Minnesota Accountable Health Model

Joint Community Advisory and Multi-Payer Alignment Task Force

Wednesday, January 18, 2017 | 9:00 a.m. - 12:00 p.m.
Shoreview Community Center, 4580 Victoria St. N., Shoreview, MN 55126

MEETING MINUTES

Attendees

Members: Jennifer Lundblad (CATF Chair), Garrett Black (MPATF Chair), Courtney Baechler, Karen Chapin, Kenneth Bence, Sarah Keenan, George Klauser, Jonathan Lundberg, Nathan Moracco, Jeffrey McGonigal, Carolyn Pare, Brett Skyles, John Sohigian, Catherine Von Rueden

State Staff: Commissioner Dr. Ed Ehlinger, Jennifer Blanchard, Jennifer Fritz, Bonnie LaPlante, Krista O’Connor, Heather Petermann, Diane Rydrych, Mat Spaan, Jeff Schiff

CHCS Staff: Greg Howe, Diane Stollenwerk

Welcome and Overview of Agenda

Jennifer Lundblad, CATF Chair, welcomed everyone and provided an overview of the meeting agenda. She then helped ground the group in the Driver Diagram and went over the 2016 updated infographic showing that SIM goals are on target or have been surpassed. Jennifer explained that the emphasis of this meeting would be on sustainability.

Commissioner Ed Ehlinger gave opening remarks: the work that each Task Force is doing in support of activities across the state is incredibly valuable. He discussed the need to continue to address health care cost, quality, equity, providing care in an integrated manner, and community engagement. As changes occur in the environment, this work is more important than ever at the state level to model for others including policy makers at the federal level.

Updates

Diane Stollenwerk, CHCS, provided an update on the status of the CMMI Request for Information (RFI).

- CMMI has not released results yet, but the themes from recent HHS memos and blog posts show that they are listening to the input that the states have provided.

Krista O’Connor, DHS, provided updates on the evaluation.

- Progress has been made on the organizational survey and Accountable Care Matrix. SHADAC’s role was explained, as was the importance of relationship building and eHealth in transformation efforts. Revisions were made to the survey instructions, sections were re-ordered, and capabilities added. Bluestone and Ascension Health offered to pilot the survey, which will be sent to them this week so that SHADAC can receive feedback. Ultimately, this survey will reach over 300 organizations.

- The next step for the evaluation is to assess ACO barriers and progress under Driver 5—payment methodologies. The TF members will receive a homework assignment within a few days of the meeting on this topic.

Information: SIM MN Website, www.mn.gov/sim
Contact: SIM MN Email, sim@state.mn.us
Diane Rydrych, MDH, provided updates on SIM resources.

- A Public Health Informatics Institute podcast in November featured a discussion of the e-Health Roadmap, specifically related to sharing information about students with asthma.
- The e-health roadmaps website has been updated with easy, efficient access to recommendations, actions and resources.
- Emerging Professions Toolkits: the Community Paramedic toolkit was released in December. The Dental Therapist toolkit is being developed and will be released shortly.

Diane Rydrych, MDH, provided updates on 2017 SIM funded Grant Opportunities.

- Ten organizations received awards in the fourth round of the Practice Transformation grant program to support a variety of projects that advance integrated care.
- Six Accountable Communities for Health (ACH) received funding in round two. These organizations will build on their existing infrastructure to expand their ACH model.
- Six organizations received Health Information Exchange and Data Analytics grants to support the secure exchange of health information and data analytics efforts to improve health care and population health.
- The Oral Health Access Grant was awarded to Unity Family Health Care in Little Falls, which will go through September 2017.
- The RFP has been posted for the Primary Care Public Health Learning Community grant. The grant will provide opportunities for local public health and primary care partners to share ideas in a learning community. Responses are due January 20.
- Save the Date: Minnesota’s e-Health Summit; June 15, 2017 at the Earl Brown Heritage Center.

Sustainability and Evolution of SIM-Related Initiatives

Diane Stollenwerk, CHCS, facilitated discussion on the activities undertaken or planned by the TF members regarding the sustainability and evolution of SIM-related initiatives.

**Community Engagement:**

Krista O’Connor, DHS, gave background on learnings from the Health Equity Summit, evaluation findings, and future opportunities. The discussion then included the following comments:

- There is now a greater awareness of the need and value of community engagement.
- SIM has fostered the “public health perspective.”
- There is an eagerness for community organizations to work with high schools. Students have valued training on mindfulness. The YMCA has many students using this programming.
- Organizational and individual leadership will be important to ensure sustainability.
- There are collaborations between Bluestone and Healthstar that focus on improving services for people with disabilities.
- eHealth has been the catalyst for community collaboration, including working to have better eHealth integration between physical and behavioral health, putting the person at the center, and accounting for total cost of care.
- County governments are important partners.
- How funding is distributed is often more important than the total amount available.
- There cannot be accountability if there’s no information available.
- The role of psychiatrists is important, especially when addressing behavioral health across the community.
- Medicaid expansion brought more people into the system.
Financial viability is critical for all types of organizations engaged across the community, including nonprofits.

**eHealth Use and Data Exchange:**
Jennifer Fritz, MDH, provided an overview of the consent RFI, the HIE Study, and HIO Connectivity. The discussion then included the following comments:

- Primary care providers are going to be paying more attention to interoperability.
- “Provider” must be defined in broad sense—not just medical. Community providers are sometimes more enthusiastic about connecting with others than are medical providers.
- We need to look at what data is required in specific situations, e.g., integrated alerts can be helpful when an incident happens that affects the needed response by one or more community partners.
- Addressing data about medications is “low hanging fruit,” there is a universal need to ensure that medication data is accurate and the information is shared among relevant providers.
- Results from a 15 month study done by Wilder showed the importance of assessing the impact of data exchange.
- One health system piloted Open Notes, a successful program which allows patients access to their medical records and helps to build trust among patients and providers. It is worth expanding the philosophy of Open Notes and greater transparency across the state.
- One health plan coordinated with providers so that a provider could check a patient’s eligibility for coverage and benefits.
- We need to find ways to give patients more access to their own data and let them know who is accessing it.
- Health plans need access to medical records as well, to coordinate care and check benefits and eligibility.
- The boundaries of data exchange need to reflect patterns of care.
- We need to remember the “sneaker” network of people who are caregivers for others (kids, people w/ disabilities, elderly)—data exchange must work for them also.

**Payment & Care Delivery Reform:**
Mat Spaan, DHS, and Bonnie LaPlante, MDH, gave background on the IHP 2.0 Model evolution and HCH Model evolution, including an overview of the IHP model, what was learned through SIM activities and the RFI, and what is coming next with IHP 2.0. The discussion then included the following comments:

- There is a need for actionable data, especially relating to social service organizations.
- Long-term sustainability is still a challenge; participation itself can still be burdensome. There needs to be a longer, multi-year perspective.
- Health Care Homes are critical to the Triple Aim—to improve cost, be patient-centered, and improve the health of the population.
- It is important to engage patients in the payment and delivery reform process.
- Payment reform is still building on a fee-for-service system. Instead, purchasing reform may be another focus, as it is more about engaging employers and providers directly and this is a gap that has not yet been fully bridged. Purchasers want to construct a new model to address gaps.
- Tools to help assess purchasing opportunities are important, e.g., a roadmap to know what’s out there and to provide ideas for additional actions.
Care coordination is a key issue. Payers pay differently for care coordination services. We need to construct a new model.

There may also be value in focusing on pharmacies and their role in health care delivery.

Risk adjustment continues to be a challenge.

One employer described their use of ACOs as a benefit option for employees. Over the past few years, the enrollment in the ACOs has had consistent growth and improved competitive pricing. Their tracked measures show 95% retention of enrollees in the ACO plans, and the use of preventive care has been excellent. There was also greater value when people moved to the ACOs rather than high deductible health plans.

There is a need to address areas generating the majority of cost: specifically, specialty care and prescription drugs.

One health plan is making better progress on quality than cost incentives.

PPO and ACO costs aren’t much different. There needs to be more economic alignment to motivate people to move to an ACO model.

One health system is tied into ACOs instead of higher deductible plans.

**National Perspective on Transforming Health Care:**

Greg Howe, CHCS, reviewed Secretary Burwell's framework for thinking about health policy, as described in a recent blog post, current health care policies such as MACRA and related challenges, and how the health care system has evolved since the implementation of the ACA. The discussion then included the following comments:

- MACRA allows for options for providers to get more involved in alternate payment arrangements or to participate in MIPS, which is still built on a fee-for-service system.
- Much innovation has occurred and the infrastructure is in place within Minnesota to create opportunities for continued success in improving health and health care.

**Wrap-Up Discussion across Sections**

The discussion included the following comments:

- There is a lack of awareness of the work that’s been done under MN SIM among schools, parents, and community organizations like the YMCA.
- Among the things that Minnesota has done very well are quality measurement and quality improvement. The existing quality measurement and quality improvement infrastructure in the state should be brought to the forefront.
- Data analysis work must continue.
- We need to capitalize on being in a strong position by continuing to build on the existing innovation and structures throughout the state.

**Public Comment**

No audience members chose to offer any public comments

**Next Steps/ Future Meetings**

Garrett Black, MPATF Chair, offered concluding remarks:

- Garrett provided an overview of the forthcoming homework assignments and reminded the TF
members that the next and final joint Task Force meeting will be on April 19th at the Wilder Center.

- Jennifer Lundblad, CATF Chair, thanked and shared comments of appreciation for Garrett Black, who has chaired the Multi-Payer Alignment Task Force for the past three years. (Garrett will not be able to attend the April meeting.) Commissioner Ehlinger presented him with a certificate of appreciation, and thanked Garrett for his leadership.

The meeting was adjourned just before noon.