Community Care Team:

Mayo Clinic, Olmsted Medical Center & Olmsted County Public Health

Accountable Community for Health

The Community Care Team/ACH is a collaborative of Mayo Clinic’s and Olmsted Medical Center’s Health Care Homes, Olmsted County Public Health, the Intercultural Mutual Assistance Association and Elder Network. The ACH assists community dwelling adults with multiple chronic health conditions in connecting with and utilizing community services to help meet their priority needs.

The ACH is measuring how a 12 week intervention consisting of 2 group sessions and weekly individual sessions increases health outcomes and use of community services for people in the target population. The ACH will use survey data from participants and team members to measure its results over time.

Care Model

The community care team originated in 2011 and has developed into a cohesive group that works together for the benefit of the patients and families it serves. 2015 adaptations included adding a public health nurse and community health worker to the team, providing training in group process, and strengthening the community social worker role on the team. The team also expanded the target population beyond patients receiving nurse care coordination in the two health care homes clinics to include referrals from other clinics and the community. The care team meets with the patient to jointly review patient/family strengths, develop an action plan and to increase social support from the family and community resources.

Target Population

The target population is the approximately 545 community-dwelling, primary care patients at Mayo Clinic’s or Olmsted Medical’s Health Care Home with multiple chronic health conditions aged 40+ years who are enrolled in nurse care coordination.

Key Partners

- Elder Network
- Intercultural Mutual Assistance Association
- Mayo Clinic*
- Olmsted County Public Health
- Olmsted Medical Center†

*Accountable Care Organization
†Health Care Home
‡Lead organization

Success Story

RC is a 59 year old woman who has not had stable housing for years. She was staying with a friend about an hour from Rochester but this was not a long term option as all of her medical cares are based in Rochester and RC wanted that to continue. She was able to get a ride to Rochester, but then was essentially “stuck” there and had nowhere to live, sleep, or eat.

Because of RC’s limited income options were slim, but the CCT assisted her with submitting an application for an apartment complex she could afford and for General Assistance with Olmsted County. She was approved for $500 (the maximum) and an additional $80/month as head of household. Between the little

Location

Olmsted County
money RC had left for the month and borrowing money from two friends, she was able to pay the application fee and prorated rent. After several months of consistent work RC got the keys to her apartment. With tears in her eyes, RC shared this was the first place that was ever all her own and the first time her name was on a lease. She was also assisted with getting furnishings for the apartment and completing an Energy Assistance application as she will be paying her own utilities each month.

Now that RC has a stable and affordable place to live she talks about taking computer classes, working to better control her blood sugar, and volunteering at the Salvation Army. She doesn’t feel like she is living day to day anymore.

Measurement

The CCT collects data on patient demographics, priority problems, outcomes, and services recommended and used, and utilizes several patient-focused instruments such as the Patient Assessment of Chronic Illness Care, Global Health and Well-Being.

Sustainability

The CCT is identifying individuals served by the Mayo Integrated Health Partnership (IHP) who are in the target population and will be contacting these individuals and encouraging them to participate in the CCT. If the CCT is shown to be effective at improving quality and controlling costs in this population, the CCT will be incorporated as an important component of the evolving Health Care Homes ACO model. This model element will then be offered in subsequent contractual value based arrangements for the delivery of health care to identified populations making the CCT an integral element of the population health care model.

The CCT also is submitting a proposal to the funding opportunity announced by CMS for an Accountable Health Communities Model. Obtaining this funding would assist in leveraging and sustaining the CCT/ACH, public health, and community health innovations across a 12 county region in southeast Minnesota.

Minnesota Accountable Health Model – SIM Minnesota

This project is part of a $45 million State Innovation Model (SIM) cooperative agreement awarded to the Minnesota Departments of Health and Human Services in 2013 by the Center for Medicare and Medicaid Innovation (CMMI) to help implement the Minnesota Accountable Health Model.

About $5.5 million of SIM funds are dedicated to 15 Accountable Communities for Health (ACH) grant projects. ACHs meet the clinical and social needs of a defined population through person-centered, coordinated care across a range of providers. ACH grantees were selected through a competitive process. Awards were for $370,000 over a two-year period, 2015-16. Minnesota is evaluating if community-led ACH models result in improvements in quality, cost, and experience of care.

Population Health

The target population of the CCT (community-dwelling adults with multiple chronic conditions) has high rates of financial stress, homelessness and mental health issues. The goal is to target CCT activities that align with the similar priorities identified in the Community Health Improvement Plan (CHIP) (2015-2017) for Olmsted County.