, nonprofit and for-profit partners, military, media and all sectors of the community to become an official LWSD partner and participate in a range of specific program efforts.

"It sounds audacious, but that is exactly what we have accomplished," Macchione says. "Government can't do it alone. No government has ever done it alone. Our experience with collective impact shows that you need a community-based approach in order to make broad improvements."

LWSD started in 2010 with the building better health component. Macchione needed, he says, "potent simplicity," and distilled his health goals into the 3-4-50 framework — three unhealthy behaviors (poor diet, lack of exercise and smoking) cause four chronic conditions (cancer, heart disease, Type 2 diabetes and respiratory disease) that lead to more than 50 percent of all deaths. "About 75 percent of those disease cases are preventable, so you can delay or prevent many of these conditions by changing behavior and lifestyle," he says. "There is an economic imperative to this. We measured it at nearly $4 billion in direct medical

> “Government can’t do it alone. No government has ever done it alone. Our experience with collective impact shows that you need a community-based approach in order to make broad improvements.”
>
> — Nick Macchione, Director, County of San Diego’s Health and Human Services Agency

expenditures, and that’s a huge burden on taxpayers and employers. This was our beachhead, something to get the entire community around and say, ‘It’s not government’s problem to solve, it’s all of ours collectively.’”

Macchione reports technology is helping to achieve the LWSD mission. “Technology is a huge enabler to achieve our goals” says Macchione. San Diego’s health information exchange, initially funded by the federal government, will make it possible to share patient information across hospitals, so that if you go to hospital X, it can get your information from hospital Y. “We have many other examples where technology is being used, such as helping school districts address childhood obesity and helping patients control high blood pressure.”

Macchione recognizes it takes a broad array of programs, approaches and partnerships to make any community-based initiative successful. “Income support is one aspect, but also important are education, safe communities and neighborhoods, and jobs — the full 360-degree view. We try to help people across the board so they can succeed and grow,” he says.[57]

New Orleans. In February 2011, the city of New Orleans, with funding and support from the Robert Wood Johnson Foundation Center to Prevent Childhood Obesity and the Arkansas Center for Health Improvement, convened key partners to develop a blueprint to increase physical activity and end childhood obesity. They called it Fit NOLA.[58]

The Fit NOLA partnership adopted the Institute of Medicine’s (IOM) Social-Ecological Model as a framework to consider the causes, consequences and solutions related to obesity and fitness. The IOM model encourages communities to engage all sectors to address obesity, nutrition and physical fitness. To that end, the partnership now comprises more than 100 organizations working together to make

CITY OF NEW ORLEANS HEALTH DEPARTMENT

The city of New Orleans convened key partners to develop Fit NOLA, a blueprint to increase physical activity and combat obesity.

The 100 organizations that comprise Fit NOLA work together to change policy and environmental factors in an effort to decrease obesity rates and increase wellness.

CITY OF NEW ORLEANS HEALTH DEPARTMENT

recommendations on policy and environmental strategies that make healthful nutrition and physical activity options easier for all residents. Some of their efforts include:

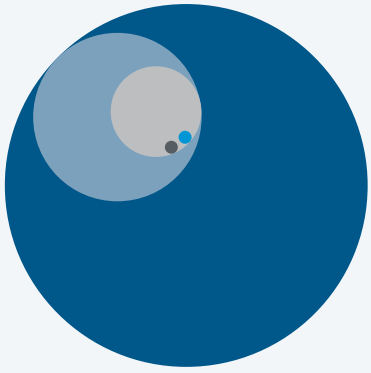
- Creating a Fresh Food Retailers Initiative to increase access to fresh foods in traditionally underserved neighborhoods by awarding forgivable and/or low-interest loans to supermarkets, grocery stores and other fresh food retailers
- Enhancing recreation opportunities for youth and families by operating summer camps serving 4,036 children and 800 teens, and opening 12 pools that had 82,000 visits and 40,000 hours of swim lessons in the summer of 2011
- Rebuilding Joe W. Brown Memorial Park in New Orleans East in collaboration with NIKE and several other donors to house a world-class sports complex featuring Victory Football Field, Victory Hall Recreation Center and a championship track
- Adopting a "Complete Streets" policy, which ensures that road designs consider biking, walking and public transit as modes of transportation
- Building lactation rooms and installing bike racks at City Hall

Savannah, Ga. The nonprofit group Step Up Savannah is working to eliminate endemic poverty in the city and county, which reaches 50 percent and higher in some neighborhoods. Step Up is a 501(c)3 with a 39-member board of directors and 95 partner organizations, including business

Private-public partnerships are crucial to success.

- **56%** Agree completely
- **26%** Agree somewhat
- **14%** Neither agree nor disagree
- **2%** Disagree somewhat
- **2%** Disagree completely

Source: Governing Health and Human Services Survey, 2014



and government leaders, social services providers, neighborhood leaders and local volunteers.

Step Up supports, among other things, workforce development, wealth building, advocacy and policy. Part of its mission is to support organizations and community leaders in:

- Finding or developing innovative approaches that work locally
- Identifying policies and systems that are barriers to success
- Mobilizing resources for local organizations
- Assisting individuals who work to improve Savannah's neighborhoods

In 2013, the organization served 11,632 individuals with education, jobs, asset assistance and other actions.[59]

New York City. One of the most ambitious social services reforms in the nation is occurring in the Big Apple. An initiative known as HHS-Connect is integrating information and activities across nine New York City HHS agencies that serve millions of people, many of whom are in crisis.

The initiative was launched by Linda Gibbs, who was deputy mayor of Health and Human Services under former Mayor Michael Bloomberg, and Kamal Bherwani, CIO of Health and Human Services and executive director of HHS-Connect.

HHS-Connect works with the city Department of Education to let New Yorkers check their eligibility for the federal school lunch program online. A Web portal called Worker Connect provides social services caseworkers access to better client information such as basic demographics, a financial snapshot, employment history and information about a client's enrollment in programs like SNAP and Medicaid. And it built a common client index (CCI), which is a master registry of client information across multiple benefits programs. As more data is pulled into the CCI, it will become the foundation for an electronic content management (ECM) system that gives social services caseworkers a holistic view of a person's circumstances, allowing caseworkers to deliver a set of services tailored to a client's individual needs.

The initial mission of HHS-Connect was, "Trying to figure out how to help front-line managers do their casework more effectively," says Gibbs. "Instead of dealing with crises, we wanted to help them do a more holistic job by looking at root causes, and by sharing information across agencies. We also wanted a more efficient system for clients. I saw over and over again how much time and effort was put on the clients for documentation."

HHS-Connect, which launched in 2008, is a federation of existing systems connecting hundreds of millions of pieces of information into the CCI. A computer algorithm ensures it is the same person across agencies and provides a snapshot of the client to every agency involved in that client's life.

"It was custom-built. There was no off-the-shelf technology then," Gibbs says. "Identifying one person across multiple agencies despite differences in information was a huge math problem."

She says HHS-Connect 2.0, which will incorporate more data sources addressing more complex issues, is currently underway. "I think it's time to go to 3.0," she says.[62]

BEST PRACTICES: THE ILLINOIS FRAMEWORK

For any cross-agency technology initiative, states need comprehensive standards and executive buy-in firmly in place. The Illinois Framework shows how it can be done.

The Illinois Interoperability and Integration Project, funded by a $1.125 million State Systems Interoperability and Integration Projects planning grant from the Office of Management and Budget (OMB) Partnership Fund, established and implemented a governance model for the Illinois Framework for Healthcare and Human Services project, known as the Framework. This multi-agency collaborative effort is charged with developing a "modern, horizontally integrated state health and human services delivery system."[60]

The Framework "provides strategic insight, organizational support and guidance on federal standards to advance Illinois' health care and human services enterprise," in order to improve service coordination and lower costs of HHS programs for the state and its populace. Person-centered services will make it easier for consumers to access multiple services online, in-person and by phone, with less paperwork and fewer office visits.[61]

What About Tomorrow?

When survey respondents were asked if they thought HHS delivery was headed in the right direction in their state, 51 percent said yes and 33 percent said no, while the rest weren't sure. The fact that a majority of leaders have a positive attitude shows how far HHS has come in the past year. With the new focus on technology-driven, outcomes-based service models and Pay for Success mindsets, the space is poised to provide even better service in the coming months and years.

While improving citizens' health and lives is still an enormous challenge, thought leaders are more confident than ever this challenge will be met. In fact, both public sector and private sector subject matter experts predict positive outcomes in the future.

Based on the evolution of technologies and HHS policies, missions and priorities, we may see these predictions come true. As agencies continue to invest in Pay for Success initiatives, whether in the form of direct services or preventative care, technology will play an integral role in supporting this shift. Creative and cost-effective programs that allow for collaborative and personalized service will drive this change. Pay for Success isn't just about investing in new technologies — it's about investing in our future and improving the health of citizens. ✚

PREDICTIONS FOR POSITIVE OUTCOMES IN THE FUTURE:

1 More states will put Pay for Success definitions into contracts and link payments to their achievement.

2 States and vendors will partner to explore more creative financing models for building and implementing programs to meet HHS needs.

3 Data analytics and similar technologies will enable governments to assess programs at a granular level and better determine the correct actions to take to help those in need.

4 Technological solutions will increasingly be based on open and modular architectures to ensure health and human services agencies can keep pace with change. Legacy-based systems will continue to be replaced by more agile solutions. Software-as-a-Service (SaaS) and other cloud-based services will provide HHS agencies with more flexible financial options and help ensure technology is current.

5 Increasingly sophisticated anti-fraud and security solutions will emerge to ensure taxpayer money is not wasted and individuals who truly need help receive it.

6 Calls for efficiency and reduction of duplicate work will increase efforts to integrate health and human services through organizational and technological changes.

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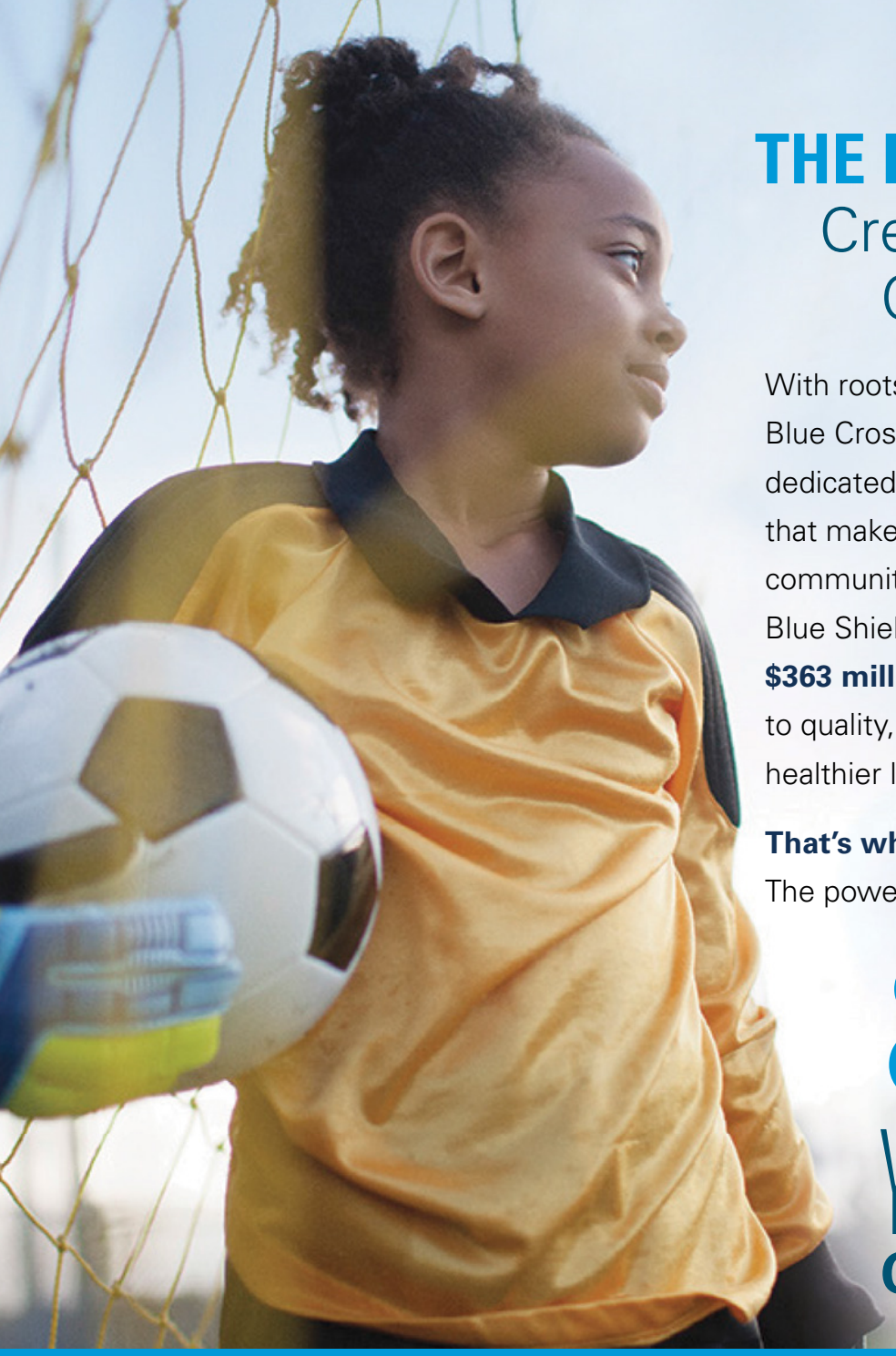

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Transforming the Health and Human Services Market

Technology Supports Innovative Change

The health and human services (HHS) market is transforming like never before. Citizens are driving change in the way services are bought and consumed, the way organizations connect with their customers and even the way we collaborate on a daily basis. Supporting this alignment of health care transformation are new IT shifts in mobility, social media, cloud computing solutions and big data analytics.

2.5 quintillion

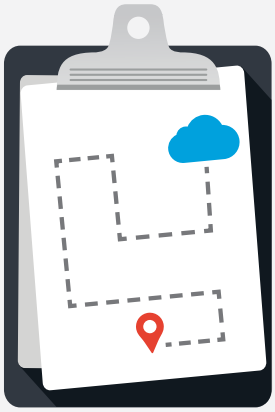
bytes of health care data are created every day (a quintillion is the number 1 followed by 18 zeros)

46%

of consumers believe mobile health care apps will reduce overall health care costs

48%

of consumers think access to mobile health will improve their care



37%

of health care organizations have developed a strategic plan for cloud computing

40%

of consumers say information found via social media outlets influences their health care decisions

Source: New IT Drives Healthcare Transformation InfoGraphic, HP and Frost & Sullivan, 2014

These statistics are just a snapshot of some of the changing expectations and needs in health care. Today, organizations operate more like an ecosystem — they actively connect with consumers and communities as well as partners, suppliers and regulatory agencies. There has been a lot of change, but that creates room for new opportunities.

As a health care IT leader, HP is a strategic partner that can help HHS agencies evolve to succeed in a challenging marketplace. HP can help HHS agencies offer information-driven and tech-savvy citizens the innovations they demand and work to create a new and more efficient health care ecosystem.

To learn more about HP's solution for a transforming health and human services marketplace, visit: www.hp.com/enterprise/healthcare

Digging Deeper:

LexisNexis Helps States Prevent Health Care Fraud with Multi-Tiered Approach

States serve a critical role in health care; first through traditional programs like Medicaid, second through their emerging role as providers of online insurance marketplaces that offer convenient unified eligibility services to the most vulnerable populations for a myriad of state programs. It is incumbent upon the states to ensure that taxpayer dollars go to these populations and not to the fraudsters who seek to exploit these programs.

The Affordable Care Act (ACA) has brought new programs and dollars, as well as higher eligibility and enrollment standards to the states. This landmark legislation, along with the unfortunate realities of electronic identity theft, make states and their citizens easy targets for modern-day scams. The truth of the matter is that many people's identities have been compromised, or stolen, in some capacity. Criminals have access to a wealth of information over time and can use it to steal an individual's complete identity or even fabricate synthetic identities out of a multitude of data elements. In an increasingly digital world, the key concerns become: Is this person real? Do they own this identity? Can they prove it? Answering these questions is essential to protect public funds. States must protect taxpayer dollars from identity-based fraud, and thereby ensure that eligible citizens have access to the care and services they need. Agencies have identity-verification tools available for their programs to validate that an individual is who they say they are before granting them access to critical services and ensure that services and benefits are provided by credentialed providers and qualified individuals.

Though federal exchange databases provide a snapshot of an individual's financial data, LexisNexis' identity proofing and management requires out-of-wallet information — data that cannot be found by stealing an individual's wallet or bank account records. Instead, it requires the comprehensive knowledge of an individual's life, nuanced details that only the actual individual could answer and that are only revealed through an exhaustive accumulation of public and proprietary data sources.

This approach to identity authentication draws from a variety of data sources, which includes data on a population that is typically unidentifiable, namely the "unbanked." Program participants may be homeless, young, highly transient and may not carry a credit card. The reality is that many program recipients have limited to no access to financial institutions or credit cards, which typically makes it impossible to identify them through financial-driven means. LexisNexis solves this dilemma through its concatenation of data, building a holistic identity that encompasses far more than just their financial footprint. In addition, LexisNexis can use comparative analytics to identify individuals who are trying to use the identies of those who are deceased or incarcerated, which supports agency program integrity efforts by mitigating fraud, waste and abuse.

The Power of Integration

A Framework for Driving Health Ownership

Integration of services and coordinated care are just a few of the newest initiatives in the health and human services market — and for good reason. Integration of services can lead to reduced costs and elimination of duplicative efforts, while ensuring individuals receive the right services at the right time. UnitedHealthcare helps break down traditional medical administration and clinical program silos by developing employer-sponsored health plans that support an integrated health framework.

The same is true when thinking about improving health outcomes. In order to reduce the likelihood of preventable diseases (such as Type 2 diabetes), help improve decision-making and create a personalized care experience, an integrated approach combining medical and clinical programs designed around individual needs can be critical. By leveraging technology, clinical expertise and behavior change management, we create an experience that supports members' basic health decisions, or at time of critical care needs, helps to optimize outcomes and reduce cost. The result is demonstrated performance that shows the power of integration relative to disparate stand-alone programs.

For UnitedHealthcare, combining medical and clinical programs has shown to help improve member health and reduce costs.[1] Specifically:

- Shortened in-patient stays by 12%
- Reduced readmission rates by 7%
- Increased primary care visits by 12%
- Reduced the rate of heart attacks and strokes by 10%

UnitedHealthcare®

To learn more, contact Paul Campbell,
Vice President, State & Local Solutions,
(847) 870-0952, Paul_J_Campbell@uhc.com

1. "The Power of Clinical and Medical Integration," UnitedHealthcare, 2014. *Savings calculated on book-of-business case rate savings for these programs. Savings for enrolled members are case specific and are not a guarantee of results. Results will vary based on client specific demographics and plan design.*

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Modernizing Legacy Systems

Making Technology Work for Those in Need

Many health and human services (HHS) agencies, especially child welfare organizations, are still dominated by legacy systems that cannot keep up with the demands of today. As resources continue to grow scarce, it's more important than ever for child welfare agencies to have reliable tools to support children and families in need. In fact, since 2006, the percentage of children in low-income families has been on the rise – increasing from 40 percent in 2006 to 45 percent in 2012.[1]

Unisys Secure Family Net (USFN) was designed specifically with child welfare agencies in mind. USFN is a robust, agile, next-generation Statewide Automated Child Welfare Information System (SACWIS) platform that provides a more holistic suite of tools and functionality to handle complex caseloads, meet state and federal outcome guidelines, and increase transparency.

The USFN solution recognizes the increasing necessity of being able to provide services anytime, anywhere. USFN features a mobile application built around this concept to aid case workers in performing their job functions while out in the field. Using the inherent power of mobile technology in a way to help capture and utilize information, in real-time, significantly reduces worker time and increases speed to service for children and families. Equally important is the safety of the field workers, which is why USFN features a panic button and geo-locator to increase case worker safety while in the field.

There are nearly 400,000 children in foster care in the U.S.[2] Accessing and effectively using information about this critical population of children is more important than ever. The USFN solution includes dashboards and analytics to provide leaders with accurate data to manage workforce issues and caseloads. Analytics enables case workers to make fact-based, informed decisions to efficiently serve their clients.

USFN provides child welfare agencies with:

- Mobile functionality
- Data analytics with dashboard measurements
- Secure access
- Web-enabled software and applications
- Local or cloud hosting
- End-to-end or modular solutions

With 32.3 million children living in low-income families, the need to streamline and increase service is clear.[3] The USFN solution can help speed up response times in the field, increase productivity, provide insights based on evidence, enable access to critical data while in the field and improve collaboration with community partners.

1. www.nccp.org/publications/pub_1089.html
2. Unisys Secure Family Net brochure
3. Ibid.

Protecting Patient Information:

Enhanced Security Solutions Help Mitigate Risk and Ensure Compliance

Eighteen years after the passage of HIPAA (The Health Insurance Portability and Accountability Act of 1996), health and human services (HHS) agencies are still struggling to comply with federal regulations designed to protect patient information. The HHS Office of the Inspector General recently released an audit report that detailed 79 security control failures across 10 state Medicaid agencies audited between 2010 and 2012. The results indicate there is a clear need to increase security of patient data. Of the 10 agencies audited:

- Eight failed to distribute encryption technology in accordance with their encryption policies
- Nine had substandard network device management and monitoring
- Six had insufficient control over identification and authentication of users
- Five had substandard configuration management policies

Symantec's security solutions are built to help HHS agencies protect patient information from the constant onslaught of threats. With continuous monitoring and enforcement of information and system security policies, Symantec's solutions can help HHS agencies protect patient data and secure the systems in which it resides. Symantec's solutions include:

Control Compliance Suite

- The Control Compliance Suite automates continuous assessments and delivers a holistic view of security controls and vulnerabilities, which allows for prioritization of security remediation and enables secure migration to the software-defined data center. To learn more, visit: www.symantec.com/control-compliance-suite

Managed Security Services & Advanced Threat Protection

- Managed Security Services provide around-the-clock monitoring, while Symantec's Advanced Threat Protection minimizes the impact of advanced, targeted attacks. With edge to endpoint coverage and the ability to pinpoint critical threats, Symantec can help streamline security processes. To learn more, visit: www.symantec.com/managed-security-services

Data Loss Prevention

- Symantec's Data Loss Prevention solution allows agencies to discover, monitor, protect and manage confidential data, which is necessary to comply with HIPAA guidelines. To learn more, visit: www.symantec.com/data-loss-prevention

Advanced User Authentication

- By combining multiple identification factors, Symantec's Advanced User Authentication solutions help ensure that only those with the proper credentials and clearance access patient data. To learn more, visit: www.symantec.com/user-authentication

Encryption Software

- Encryption software allows HHS agencies to protect data through centralized policy management, standards-based technology and compliance-based reporting. To learn more, visit: www.symantec.com/encryption

In an age of increasing threats and high-profile security breaches, HHS agencies cannot afford to leave patient data unprotected. Symantec can help mitigate the risk and ensure compliance with federal regulations with its proven suite of security solutions.

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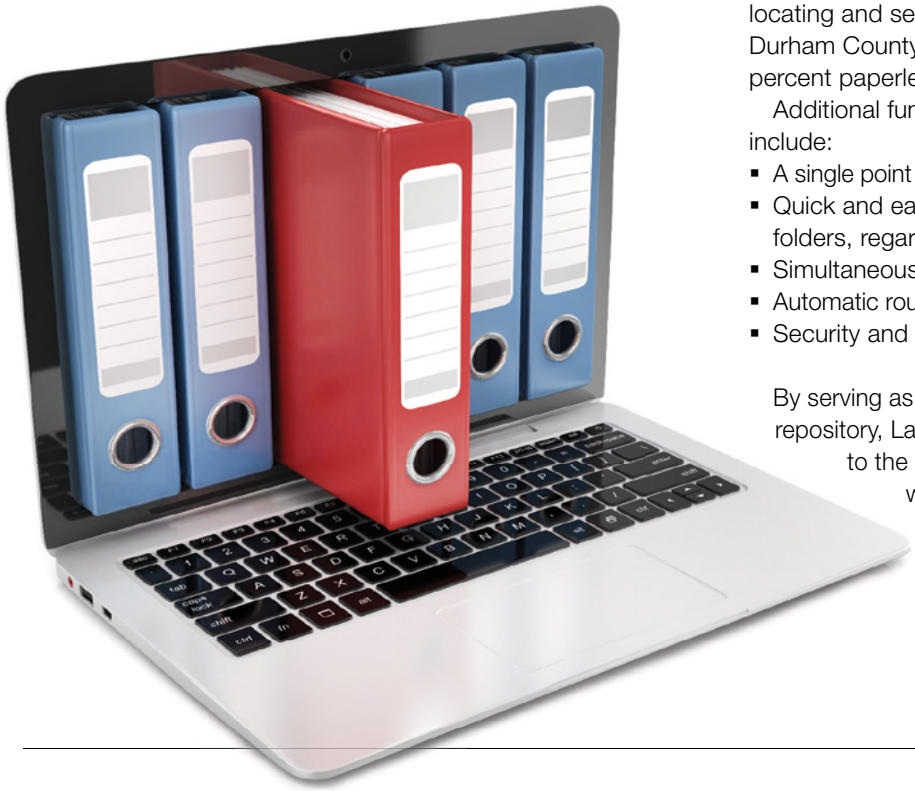
Streamline Case Management with End-to-End Services

The Affordable Care Act, Medicaid expansion in 27 states and the recession's impact on low-income populations have all contributed to increased demand for government services. State and local social services agencies are encountering increasing case loads, but the majority of these agencies don't have the resources to hire additional personnel. For many, increasing efficiency and streamlining services is critical if they are to adequately serve their jurisdiction's most vulnerable populations.

To help resolve this challenge, many agencies are capitalizing on Laserfiche's end-to-end enterprise content management (ECM) suite to streamline management of client cases and workloads.

For example, the Norfolk, Va., Department of Human Services (NDHS) uses Laserfiche's ECM suite during the entire case management life cycle — from information capture to processing to records retention.



NDHS collects and processes a large number of documents for its Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP) and public assistance initiatives — so much so that it had a four- to five-day backlog of scanned documents. Using Laserfiche's ECM suite to provide end-to-end case management services, NDHS was able to streamline its processing, workflow and communication with clients while ensuring retention. With 150,000 active cases on file, NDHS is able to search for specific cases using Laserfiche's solution, creating additional efficiencies within the department.

Additionally, North Carolina's Durham County Department of Social Services uses Laserfiche's solutions to automate the case management process in preparation for child welfare cases. Using a county case number, created by the ECM suite, materials can be requested, identified and distributed — skipping the time-consuming process of locating and sending paper-based files. Using the ECM suite, Durham County's ultimate goal is to become at least 95 percent paperless.

Additional functionalities of the Laserfiche ECM suite include:

- A single point of control for all cases throughout their life cycle
- Quick and easy access for users to add and edit record file folders, regardless of format
- Simultaneous access for multiple users
- Automatic routing, indexing and filing of incoming documents
- Security and privacy of confidential client files

By serving as the universal end-to-end case management repository, Laserfiche's ECM solution provides instant access to the information agencies require to serve citizens who need help. Increasing efficiencies and reducing paper-based processes ensure that HHS staff time is spent serving their clients, not filing paperwork.

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State and local health and human services (HHS) agencies are transforming how they see and use data sets from multiple agencies. In this era of waning budgets and increasing case loads, it's essential to leverage data to create a holistic view of beneficiaries. But data is only valuable when it leads to insight that impacts healthcare cost, quality, and access.

Truven Health Analytics™ helps federal, state, and local government solve their healthcare data challenges and find actionable answers to improve the cost and efficiency of their programs and make meaningful impacts in the lives of its citizens. Our solutions and services have generated major savings for our government clients through better budgeting, rate-setting, benefit design, program planning, managed care oversight, and program integrity. Our work in healthcare and human service analytics has been our sole focus for more than three decades. No other company has as much experience in health and human services quality improvement and accountability.

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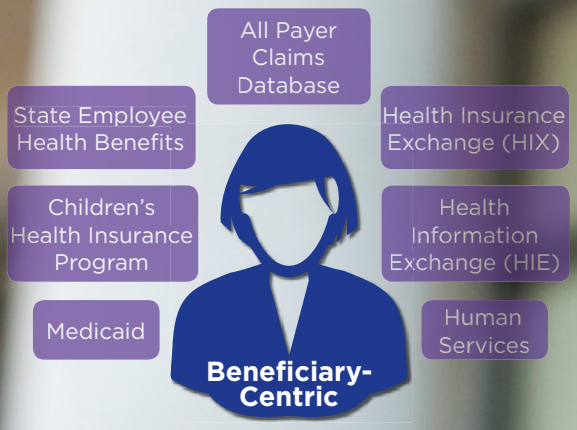

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- Research database for benchmarking contains 27 years of health claims data for 160 million U.S. lives

Coordinated Delivery of Care

Technology Provides Data for Better Client Outcomes

Siloed records can lead to fragmented and disjointed care for health and human services (HHS) agencies. With the expansion of HHS programs and initiatives such as the Affordable Care Act, it's imperative that each HHS agency and department share records to ensure citizens receive holistic care. Microsoft, in conjunction with its partners, provides care coordination solutions to help bridge the gap among HHS agencies, departments and other social programs to provide case workers with a comprehensive understanding of citizen needs.

The benefits of Microsoft's solutions for care coordination include:

- **Efficient Case Management:** Microsoft's case management solutions provide HHS agencies with a common data platform, combining or providing access to data otherwise confined to technology most agencies already have in place.
- **Constituent Relationship Management:** The care coordination solution, based on Microsoft Dynamics CRM platform, helps to connect departments, streamline processes and provide better outcomes for employees and clients. Using cloud-based or on-premises technology, it ensures HHS agencies have the resources to handle increased caseloads, additional services, and the ability to track requests.
- **Centralized Records:** HHS agencies can access a centralized, automated platform that allows for the sharing of case records and client data among organizations.

Additionally, solutions can be customized to address investigative, regulatory, security and legal guidelines that extend beyond existing systems. The availability of records and improved access can help HHS agencies monitor at-risk cases and improve client outcomes.

The Ohio Department of Development Disabilities (DODD)[1] deployed a Microsoft Dynamics CRM platform across 18 counties, which supports the department's person-centered philosophy and gathers critical data, such as an individual's life goals. "With Microsoft Dynamics CRM, you get case management, workflow capabilities, a database, security, and alerts and notifications — all without having to code anything," says Bryant K. Young, CIO of Ohio DODD. "All this makes the system very appealing when you are looking to speed the time-to-value of a new application."

The Mississippi Department of Mental Health[2] also engages patients and closes the clinical loop with cloud-enabled apps using Microsoft Dynamics CRM.[3] This approach to coordinated care makes a difference in the lives of Mississippians diagnosed with a mental illness or intellectual or developmental disabilities.

Case management is about more than simply monitoring and capturing data. To successfully provide citizens with holistic, coordinated care, HHS agencies need to invest in technologies that ensure citizens are seen as people with specific needs — not just a number. Microsoft and its solution partners can help your agency make this transition.

1. www.microsoft.com/casestudies/Case_Study_Detail.aspx?casestudyid=710000004481
2. https://customers.microsoft.com/Pages/CustomerStory.aspx?recid=911
3. www.microsoft.com/en-us/dynamics/crm.aspx

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Integrated Service Delivery Improves HHS Outcomes

Health and human services are not only increasingly complex, they are also intrinsically connected. As such, integrating health and human services data and systems, while creating a single point of access to all HHS programs, is essential to develop and sustain a healthy population and help those most in need.

To bridge the gap between health and human services programs, KPMG is developing the KPMG Resource Integration Solution (KRIS), which is anticipated to be a fully integrated, preconfigured solution that leverages commercial-off-the-shelf (COTS) products to support health and human services programs.

KRIS is being designed to offer a flexible, scalable solution aligned with federal reference architectures to support state-level HHS programs while meeting national compliance regulations.

Because of its intended flexibility, scalability and interoperability, KRIS may be programmed specifically to meet the needs of individual states. Beyond that, KPMG envisions that it will leverage reusable knowledge and tools and can be updated as new policies and regulations emerge. Further, it is anticipated that KRIS will be deployed either as an on-premises solution, or hosted in the cloud. In the cloud environment, KPMG would maintain responsibility for software maintenance while the on-premises solution would be appropriate for states that wish to handle maintenance in house.

KPMG foresees the platform including multiple channels of access for both citizens and HHS staff, including Web and mobile applications. These multiple channels of access should help to remove barriers to services and enable staff to better serve clients.

KPMG is creating the KRIS solution with efficiency in mind. Increasing HHS delivery effectiveness and maintaining successful, efficient programs helps to ensure that even the most vulnerable populations receive the services they need, when they need them. Cutting through the red tape associated with public assistance programs and sharing data across departments and programs will make the “no wrong door of entry for services” dream a reality.

KPMG

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