

Minnesota Accountable Health Model

PRACTICE FACILITATION
Community Forum
December 2, 2014



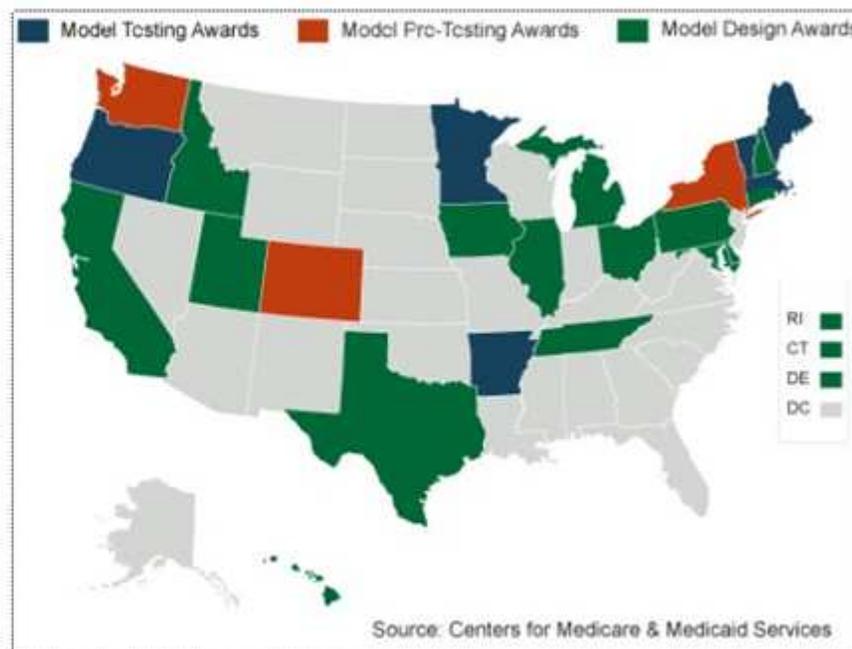
Agenda

- Brief SIM-Minnesota overview
- Health Care Homes and Transformation
- Practice Facilitation - What is it?
- Practice Facilitators – What do they do?
- Small Group Discussion

National State Innovation Model (SIM)

- SIM provides support to develop and test state-based models for payment and health care delivery systems transformation
- Minnesota awarded largest testing grant (\$45.3 million), February 2013
- Five other states also received [SIM testing grants from CMMI](#): MA, ME, VT, OR and AR.

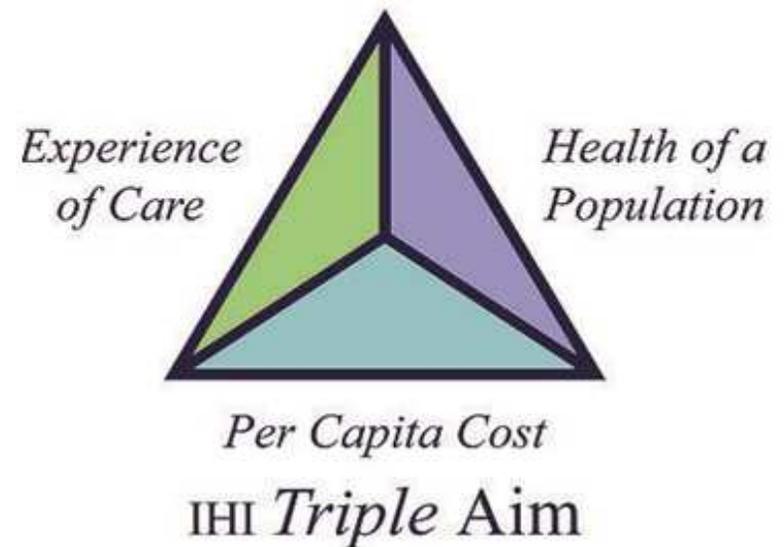
The Participating States



Minnesota Accountable Health Model Goals

Minnesota's Health Reform Goals

- Improved experience of care
- Improved population health
- Lower costs

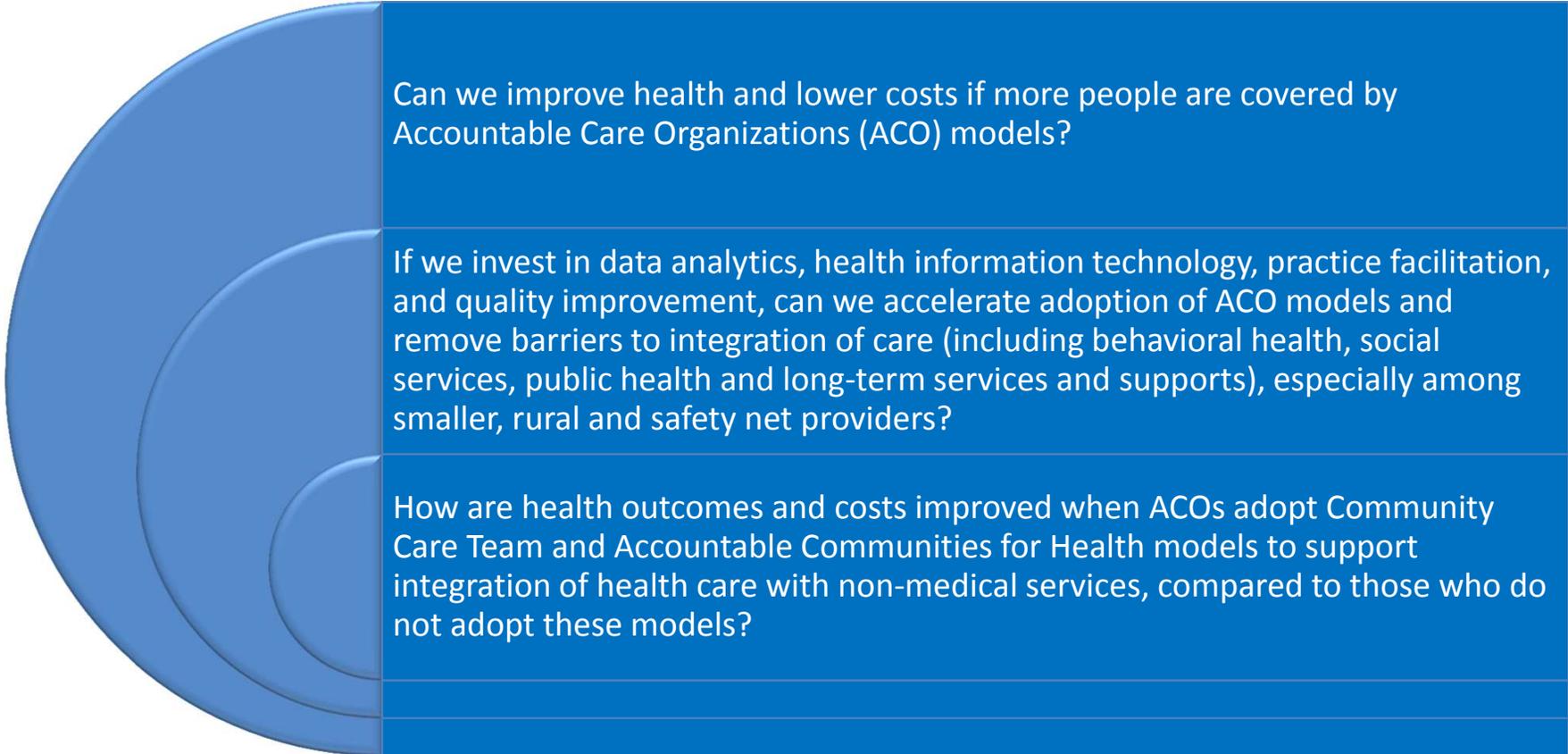


Part of the Affordable Care Act is Testing New Ideas



[ACA] . . . doesn't pretend to have the answers. Instead, through a new Center for Medicare and Medicaid Innovation, it offers to free communities and local health systems from existing payment rules, and let them experiment with ways to deliver better care at lower costs. -- Atul Gawande -

What are We testing?



Can we improve health and lower costs if more people are covered by Accountable Care Organizations (ACO) models?

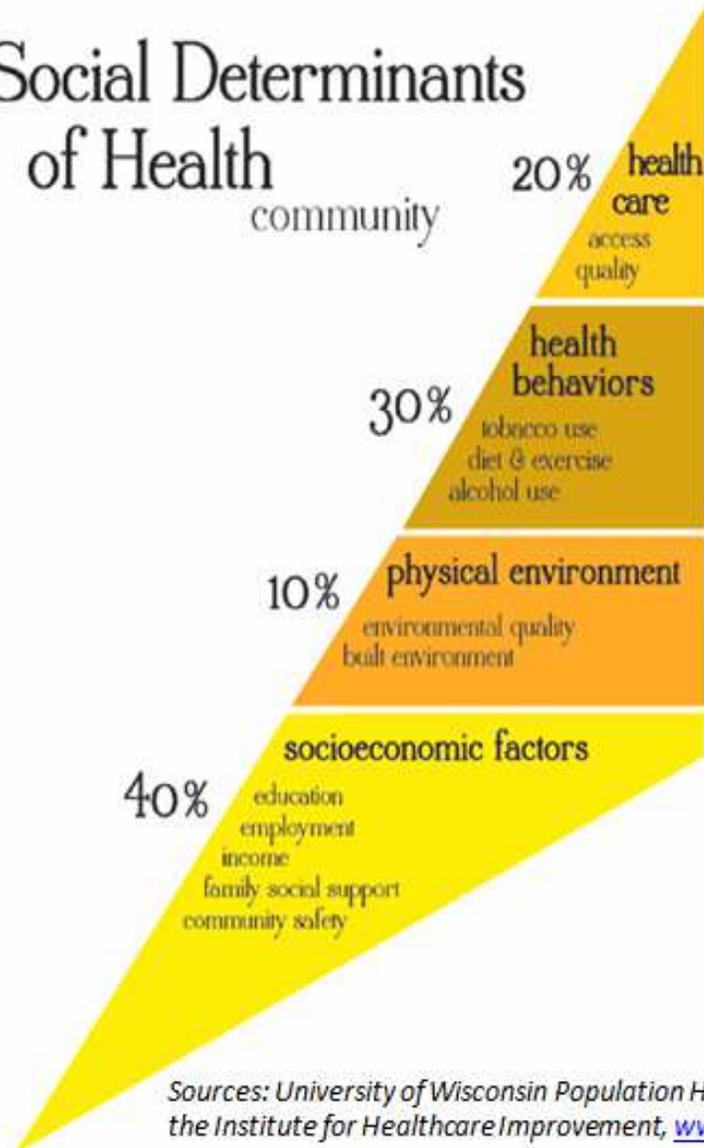
If we invest in data analytics, health information technology, practice facilitation, and quality improvement, can we accelerate adoption of ACO models and remove barriers to integration of care (including behavioral health, social services, public health and long-term services and supports), especially among smaller, rural and safety net providers?

How are health outcomes and costs improved when ACOs adopt Community Care Team and Accountable Communities for Health models to support integration of health care with non-medical services, compared to those who do not adopt these models?

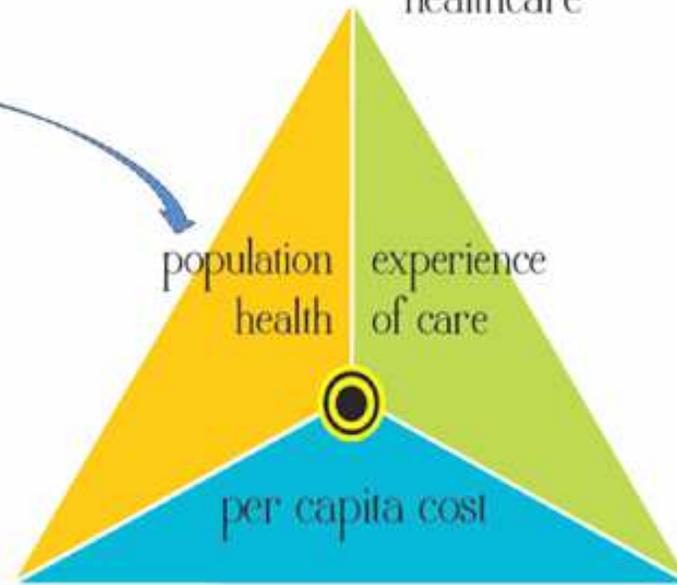
Five Drivers of Better Health

<i>E-HEALTH</i>	<i>DATA ANALYTICS</i>	<i>COORDINATED CARE</i>	<i>COMMUNITY PARTNERSHIP</i>	<i>ACCOUNTABLE CARE ORGANIZATION</i>
Increasing ability to share data for treatment, care coordination and quality improvement between providers.	Understanding data trends to manage cost and improve quality for the Medicaid ACO's	Providing practice transformation, learning opportunities, and integrating new professions to support coordinated care.	Identifying health goals and strategies in partnership with impacted populations. Accountable Community for Health (ACH).	Integrate accountability measures for populations with complex chronic conditions.

Social Determinants of Health



Triple Aim



Sources: University of Wisconsin Population Health Institute's County Health Rankings, www.countyhealthrankings.org; and the Institute for Healthcare Improvement, www.ihl.org. Figure 1 appears courtesy of the Commons Health Network.

Driver 3, Practice Transformation

Goal:

Expanded number of patients served by patient-centered, team-based integrated/coordinated care.

Implement quality improvement initiatives:

- Provide **practice facilitation** and practice transformation grants.
- Provide start-up grants to providers to integrate new professions into care delivery teams
- Support statewide learning collaboratives on topics related to care integration/transformation

Foundation: Health Care Homes

- Also known nationally as the patient centered medical home or federally as APC, advanced primary care or a “health home”.
- A health care home is an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic or complex health conditions.
- Reimbursement for care coordination.

Primary Care Delivery Redesign, What is different?

Today's Care	Health Care Homes
Patients are recipients of services by providers and clinics.	Patients and families are partners in the provision and planning of care.
Patients are those who make appointments to see me.	Patients have agreed to participate in our HCH and understand how to contact our HCH.
Care is determined by today's problem and time available today.	Proactive care planning is developed with the patient / family to anticipate patient's needs.
Care varies by memory or skill of the provider.	Care is standardized with evidence-based guidelines and planned visits .
Patients are responsible to coordinate their own care.	A team , including the care coordinator, coordinates care with patients and families.
I know I deliver high quality care because I'm well trained.	We measure our quality and outcomes and make ongoing changes to improve it. We include patients / families in our quality work.
It's up to the patient to tell us what happened to them.	We use a registry to track visits and tests and we do follow-up after ED and hospital visits.
Clinical operations center on meeting the doctor's needs.	A multidisciplinary team works at the top of our licenses to serve patients.

Foundation: Community Care Teams

- Three existing CCT's in Minnesota
- Initially funded through HCH program
- Multi-disciplinary care teams: clinic/HCH, hospital, community & social services
- Focus on coordinating care for whole patient, engaging all sectors
- Developing new relationships, approaches

COMMUNITY HEALTH



Transformation

"a commitment to quality and quality improvement by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management."

Practice Facilitation

A growing body of evidence supports the concept of ***practice facilitation*** as an effective strategy to improve primary health care processes and outcomes, including the delivery of wellness and preventive services, through the creation of an ongoing, trusting relationship between an external facilitator and a (primary care) practice.

Practice Facilitation – What is it?

- PF is a supportive service provided to a practice by a trained individual or team of individuals.
- These individuals use a range of methods to build the internal capacity of a practice to help it engage in quality improvement activities over time and support it in reaching incremental and transformative improvement goals.
- This support may be provided on site, virtually (through phone conferences and Webinars), or through a combination of onsite and virtual visits.

Practice Facilitators

- Practice Facilitators are specially trained individuals who assist providers in quality improvement projects.
- They are distinguished from consultants through specialized training, broad scope of practice, and long-term relationships with an organization, its providers and its patients or clients/consumers

Internal objectives for PF

Examples:

- Build organizational capacity for change: priority, will, knowledge and ability (Solberg)
- Create capacity to use data to improve process and quality improvement
- Create capacity for population health management
- Proactive population management
- Team-based care
- Involving patients/consumers in system redesign

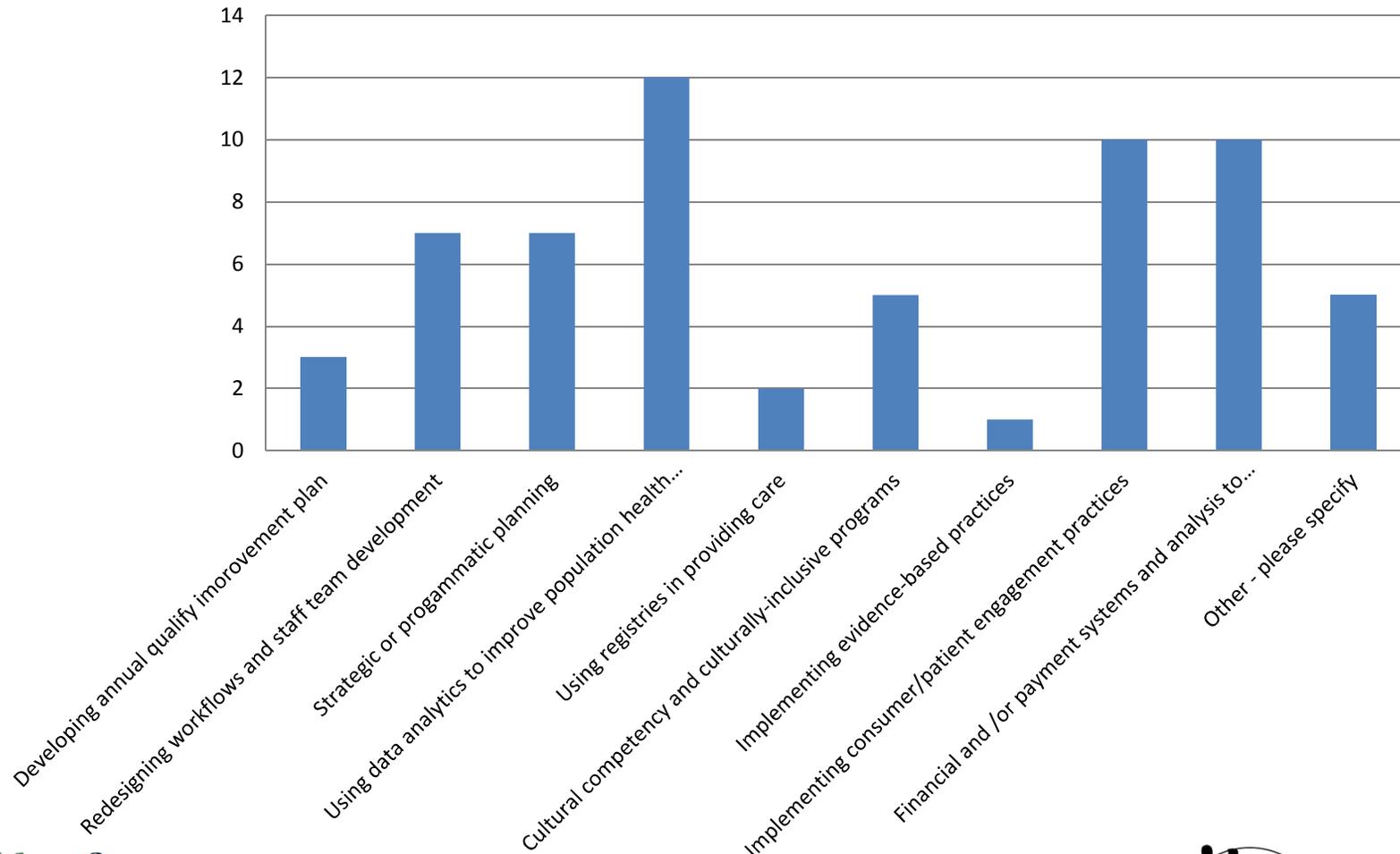
Partnership-focused objectives for PF

Examples:

- Linking or integrating services (i.e. social services, behavioral health, long term care, public health, primary care)
- Sharing care plans or data with other organizations
- Responsive community input

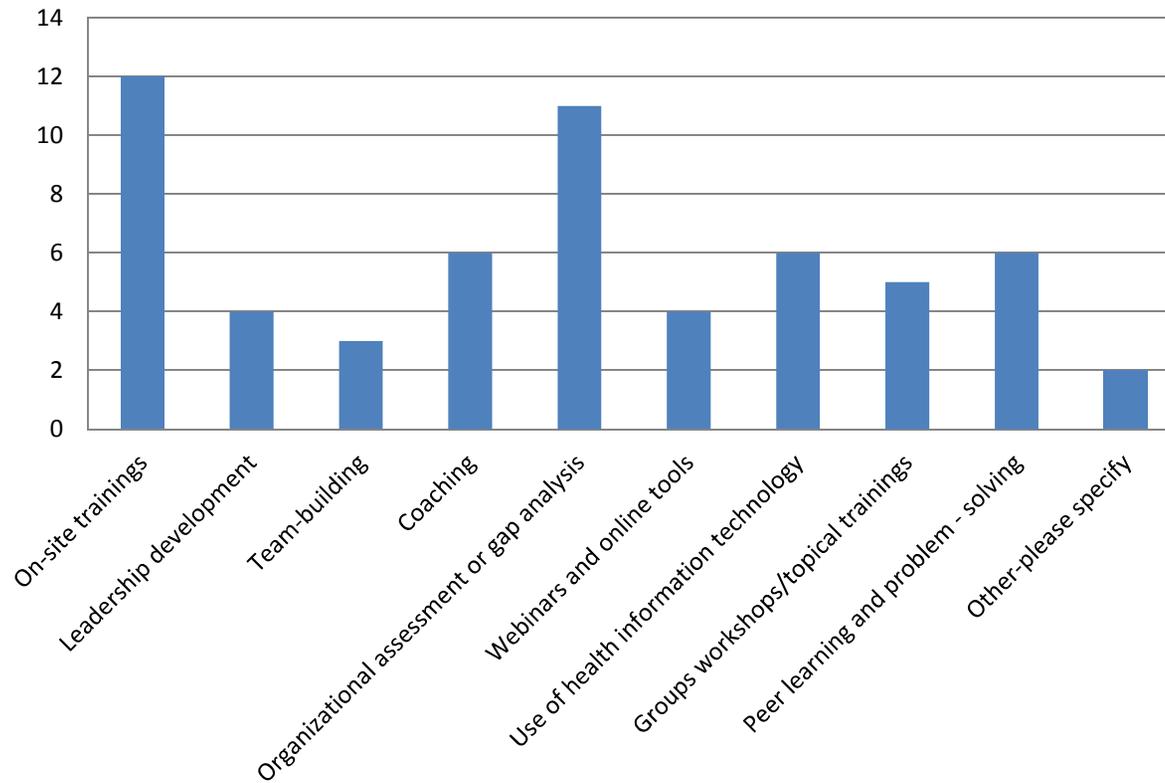
Survey Results

Most Helpful-PF Activities



Survey Results

Expectations from PF



Survey Responses

Most important activities to assist teams in providing quality care:

- Creating a culture/shared vision between team members
- Ability to work seamlessly across all systems
- Addressing the social determinants of health
- Getting and using the data
- Peer support and sharing tools

Survey Responses

Most important to enhance integrated services with other partners and providers:

- Common/shared language
- Technology that is interoperable (and user-friendly)
- Data sharing agreements
- Evaluation methods that incorporate social determinants of health
- Well-established communication networks

Small Group Discussion

- After reviewing the survey slides, do you feel the results and responses reflect your understanding of what is needed?
- Has your organization ever implemented a service delivery redesign? If so, what was your experience?
- What challenges or barriers to system redesign would you anticipate? Internal and external
- What types of practice facilitation expertise would be useful to your organization? Why?

Next Steps

- Summarize feedback from small groups
- Look for Practice Facilitation RFP release
- Thank you!

Contact Information

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