Harvest

SIM Talks: Celebrating Innovation in Minnesota

NOVEMBER 2017
Background

Action Café

1) Topic: BHH Enrollment and Engagement
2) Topic: CHW’s
3) Topic: Community and Healthcare Delivery Partnerships
4) Topic: Engaging Providers in TCOC Discussions
5) Topic: Food, Housing Insecurity
6) Topic: How to make grants and contracts more inclusive with equity lens
7) Topic: Improving Mental Health for Kids/Families in the Community and/or School
8) Topic: Momentum with Medicaid Uncertainty
9) Topic: Moving forward without SIM
10) Topic: Payment for Care Coordination or Patient Centered Medical Home
11) Topic: Privilege Index
12) Topic: Safe and Addorable Housing
13) Topic: Using Tele-med to Delivery Quality, Safe, and Cost-Effective Care
Background

On November 9th, 2017 the Minnesota Departments of Health and Human Services held an event to celebrate the 2017 year-end conclusion of the Minnesota Accountable Health Model – SIM cooperative agreement. The cooperative agreement was awarded to Minnesota as a $45 million State Innovation Model (SIM) testing grant dedicated to testing new ways of delivering and paying for health care to improve health in communities, provide better care, and lower health care costs.

The event, titled SIM Talks, combined 10 talks given in the "Ignite" style, a unique 5-minute presentation on best practices, lessons learned and areas of sustainability, and Action Café style small group discussions for attendees to further explore future goals of patient care delivery and payment models. This document serves as a companion piece to the SIM Talks event summary posted on success stories page on the Minnesota Accountable Health Model website. Details about the event are housed on a dedicated website at SIM Talks MN.

Action Café

Action Café is a combination of both World Café\(^1\) and Open Space\(^2\) concepts. Attendees build the agenda by proposing topics that they want to talk about. During this segment, known as the Action Café Marketplace, topics were sorted into five major categories:

1. E-health
2. Integrated data
3. Patient-centered, coordinated care
4. Community driven solutions
5. Payment and accountability

Once the agenda was final, anyone who recommended a topic acted as the table host for that conversation. The remaining attendees each chose a topic they wished to discuss and joined that table for a conversation on “What gaps/barriers exists?” Attendees then moved to a different table to identify “What are essential next steps” for that topic. Finally table hosts synthesized what they learned and determined next steps they could take to further their topic.

Harvest

The following pages contain the Action Café Harvest - the notes that were taken by the table hosts during and after their conversations. A dialog format was provided along with the discussion questions, prompting the participants to consider key takeaways, action steps and starting points, however table hosts were not required to submit all sections of the template.

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\(^1\) World Café is a place to have authentic, inclusive, and deep conversations that bring the most varied views into the open about the topic that is determined by the table host. It is a way of conversing that allows the knowledge of all participants to be shared to find new and creative solutions through guided conversation using open questions.

\(^2\) Open Space is another way to develop innovative ideas and to find common solutions that help to implement change.
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Harvest content was typed from handwritten notes, which were brief summaries from greater dialogue and discussions. While every attempt was made at accuracy, the state does not claim to have perfectly deciphered any individual’s personal cursive style, or captured the entire context and intended meaning of the discussion.

1) **Topic: BHH Enrollment and Engagement**

*Category:* Patient Centered, Integrated Care

**Discussion #1: What gaps/barriers exist?**
- Unknown program
- MCO pushback
- BHH standards set high expectations
- Compliance with standards BHH/CCBHC
- Keeping consumers engaged long-term
- Competition with similar services
- Organizational silos

**Key takeaways:**
1. Timeframe for the 1st 3 encounters is too long
2. MHIS reporting is strenuous
3. Need to educate PCPs how simple it is to refer without an order

**Discussion #2: What are the essential next steps?**
- Looking for opportunity to create synergy – connecting dots to break down the silos

**Key takeaways:**
1. DHS needs to get out and tell the story
2. Media – tell our story to the world

**Action steps:**
1. Enlist other MH providers to refer for care management that don’t offer it
2. Address social determinants of health as early as requested by the consumer
3. Discuss how to tell the BHH story in the health care community as a group of BHH agencies

**What do I do first?**
- Action step 1

**What am I grateful for?**
- Intro to Dr. Ellinger’s MCH course in 2000

2) **Topic: CHW’s**

*Category:* Payment and Accountability

**Discussion #1: What gaps/barriers exist?**
- Current payment is limited
  - Other funding sources have not engaged
- Process is difficult
Focus on health outcomes vs. health equity
- Grant funds not sustainable
- Lack of knowledge and understanding of role
- More scrutiny to show ROI/chicken or egg
- Evidence is limited, not broad enough in scope
- Organizational priorities change
- Fragmentation
  - “Piloted to death”
  - Potential for duplication/fragmentation within providers/systems

Discussion #2: What are the essential next steps?
- Billing toolkit:
  - CHW services separate from bill
  - Onboarding/orientation needs in primary care
    - More training on boundaries
  - Governing board for CHW’s (cost may be a concern)
    - Certification, ethics
  - Resources for additional training
  - Safety of individual in community/homes
    - Major issue
  - Add documentation to curriculum
  - Clarify scope of work for CHW’s, in comparison to other professionals
  - Clarify roles/duties/needs of supervisors
- Expectation for:
  - Documentation of payment for CHW’s
  - Better communication on Medicaid payment process
  - Get PMAP’s engaged
  - Professionalize vs. maintain flexibility
  - Maintain freedom of CHW role
  - More examples of how CHW’s are used
  - Specialization of CHW’s for different roles/systems

Action steps:
1. Add components to the curriculum
2. Safety
3. Boundaries
4. Documentation
5. Clarify scope
6. Grant funding to create governing structure for CHW’s

What do I do first?
- Engage with CHW Alliance on curriculum, governance
3) **Topic: Community and Healthcare Delivery Partnerships**

**Category:** Integrated data

**Discussion #1: What gaps/barriers exist?**
- Granularity/access to more detailed geographic information
- Lack of consumer perspective
- Gap in gathering of relevant data and means to analyze it
- Inventory of what we have
- Identify needs
- Consumer champions

**Key takeaways:**
1. Consumer perspective
2. Cataloging community needs

**Discussion #2: What are the essential next steps?**
- Involve community in planning process
  - Where are the conversations occurring?
- SIM provide case examples
  - Data on programs
- Understanding of respective data fields
- Find data sources that already exist

**Key takeaways:**
1. Involve: communities and community based organizations
2. Identify: data sources, community champions

**Action steps:**
1) Identify: data sources, community champions, community resources, community needs
2) Involve communities in opportunity identification process
3) Engage stakeholders from both the community and health care

**What do I do first?**
- Identify action step 1

**What am I grateful for?**
- Good conversation

4) **Topic: Engaging Providers in TCOC Discussions**

**Category:** Payment and Accountability

**Discussion #1: What gaps/barriers exist?**
- Small #’s in patients
- Large health system hard to engage individual providers
- Common perspective: who/what is being measured?
• How does TCOC impact a provider’s job?
• Identify the right opportunity
• Conflicting interest within the same organization
• Coding and documentation

Key takeaways:
1. Common understanding about purpose and reason for cost measurement
2. Identify the right opportunities/projects
3. Conflicting interests/goals about TCOC within the same organization

Discussion #2: What are the essential next steps?
• Practice facilitation with multiple stakeholders
• Establishing context around payment reform, new payment models
• More transparency for procedures, labs, etc. for providers and patients
• Give providers time to understand/interpret data
  o Reduce documentation burden
• Mechanism for incentives/saving to trickle down
• Consensus on which cost measure is used

Key takeaways:
1. Make sure information is actionable
2. Mechanism for incentives/savings to trickle down to providers/care teams
3. Identification of areas of overlap between care models best practices and ways to reduce cost

Action steps:
1. Define the clinical case for TCOC in a way providers understand
2. Create a mechanism whereby cost savings or incentives are infused into the care model
3. Make the data actionable and give providers the time to incorporate into work flows

What do I do first?
• Prioritize the cost projects that align with best practices (care model)

What am I grateful for?
• Actionable data

5) **Topic: Food, Housing Insecurity**

Category: Community Driven Solutions

Discussion #1: What gaps/barriers exist?
• Sector specific (e.g. Health plan) data may not be complete/accessible to identity patients with housing security are hard to reach, status changes quickly – support available
• Standard medical intake exists, no SDOH screening – could social and medical EMR be joined demographically?
• Population specific screenings include housing questions, but narrow
• Now includes some SDOH data, but next steps may not be clear, storage
• How questions are asked matters – are CDE best practices disseminated across?
• Different SDOH (food vs. housing) are more/less easily seen via proxy identifiers or more/less easy to address short term – food deserts, urban gardens
• Insecurity can be identified but education may be needed to address
• Is there a path to drive from social services intake to medical settings
• Data privacy, stigma (in-person identification, follow-up post-identification)

Key takeaways:
1. Sectors
2. Screening
3. Next steps post identification

Discussion #2: What are the essential next steps?
• Expanding/developing cross-sector (e.g. public health into health system) data exchanges (test assumptions about sharing ability) look for aggregate and collaboration, discussion of common interest/access – policy too
• Streamlined brief screenings producing most widely needed elements
• Evidence base to support uniform SDOH screening tool (aligned industries that could develop)
• Common screening format that can be used across practice types, EMR platforms
• Knowing housing shortage, incorporate ongoing identification and treatment/support for unstably housed patients (e.g. no refrigerated medicines) tier: are, have been, ever been homeless (once unstable, more likely to be unstable) geo mapping shelters addresses
• Broader/better use, knowledge of ICD10 SDOH codes
• Funding base for SDOH rearrangement and aligned to preventive perspective

Key takeaways:
1. Expand cross-sector, discussion, collaboration, data exchange
2. Develop evidence-based streamlined, common format screenings
3. Broader understanding of insecurity graduation, repetition and how to code it

Action steps:
1. Propose/build shared accountability partnerships, methodology bringing together relevant sectors capable of sharing SDOH data
2. Work in our sectors and across to champion standardized food, housing insecurity screening and coding/data structures
3. Share knowledge across sectors about (proxy) identifiers and gradations/degrees/recurrence of insecurity

What do I do first?
• Continue conversation! Support models integration
• Seek national/regional data screenings standards
• Sharing, sharing, sharing!

What am I grateful for?
• Cross sector conversation, sharing comfort with sharing gaps in knowledge
6) **Topic: How to make grants and contracts more inclusive with equity lens**

**Category:** Patient Centered Integrated Care

**Action steps:**
1) Ask for input of those who have money (how/why)
2) Future grantees together to help draft contract and grants
3) Language issue with process – do know about grants/contract
4) Pain points – budget, submitting reports
5) Develop options and solutions
6) Ask other agencies what they are doing for resources (i.e. – chair inclusion James Burrows works with the Gov. office procurement group)

What do I do first?
- Take back group MDH work with

What am I grateful for?
- Meeting new folks here
- Expanded knowledge
- Mission driven people who care
- Opportunities to collaborate

7) **Topic: Improving Mental Health for Kids/Families in the Community and/or School**

**Category:** Community Driven Solutions

**Discussion #1: What gaps/barriers exist?**
- “Babel” – different cultures, terminology, etc.
- Lack of trust (from individuals, among providers, etc.)
- Need to recognize expertise of patients/families
- Lack of access to mental health services (especially youth)
- Stigma of seeking help for mental health
- Data sharing = barrier (“too busy”)
- How to start connections in communities, schools, etc.?
- Confidentiality concerns
- How to talk about mental health without stigma?
- How to mitigate onset of MH problems?
- Need for other supports
  - Economic/job skills
  - Transpiration
  - Cooking
  - Parenting skills
- Not real “parity”
- Low money for mental health providers
Key takeaways:
1. Need to connect with patients
2. Need to reduce stigma
3. Need more mental health services

Discussion #2: What are the essential next steps?
• Full community wellness approach to behavioral health
  o “all hands on deck”, health care, schools, families
  o Help people get support/help they need
• Evaluation of the gaps – broken system
• Advocate for more funding/resources for MH
  o Providers needed (long wait), intensive treatment
  o Housing/support services
• Early intervention/upstream, i.e. social workers in school, teachers
• How can we do more of a family approach
  o Who’s job – school? Health care? Social services CPS?

Key takeaways:
1. MH impacts everyone – flows into society all directions
2. Dire issue that needs to be addressed
3. Children’s MH needs the whole community – need that lens for interventions

Action steps:
1. Advocating models for funding/resources
2. Identify models for best meeting children’s MH needs
   a. Best practices
3. Simplifying how to get access MH resources, especially for parents
4. Reducing stigma

What am I grateful for?
• People who are aware and passionate about making change

8) **Topic: Momentum with Medicaid Uncertainty**

Category: Patient Centered, Integrated Care

Discussion #1: What gaps/barriers exist?
• How do we keep the momentum moving in the midst of Medicaid uncertainty?
  o Hard to keep people motivated
  o Funding (for oral health), funding is protected
  o Leadership is waiting on what to do next
  o Societal systems, corporate system do not support or not aligned
  o Disconnect between upper management and front line staff
  o Short term view
Key takeaways:
1. Building infrastructure/care integration/articulating the value in population health
2. Health in the community is essential
3. Long term vision developed with and shared by leaders (community)

Action steps:
1. Articulating the value of population health with community leaders
2. Build communication between upper management and front line staff

What am I grateful for?
- Conversations are still happening
- Organizations are committed to do something to change
- Conversation about health is broadening
- Public health and healthcare are coming together

9) **Topic: Moving forward without SIM**

Category: Solutions

Discussion #1: What gaps/barriers exist?
- Idea that, now that SIM is done, we don’t have a continuation plan.
- Simple presentation of what SIM has accomplished?
  - What was the Innovation?
  - Form doesn’t follow function, it follows financing.
- Private market missing as a participant.
- Translating the babble
  - People understand they need transportation, a team, a plan, a nurse to call them
- Care coordination chaos- it’s a mess and that’s where the costs are.
- Our failure to respond to mental illness (dementia) jacks up health care costs.

Key takeaways:
1. This is the beginning, not the end
2. Scale up successful experiments
3. Public responds it is too complicated – need to simplify
4. Stories and results – opioid, Mary

Discussion #2: What are the essential next steps?
- Develop the story of what
- Memes and internet
- Identify a story and go small
  - How does it save money
- Identify champions, mentors, networking opportunities
- Promote this is an opportunity where HC prof don’t have to compete
- Descriptors: worthwhile, purposeful
- Nonpartisan support, support funding, local community support
- “70 year old woman selling opioids” outcome story
Key takeaways:
1. Identify champions, mentors, networking
2. Identify savings examples
3. ROI
4. What SIM was about
5. Intentional, and paid, planful community care coordination

Action steps:
1. Identify champions, mentors and support them and networking opportunities
2. Identify and collect compelling stories and savings examples
3. Take today’s show on the road

What do I do first?
• Find funding for more of these

What am I grateful for?
• Intentional, planful, paid community care coordination

10) Topic: Payment for Care Coordination or Patient Centered Medical Home

Category: Payment and Accountability

Action steps:
Encourage interoperability

Sharing of data – between providers – care teams – insurance – all entities with patient contact/involvement

Payment decrease for primary care not providing the basic services of patient centered medical home/care coordination type care (or incentive for positive outcomes)

Make sure they are reimbursed well in first place

Ask private payers what they need/want

11) Topic: Privilege Index

Category: Community Driven Solutions

Discussion #1: What gaps/barriers exist?
• Hard to define what would be measured
• What is the purpose of such a measure
• Developing a scale of what measure
  o Develop collective goal
  o Have a much more inclusive discussion
• Payment must follow need
• Tie quality measures to percent of improvements
• Add social determinants to measures, weight to “get housing”
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- Align with information that can be used for population health
- Apply

Key takeaways:
1. Interest in the concept
2. Need definition
   a. Who does it serve + how
3. Discussion need to be broad – include consumers, etc.

12) Topic: Safe and Affordable Housing

Category: Community Driven Solutions

Action steps:
1. Outreach to other community resources
2. Stigma – educating the general public
3. Collaborating on the local, county, state levels (think tank)
4. Visionary

What am I grateful for?
- The opportunity to serve
- All opportunities to collaborate with other providers

13) Topic: Using Tele-med to Delivery Quality, Safe, and Cost-Effective Care

Category: e-Health

Discussion #1: What gaps/barriers exist?
- Behavioral Health tele-med – gap – nursing staff use, time consume, log into
  o Need more education
  o Need more comfortable
- Oral health – integrated primary care/legal/advanced dental therapist (overseen by dentist)
  o Mobile/remote
- Need competencies
- Technology
  o Patients
  o Providers
  o Nurses/infrastructure
- Bottlenecks?
- Coding/billing
- Payers/health plans
- Technology investment
- Broadband/internet
- Credentialing
• Consumer demand high
• Therapist key for dental
• ROI
• Substance abuse/gaps payment

Key takeaways:
1. Coding/billing/payers major issue
2. Having remote therapist/technician key
3. Need core competencies

Discussion #2: What are the essential next steps?
• Competencies needed
  o Providers
  o Billers/payers
  o ROI
  o Payer
  o Secure connections
• Top priorities - disease focus
  o Mental health – Alzheimer’s, dementia
  o Opioids
• IHP
  o Mental health for ages <18, >18
• Seniors – living alone
• Reimbursement
  o Simplify/clarify
  o Fee for service/value –based payment
  o In between payment models
• Organization expanding services
• Specialties
  o Push to shortage areas
  o Sell services

Key takeaways:
1. Reimbursement resolve – payers/coding/services covered
2. ROI analysis – for each component
3. Focus on Top priority disease/patient populations

Action steps:
1. Address reimbursement challenges
   a. Simplify process
   b. Payers
   c. Coding/billing
   d. Services covered
   e. Credentialing
2. Return on investment analysis – all tele-med components
   a. Technology
b. Training
c. Support staff
d. Increased access
e. Provider work time
f. # of visits possible

3. Focus on top priority disease/patient populations
   a. Chronic diseases
   b. Mental health
   c. Opioid crisis

What do I do first?
   • Need telemedicine champions
     o National (CMS)
     o State (government)
     o Local health systems
     o Health plans
     o Consumers

What am I grateful for?
   • Opportunity to address issues proactively
   • Opportunities to work with lots of hard working people
This project was 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.

Action Café content provided by Pamela Enz and Casting Vision.