Minnesota Accountable Health Model: Community Advisory Task Force
Agenda

• Welcome and Overview of Agenda
• Task Force Renewal and Staffing Changes
• Update: Minnesota Accountable Health Model
• Data Analytics Subgroup
• Presentations from Emerging Professionals Integration Grantees
• Community Engagement
• Next Steps/ Future Meetings
• Public Comment
Task Force Renewal

- Task Force members appointed in 2013
  - Two year term
  - Current membership expires May 1, 2015
- Commissioners Jesson and Ehlinger requested an extension
  - All seats must be re-posted
- Several members have moved or changed affiliation
  - Renewal is an opportunity to ensure full and varied representation on the Task Forces
Process for Reapplying to Task Forces

- Commissioners Jesson and Ehlinger encourage current members to reapply on the Secretary of State’s [Open Commissions & Appointments website](#)

**Timeline**
- April 6, 2015: Task Force vacancies published
- April 28, 2015: Applications due
- May 8 – 13, 2015: Appointments announced
- May 20, 2015: Community Advisory and Multi-Payer Alignment Task Force Meeting Scheduled
Staffing Changes

State Staff

• Marie Zimmerman, Medicaid Director
• Jennifer Blanchard, Interim Health Care Policy Director
• Jennifer DeCubellis, Assistant Commissioner, Community Supports Administration

CHCS Facilitation Team

• Shannon McMahon, Maryland Medicaid Director
• Theresa Connor and Susan Shin joining
MN SIM Update: ACO Baseline Assessment (Interviews)

Two approaches to the assessment: Interviews and Survey

Interviews
- Interview questions finalized with vendor and respondents selected
- Interviews will start the week of March 16th and be finalized the following week
- Topic areas: business process transformation, clinical pathways, community relations, contract management, and IT capabilities
MN SIM Update: ACO Baseline Assessment (Survey)

Two approaches to the assessment: Interviews and Survey

Survey

• Online survey pilot completed
• Revisions being incorporated into survey
• Anticipate survey distribution to additional stakeholders week of March 16th

Final distribution will go to medical group contacts (not each clinic), hospitals, and health plans
MN SIM Update: E-Health Roadmaps

• Purpose: To describe a path forward and a framework for providers of a particular setting to effectively use e-health to participate in the Minnesota Accountable Health Model

• Focus settings:
  - Behavioral health
  - Local public health
  - Long-term and post-acute care
  - Social services

• More than 800 providers and other experts have volunteered for the Roadmap Steering Team, workgroups, reviewers, or Community of Interest

• Kick-off in February; First workgroup and Steering Team meetings in March
MN SIM Update: Learning Community Grants

• Four organizations were selected to implement Learning Communities to give care providers tools to improve quality, patient experience and health outcomes, while actively engaging communities and reducing health care expenditures.

• Grants awarded to:
  - American Academy of Pediatrics- Minnesota Chapter
  - Center for Victims of Torture
  - Rainbow Research, Inc.
  - The National Rural Health Resource Center
MN SIM Update: Evaluation and Learning Days

• **Evaluation**
  - Final approval of evaluation plan expected by the end of March
  - RTI (Federal evaluation) site visit is ongoing
  - Upcoming homework assignment to be discussed at May Task Force meeting

• **2015 Minnesota Learning Days Conference**
  - Focus on integrating care for Minnesotans, learning strategies for community engagement and achieving the Triple Aim
  - May 12-14
  - River’s Edge Convention Center, St. Cloud, MN
MN SIM Driver Diagram

**Aim**

**Minnesota Accountable Health Model**

By 2017, Minnesota’s health care system will be one where:

- The majority of patients receive care that is patient-centered and coordinated across settings;
- The majority of providers are participating in ACO or similar models that hold them accountable for costs and quality of care;
- Financial incentives for providers are aligned across payers, and promote the Triple Aim goals; and
- Communities, providers and payers have begun to implement new collaborative approaches to setting and achieving clinical and population health improvement goals.

**Primary Drivers**

1. Providers have the ability to exchange clinical data for treatment, care coordination, and quality improvement.
   --HIT/HIE

2. Providers have analytic tools to manage cost/risk and improve quality.
   --Data Analytics

3. Expanded numbers of patients are served by team-based integrated/coordinate care.
   --Practice Transformation

4. Provider organizations partner with communities and engage consumers, to identify health and cost goals, and take on accountability for population health.
   --ACH

5. ACO performance measurement, competencies, and payment methodologies are standardized, and focus on complex populations.
   --ACO Alignment

**Secondary Drivers**

- Provide funding, technical assistance (TA) and other resources to incentivize community, provider and setting engagement in secure Health Information Exchange (HIE).
- Develop roadmap and provide tools/resources to promote Electronic Health Records (EHR) adoption and effective use.
- Provide investment in state technical infrastructure to support population health improvements through standards-based clinical health information exchange.
- Provide enhanced data analytics, reporting and technical assistance.
- Provide resources and training on quality improvement.
- Provide direct provider support/TA for practice transformation/transition to team based, patient-centered coordinated care.
- Support adoption of emerging provider types (e.g., community health worker, community paramedic, dental therapists).
- Establish models for Accountable Communities for Health.
- Develop a methodology/roadmap for incorporating ACH activities into payment models.
- Align and evolve ACO payment methodologies.
- Establish ACO core competencies and regulatory structures.
- Develop community core measures for ACO cost and quality.
- Develop integrated ACO financial models and measures for complex populations.
Total Funds: $45.2 Million
Data Analytics Subgroup

- Subgroup is advisory to the Task Forces
- Had three meetings, December 2014 – February 2015
- Purpose: “Develop recommendations and identify top-priority data analytic elements, to motivate and guide greater consistency in data sharing…”
- Webinar on March 3 detailed the work and outputs of the Data Analytics Subgroup for Phase One
Recap: Preconditions for Success

- Identify standard elements or information that stakeholders need in order to align their approaches to data analytics
  - Reporting timeframes
  - File types / formats, names of variables
- Clarify which elements need to be at the individual level (personal health information and HIPAA considerations)
- Assess what is needed for member consent management, to handle the proliferation and sharing of member-level data
Recap: Suggestions for Standardization

For alignment to occur, standardization is needed in some areas:

- Measurement and reporting period timeframes for all arrangements (e.g., calendar year, quarterly)
- Consistent formatting (e.g., granular data sets using standard file types, such as SAS or .csv, and standard names for variables)
- Shared definitions that are clear and consistent
Recap: Guiding Principles

1. The State of Minnesota and other payers, purchasers and providers should “lead by example,” placing top priority on alignment, consistency, and sharing of data on physical health, behavioral health (including mental health and substance abuse disorders), and social factors to achieve greater integration of care and better management of populations (including the use of comparison groups) across health organizations. Entities should encourage such alignment through contracting, regulatory authority, or other means, while acknowledging the need for unique approaches when necessary.

2. Payers, providers, and other stakeholders should be able to tailor systems of data collection and analysis to accommodate the range of care settings in Minnesota (e.g., urban to rural, large integrated organizations to individual providers) and to align with the various health information technology structures across Minnesota.
3. Systems should **build upon existing data integration efforts**, reducing parallel data collection and maximizing the use of common technology and process platforms (including consent management).

4. Data analytics should **support the Triple Aim**, including a wide range of demographic data (e.g., race, ethnicity, language, and tribal affiliation, both existing and under development) to foster organizational collaboration across geographic and demographic boundaries.

5. When looking to change existing approaches to data analytics, each organization should **strive to achieve an appropriate balance between the benefits of the new system to achieving the Triple Aim for the community large and the costs** of new system development, maintenance, and staffing.
Recap: Prioritized Data Components

- Contact Information, Primary Care Provider
- Risk Level
- Total Cost of Care
- Health Status by Demographics
- Patterns of Care Within and Outside ACO Providers
Advice from the Subgroup

• Focus initial alignment in five topics for data analytics
• Define certain elements to allow alignment to occur (e.g., variable names, file format, consistent timeframe)
• Continue this work . . .
  ▪ Engage in more discussion about key standardization topics
  ▪ Begin alignment through ‘leading by example’
  ▪ Move to Phase Two
Data Analytics Subgroup: Key Questions for Discussion

1. What are the potential benefits or challenges associated with these guidelines and recommendations?
2. How does the Task Force intend to proceed with these recommendations?
3. How can Task Force members drive awareness and adoption of the recommendations?
4. What approach should be taken to continue the work into Phase Two?
Emerging Professions Background

- MN is a national leader in development of new professions
- Medicaid as one kind of incubator
- New professions have clear alignment with SIM goals
  - Access for underserved populations
  - Extenders for primary care providers
  - Bridge between healthcare and population health goals
  - Connector between sectors
What is an Emerging Profession?

For SIM, a relatively loose definition

• Potential for high impact on Triple Aim goals
• Grassroots, need-based development
• Medicaid funding established
• Challenges / barriers to broader adoption
• A role for the state in offering assistance
# Emerging Professions

<table>
<thead>
<tr>
<th>Profession</th>
<th>Primary Role</th>
<th>Key Strengths</th>
<th>Early Adopters</th>
<th>Opportunities</th>
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</thead>
<tbody>
<tr>
<td>Community Health Worker (CHW)</td>
<td>Educator, Navigator, Advocate</td>
<td>Cultural awareness, communication</td>
<td>Public health programs, FQHCs, metro hospitals</td>
<td>ACOs serving diverse populations, grow Medicaid payment</td>
</tr>
<tr>
<td>Community Paramedic</td>
<td>Primary care physician extender</td>
<td>Broad medical knowledge, flexibility</td>
<td>Metro hospitals for ER diversion and post-discharge follow-up</td>
<td>Expansion, especially into rural</td>
</tr>
<tr>
<td>Dental Therapist/Advanced Dental Therapist</td>
<td>“Midlevel” dental practitioner</td>
<td>Access, access, access</td>
<td>Non-profit community dental clinics, FQHCs</td>
<td>Broader adoption in private practice</td>
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<tr>
<td>Doula (2016)</td>
<td>Educator, advocate before, during and after delivery</td>
<td>Population health in a personal relationship</td>
<td>Independent practitioners, birth centers, HCMC</td>
<td>Build on new Medicaid payment</td>
</tr>
<tr>
<td>Certified Peer Support Specialist (2016)</td>
<td>Non-clinical mental health advocate with personal experience</td>
<td>Credibility, support, cultivates informed, independent decisions about care</td>
<td>Inpatient settings, community behavioral health programs</td>
<td>Integration into BHH’s, Broader knowledge of the profession</td>
</tr>
</tbody>
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Emerging Professions Work

SIM-funded projects

- **Integration Grants**
  - 3 rounds of funding for individual practitioners in innovative settings
    - Up to $30,000 per CHW, CP, DT/ADT
    - 2 rounds funded
    - 9 grants currently underway

- **Toolkits for Employers**
  - $100,000 each for CHW, CP, DT/ADT
  - In negotiations with 3 vendors

- **Data collection**
## Integration Grants Summary

<table>
<thead>
<tr>
<th>Profession</th>
<th>Grantee</th>
<th>Grant Serves</th>
<th>Focus</th>
<th>ACO?</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHW</td>
<td>Well Being Development</td>
<td>Ely</td>
<td>Mental health clubhouse</td>
<td>Yes</td>
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<tr>
<td>CHW</td>
<td>MVNA</td>
<td>North Metro</td>
<td>Hospice</td>
<td>No</td>
</tr>
<tr>
<td>CHW</td>
<td>Hennepin Health</td>
<td>Minneapolis</td>
<td>Hennepin County jail</td>
<td>Yes</td>
</tr>
<tr>
<td>CP</td>
<td>HealthEast</td>
<td>St Paul</td>
<td>Post-discharge MH follow-up</td>
<td>Yes</td>
</tr>
<tr>
<td>CP</td>
<td>Essentia Health Ada</td>
<td>Ada</td>
<td>Rural chronic disease population</td>
<td>Yes</td>
</tr>
<tr>
<td>CP</td>
<td>Ringdahl Ambulance</td>
<td>Fergus Falls</td>
<td>ER diversion, readmission reduction</td>
<td>Yes</td>
</tr>
<tr>
<td>DT</td>
<td>West Side</td>
<td>East Metro</td>
<td>Access for women and children</td>
<td>Yes</td>
</tr>
<tr>
<td>DT</td>
<td>Children’s Dental Services</td>
<td>Mpls, Stearns Co.</td>
<td>Access for underserved children</td>
<td>No</td>
</tr>
<tr>
<td>DT</td>
<td>Northern Dental Access</td>
<td>Bemidji</td>
<td>Access for low-income population</td>
<td>No</td>
</tr>
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Emerging Professionals Integration Grantees

Goal:
To foster the integration of emerging professions – Community Health Worker, Community Paramedic, and Dental Therapist/Advanced Dental Therapist – into the workforce
• 12-month grants of $30,000 each (9 total awarded, in 2 rounds)

West Side Community Health Services
Hire a Dental Therapist working toward completing their Advanced Dental Therapist clinical hours
• Serves underserved children and pregnant women in the diverse community of St Paul’s East Side
Presentations from Emerging Professions Grantees

- Overview of the program

- How have grant funds been used?

- What are some barriers or challenges, and successes under this grant?
Emerging Professions: Discussion Questions

1. How are Task Force members’ organizations using or interacting with these grantees?

2. What should be the Task Force’s role be in advancing the work associated with Emerging Professions, but outside the grant structure?

3. What are some of the opportunities to disseminate best practices?
Task Force Feedback on Community Engagement

- Survey conducted in early December 2014
- Questions: How do Task Force members’ organizations conduct community engagement?
  - Overview of activities
  - Connections with Local Public Health
  - Assistance needed in supporting and encouraging participation from stakeholders in other settings and fields (e.g., community and local public health and providers)
Survey Responses:
Community Engagement Activities

- **Wide range of community engagement activities:**
  - 1-on-1 staff outreach and engagement
  - Committee representation and partnerships
  - Community-wide forms and assessments
  - Participation incentives (grants/ funds allocations)

- **Interactions with local public health include:**
  - Technical assistance
  - Shared population health goals and action plans
Survey Responses: Challenges

- Lack of data (complicated by structural and policy barriers to sharing data)
- Limited staff time or capacity
- Lack of infrastructure/relationships
- Misaligned incentives, silos
Survey Responses: Assistance Needed

- Clear goals and expectations from leadership - build the business case over time
- Reporting positive outcomes/ successful programs to community partners and the general public
- Mandates or financial levers to promote engagement
- Easy to understand fact sheets on various public health entities and how they work together
Other Task Force Comments

• Community engagement is an ongoing effort
• Leverage the expertise of others
  ▪ Become intentional about working with communities, not doing things for or to them
  ▪ Have broader community conversation
• Frequent focus on medical systems: don’t forget mental health and social services agencies
• Need to differentiate between MNsure and SIM
Example: Zumbro Valley Health Center Primary Care Community Advisory Board

- Mayo Clinic
- Olmsted Medical Center
- Olmsted County
- United Way
- Rochester Area Foundation
- Olmsted County Public Health
- Minnesota Department of Human Services
- Minnesota Department of Health
- Zumbro Valley Health Center Board, Staff and Leadership Team
Community Engagement

The MN SIM community engagement goals are:

• Creating accessible ways for target populations to be involved in SIM processes
• Building awareness and supporting interest in changing service delivery and integrating care
• Connecting resources to support community capacity to effectively participate in partnerships
Community Engagement: Discussion Questions

1. What activities does your organization participate in to support the project’s Community Engagement Goals?

2. How does Community Engagement promote transformation in your organization’s health care settings?

3. What are effective ways to expand Community Engagement to be a part of all health care settings?
Next Meeting

Joint Meeting of the
Community Advisory and Multi-Payer Alignment
Task Forces

May 20, 2015
1:00 pm - 4:00 pm
Wellstone Center
179 Robie Street, St. Paul
Public Comment
Contact Information

Community Advisory Task Force

• Jennifer Lundblad (jlundblad@stratishealth.org), Chair
• Diane Rydrych (Diane.Rydrych@state.mn.us), MDH
• Jennifer Blanchard (Jennifer.Blanchard@state.mn.us), DHS

Facilitation Team

• Diane Stollenwerk (diane@stollenwerks.com)
• Christian Heiss (cheiss@chcs.org)
Phase One Element: Contact Information, PCP

**Purpose**
Find the people
Know the ACO/ACH population you need to manage

**Data Elements**
Contact information (full name, DOB, address, phone number, health plan)
Information about PCP (by payer)

**Opportunity to Add Value**
Establishing a relationship with primary care and care coordination
Ability to identify people who aren’t receiving needed care

**Data Sources**
Health plan enrollment data
Electronic Health Record
Social services data (as possible)
Phase One Element: Risk Level

**Purpose**

Understand health status and risk level

**Data Elements**

Risk level of different sub-populations

Diagnoses

Current spend

Primary care utilization

**Opportunity to Add Value**

Reduce cost

Focus spending in the right setting

**Data Sources**

Claims data from CMS, DHS, health plans and Pharmacy Benefit Managers

Clinical data
Phase One Element: Total Cost of Care

Purpose
Assess high cost areas

Data Elements
Medical cost, Hospital IP and ED, PAC (SNF, HH, AL, Behavioral Health), Pharmacy, Specialty MD, PCP, OP/ASC, Laboratory, Radiology

Opportunity to Add Value
Understand cost trends, performance for overall medical spending
Improve service delivery efficiency

Data Sources
Claims data from CMS, DHS, health plans and Pharmacy Benefit Managers
Phase One Element: Health Status by Demographics

**Purpose**
Understand demographics

**Data Elements**
Health status indicators, stratified by demographic characteristic
Patient sub-populations, grouped by demographic characteristic

**Opportunity to Add Value**
Reduce disparities
Identify high risk patients
Build trust to engage patients
Identify gaps in care in populations

**Data Sources**
Health plan enrollment data
Claims data from CMS, DHS, health plans and Pharmacy Benefit Managers
Clinical data
Phase One Element: Patterns of Care Within and Outside of ACO Providers

**Purpose**
Assess care coordination

**Data Elements**
Utilization and cost, including:
- Frequency of insurance shifts
- Number of outside providers engaged in patient care (by location and/or specialty)
- Profile of patients seeking outside care

**Opportunity to Add Value**
Determine effectiveness of the ACO
Improve care coordination
Improve patient engagement

**Data Sources**
- Claims data from CMS, DHS, health plans and Pharmacy Benefit Managers
- Clinical data