

# Minnesota Accountable Health Model: Joint Task Force Meeting

THURSDAY, MAY 15TH  
THE WELLSTONE CENTER  
179 ROBIE STREET EAST, SAINT PAUL, MINNESOTA

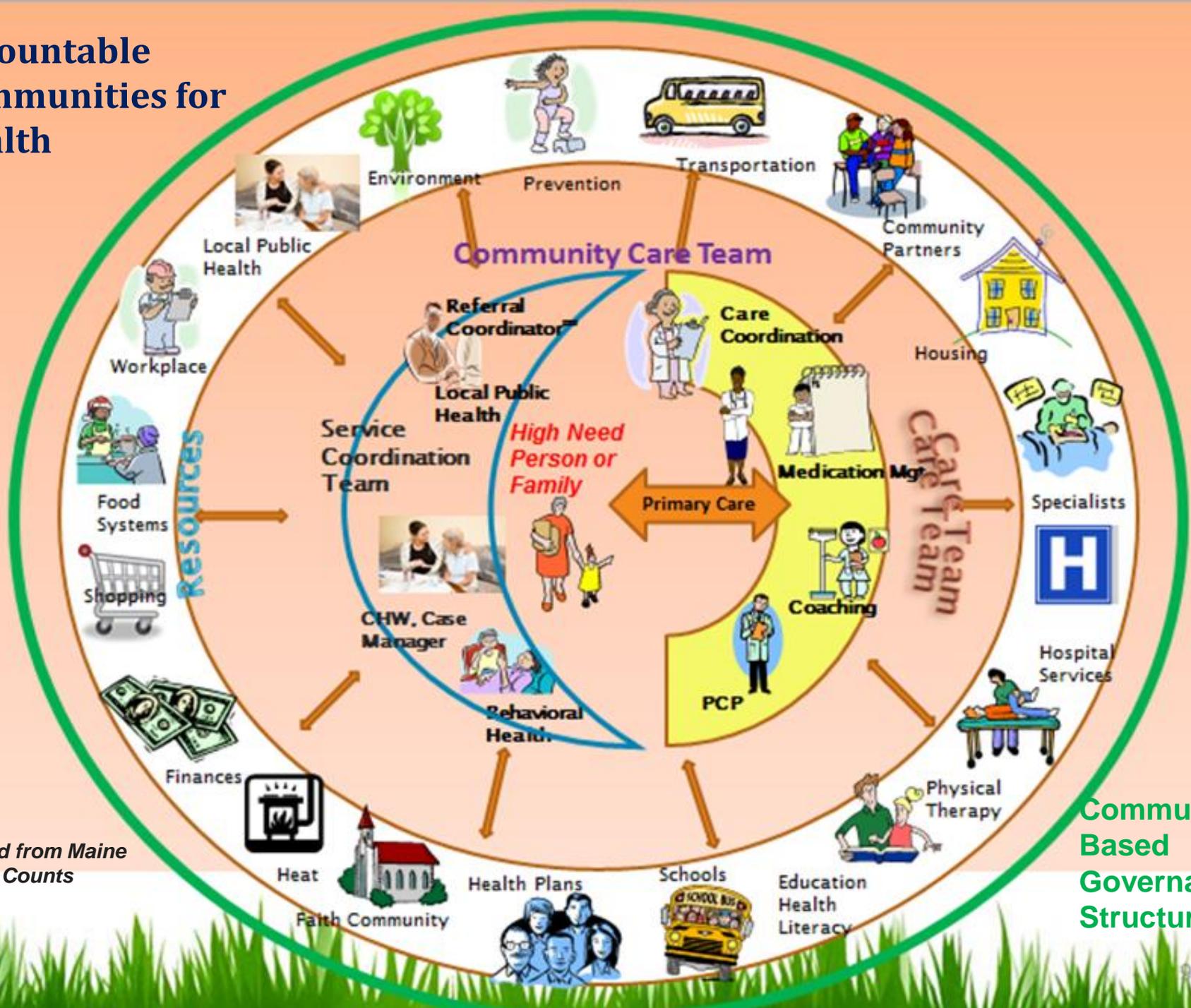


# Agenda

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- **Update of Accountable Communities for Health Subgroup Activities**

# Accountable Communities for Health



Community Based Governance Structure

Adapted from Maine Quality Counts

# Accountable Communities for Health (ACH) Subgroup Activities

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Convene 12 members in February – April, 2014 to:

- Provide guidance and advice in setting strategies to raise awareness of the ACH vision across Minnesota that will create community readiness for innovation in health and health care system redesign
- Provide advice on soliciting and receiving input from diverse stakeholders and communities regarding the ACH approach and applying that input to program planning as appropriate
- Develop recommendations for selection criteria and recommendation of ACHs in collaboration with existing advisory groups and the SIM leadership team by the end of March

# Accountable Communities for Health (ACH) Subgroup Members

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Alex Alexander MPA, MBA -- Beacon Group, SE MN, Project Management Office, Mayo Clinic

Catherine Brunkow, RN -- HCMC, Community Care Team, Hennepin County Human Services & Public Health Dept

Catherine Vanderboon, RN, PhD -- Community Care Team, Mayo Clinic,

Gina Nolte -- Partnership for Health and CTG, Clay County Public Health

Heidi Favet, CHW -- Essentia Health Ely Community Care Team

Jan Malcolm -- Courage Kenny Center, Allina Health

Jennifer DeCubellis and Ross Owen -- Hennepin Health

Joanne Foreman, RN, BAN -- Institute For Clinical Systems Improvement, Accountable Health Community

Kathy Gregersen -- Mental Health Resources Center

Kevin A. Peterson MD, MPH, FRCS, FAFAP – Dept of Family Medicine & Community Health, Univ of MN, Minnesota Academy of Family Physicians

Kristin Godfrey, MPH -- HCMC, Community Care Team, MPHA

Roxanne King, CHW -- NorthPoint Health and Wellness

Sarah Keenan RN, BSN -- Bluestone

Susan Severson -- Stratis Health

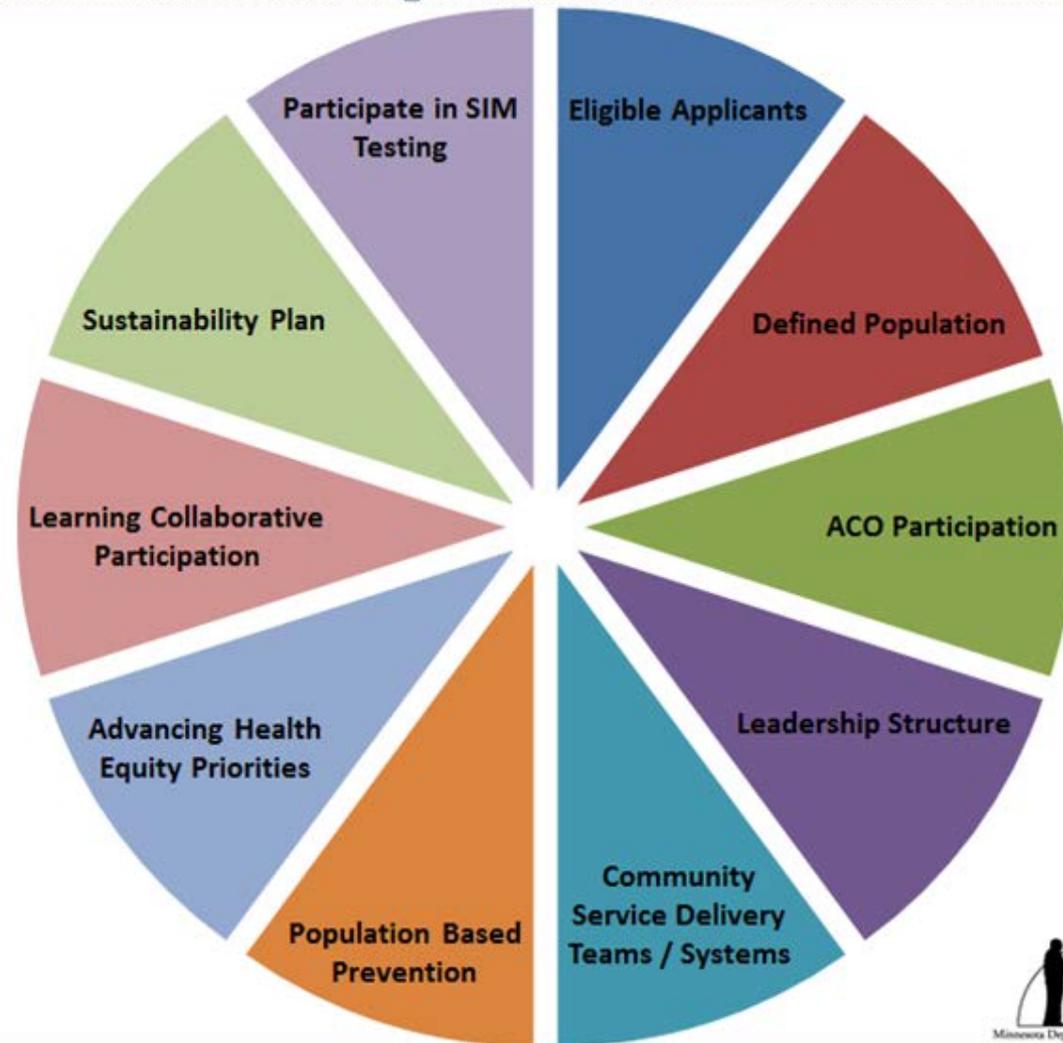
# Accountable Communities for Health (ACH) Subgroup Activities

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ACH Advisory Subgroup will meet three times:

- February 28
  - ACH Goals
- March 14
  - Eligible applicants
  - Populations to serve
  - Leadership structure
  - Care Coordination Team
  - Population based prevention
- March 28
  - Sustainability planning
  - Advancing health equity
  - ACO participation
  - Putting it all together

# Accountable Communities for Health Proposal Elements



# Who can apply?

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## ***MN SIM Project Narrative Language:***

Eligible applicants include: provider, a tribe, a community or consumer organization, a county, and/or other non-profit entity, such as a health plan or a consortium with a designated fiscal agent

## ***We asked:***

Should there be limits on who can be the applicant?

# Who can apply?

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## ***ACH Subgroup Feedback:***

- Leave this as broad as possible to allow for innovation
- Be clear that ACO does not need to be the *lead applicant* but must be at the table.
- Ensure that partners are identified in a meaningful way
- Do not exclude for profit organizations as applicant

# Population to be Served

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## ***MN SIM Project Narrative Language :***

- Population is broadly defined such as, geographical, defined by patient population, or health needs of the community, high resource use in a smaller segment of the communities population, or a specific population such as a high rise or a virtual population of members.
- Intentional efforts should be made to reach marginalized and underserved communities.

## ***We asked:***

Who must participate, should there be limits?

# Population to be served

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## *ACH Subgroup Feedback:*

- Keep range of options open
- Do require a clear definition of the population to be served
- Focus on largest population with unmet needs.
- Access to data on the population to be served should be essential, but acknowledge that this could be a challenge depending on how the population is defined

# How to Get Started to Identify Population, Build On Community Based Data

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- Build on local public health or hospital community assessment.
- Check out your local public health agency. Each public health agency needs to complete their community health assessment by February of next year.
- Use SHIP Community Assessment data.
- Health Systems Data or Health Plan Data.
- Workforce or community collected data.
- CDC / BRFSS: Behavioral Risk Factor Surveillance System.

# Leadership Structure

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## ***MN SIM Project Narrative Language :***

- Be guided by a community-led oversight body / leadership team.
- Demonstrate significant community responsibility for strategies and priorities
- Focus on local solutions and move toward inclusion of services beyond health care to create a greater degree of accountability across health care, long term services and support, public health, mental health, chemical health, oral health, and social services

## ***We asked:***

- Does a community led leadership body need to be in place ahead of time, before the grant?
- What should the requirements be for the makeup of the community led oversight body?

# Leadership Structure

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## ***ACH Subgroup Feedback:***

- Ensure that the community has a voice within the decision-making structure, not simply “advisory”
- Identify a leader to facilitate communication and sustain project’s focus
- Demonstrate commitment of partners in a meaningful way
- Look to innovative ways to evaluate commitment of partners (e.g. interviews)

# How to Get Started in Developing a Leadership Structure

## Engage Community Members, “Reach Out”

Goal: ACH’s will engage community members and stakeholders to establish priorities to impact health goals, build partnerships that will integrate and coordinate care within their communities.

- Engage community members (citizens)
- Engage providers, community / local public health, community or cultural organizations, schools, tribes, faith based organizations, patient advocacy groups, worksites, employers, housing, social services, long term services and supports, behavioral health and other medical or non-medical groups who care for or provide services for all aspects of an individuals health
- Workplace / school wellness teams, people participating in “health”
- Local Public Health is Required to Participate
- Clinics /Hospitals
- ACO Partners

# Care Coordination Team

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## ***MN SIM Project Narrative Language:***

Must build on and integrate clinic and community resources including social services, local public health, home visiting, long term services and supports, behavioral health and other community partners.

## ***We asked***

Is there a minimum capacity that the Care Coordination Team needs to be able to demonstrate? What would that look like?

# Care Coordination Team

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## ***ACH Subgroup Feedback:***

- Be clear about the distinction between “care coordination team” as a hub of care for a patient involving coordination *between* clinic- and community based resources and services versus traditional care coordination *within* health care system.
- Developing a community based system / model of care coordination.

# Population Based Prevention

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## ***MN SIM Project Narrative Language:***

- Must reflect local needs assessments conducted by local public health, local hospitals or other entities
- Link with other local public health initiatives.

## ***We asked:***

- Should a community assessment plan serve as the basis for any ACH? What if it's too broad and doesn't capture the population proposed?
- What measures should communities be considering?

# Population Based Prevention

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## *ACH Subgroup Feedback:*

- Community Assessments are a good source of data but should not be the only basis for focusing efforts
- Partners should arrive at a shared definition of health for the community and providers, and consensus regarding the desired health outcomes

# Advancing Health Equity

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## ***MN SIM Project Narrative Language:***

A competitive RFP to expand up to 15 ACH's with a priority on communities in areas with a lower level of ACO penetration, greater disparities, and higher health care needs

## ***We asked:***

What ways should we consider advancing health equity in the ACHs?

# Advancing Health Equity

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## *ACH Subgroup Feedback:*

- Keep the definition of health equity broad
- Recognize that it may be difficult for communities with fewer resources to apply and consider methods to build community capacity
- Consider a phase- in approach to allow funding for some groups with less capacity up front to do planning

# SIM Testing/Measurement

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## ***MN SIM Project Narrative Language:***

Must work with SIM evaluation staff and/or contractors to develop and implement process and outcome measures for the project.

## ***We asked:***

- How should the ACH be measured?
- Is the focus on process, quality of life, patient centeredness tools, community partnership ?
- How do we evaluate intangibles that affect peoples' lives?

# SIM Testing/Measurement

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## *ACH Subgroup Feedback:*

- Be clear about what the state will be measuring vs. what ACHs will be expected to measure themselves
- Try to balance measurement on elements pertinent to all parts of triple aim, not just cost. Patient experience and population health need to be included.
- Look at quality of life measures (e.g. “healthy days”) and social determinants of health
- Provide technical assistance regarding data sources to (potential) applicants/grantees

# ACO Participation

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## ***MN SIM Project Narrative Language:***

Include at least one ACO that provides primary care services to a threshold percentage of the community's population.

### ***We asked:***

- What is the threshold for the number of people or % of the population covered?
- What if there are no ACO or ACO-like entities serving the proposed population?

# ACO Participation

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## ***ACH Subgroup Feedback:***

- State needs to be clear about what “ACO” means in the context of ACH
- Since few healthcare organizations yet have a substantive proportion of their patients in a risk-based arrangement to act like a ACO consider a step-wise process
- Ask applicants to focus on how they are *working towards* shared savings/shared risk arrangements
- Payers shouldn't be the only drivers – ensure that community is setting goals too

# Sustainability

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## ***MN SIM Project Narrative Language:***

- Develop infrastructure to support implementation of the ACH including development of a sustainability plan, and participation in rapid-cycle evaluation of the model.
- Must develop a plan that identifies sources for future funding of ACH.

## ***We asked:***

- How is sustainability defined and what does it include?

# Sustainability

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## *ACH Subgroup Feedback:*

- Financial sustainability may be very hard to demonstrate in such a short period of time
- It will probably take longer than the grant period to shift financial incentives
- Payers should not be the only drivers
- State should select metrics carefully and realistically

# General Feedback

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## *ACH Subgroup Feedback:*

- Prepare a glossary of terms to accompany the RFP
- Provide technical assistance to smaller communities and organizations to ensure inclusivity
- Reach out to non-traditional groups, share tools
- Communicate details as soon as possible to allow adequate time for prep

# ACH Community Engagement Goals

## Next Steps

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The primary goals of the community engagement process are to:

- Raise awareness of the ACH vision and other service delivery with a patient centered, coordinated integrated approach
- Create community readiness for innovation in health and health care system redesign, delivery and payment;
- Receive input from diverse stakeholders and communities regarding the ACH approach, including ACH structure and governance.

# Community Engagement, Next Steps

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- Communication through a variety of methods, webinars, newsletter, and website.
- Resources dedicated to identifying and engaging underserved communities.
- Regional presentations.
- Events already scheduled.
- Do you have an event already planned with community members? Let us know.
- Connect on our website at <http://mn.gov/sim> and Select Request a Speaker

# Tentatively Revised ACH Grant Timeline

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- ACH Advisory Subgroup Meetings thru April, 2014
- Contract with Community Care Teams Late Summer 2014
- Statewide Community Engagement through Summer, 2014 and ongoing
- Post competitive RFP September 1, 2014
- RFP review mid-October, 2014
- Contract finalization Nov./Dec., 2014
- Implementation begins in January 1, 2015

# Task Force Discussion – Accountable Communities for Health

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## Task Force member impressions

- Multi-Payer Alignment: Jim Przybilla
- Community Advisory: Jennifer DeCubellis

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# Q & A

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## State Innovation Model Grant

### Minnesota Accountable Health Model

In February 2013 the [Center for Medicare and Medicaid Innovation](#) (CMMI) awarded Minnesota a State Innovation Model (SIM) testing grant of over \$45 million to use across a three-year period ending October 2016. The goal is to help its providers and communities work together to create healthier futures for Minnesotans

- Minnesota's SIM initiative is a joint effort between the [Department of Human Services](#) (DHS) and the [Department of Health](#) (MDH) with support from Governor Mark Dayton's office.
- Minnesota will use the grant money to test new ways of delivering and paying for health care using the Minnesota Accountable Health Model (MAHM) framework.
- The goal of this model is to improve health in communities, provide better care, and lower health care costs.
- This model expands patient-centered, team-based care through service delivery and payment models that support integration of medical care, behavioral health, long-term care and community prevention services.

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