# Minnesota Accountable Health Model

## Community Advisory Task Force

Wednesday, November 19, 2014, 9 a.m. – 12 noon
Hiway Federal Credit Union, 840 Westminster, St. Paul

## MEETING MINUTES

## Attendees

Jennifer Stevens, Manny Munson-Regala, David Cook, Jennifer Blanchard, Jennifer Lundblad, Rahul Koranne, Cathy VonRueden, Jennifer DeCubellis, Renee Frauendienst, Nathan Moracco, Lucinda Jesson

**Welcome and Overview of Agenda**
Jennifer Lundblad, Chair, welcomed everyone and provided an overview of the meeting agenda.

**Update: Minnesota Accountable Health Model**
Jennifer Blanchard, DHS, provided updates on the Minnesota Accountable Health Model, including:

- Jennifer commented that there is a group of staff putting in a lot of time and effort to get RFPs out and support provider groups and organizations in their applications.
- There have been two successful rounds of the Emerging Professions grants, with lots of interest expressed from a large number of many different providers.
- The first round of the E-Health grants is moving into implementation; Round 2 will be released in the spring.
- The RFP for Accountable Communities for Health (ACH) closed October 20. The review process is complete and the top 13 applicants gave oral presentations. Decisions will be finalized in the next week or so, with announcements anticipated by the first week of December. Jennifer commented that it is exciting to see the types of groups that have come together – some that we expected, some not, with a variety of models and target populations.
- A number of other RFPs are open, and most close December 5th. All details on those RFPs can be found on the MN SIM website.
    - Emerging Professions Toolkit, providing resources to potential employers of emerging profession practitioners (community health worker, community paramedic and dental therapists/advanced dental therapists) to support integration of the emerging professions into the workforce.
    - Privacy, Security and Consent Management for Electronic Health Information Exchange: to support health care professionals, hospitals and health-related settings in the exchange of information within health settings, including improved information flows to patients and increased patient satisfaction.
        - Part A: Review of e-Health Legal Issues, Analysis and Identification of Leading Practice
        - Part B: Technical Assistance and Education to provider groups to do consent management
    - Practice Transformation: To support care coordination and integration of behavioral health and primary care. This is the first of three rounds.

- E-Health Roadmaps: To describe a path forward and a framework for a setting to enable providers to effectively use e-health to participate in the Minnesota Accountable Health Model. The state is securing the contractor for this work.
- ACO Baseline Assessment: The State has secured a vendor and is in contract negotiations with them.
- Grant and contract Management:
    - The third quarter 2014 report and the Year Two operations plan were successfully submitted to CMMI through a new reporting method. Jennifer thanked the staff for their hard work.
    - Work to evaluate the MN SIM project is moving forward with SHADAC.
    - Staff are working diligently to make the MN SIM website as user-friendly as possible.

Jennifer then responded to questions from Task Force members:

- Cathy VonRueden asked who was responsible for reviewing and awarding the RFPs under MN SIM. - who are the reviewers and awarders? Jennifer replied that the individuals reviewing and awarding the RFPs varied depending on the RFP, but included a mix of State staff and public stakeholders, with the process managed by State staff. Depends on the RFP, State manages the staff.
- Rahul Koranne noted that he is hearing from both community health workers and paramedics that they are innovating with the Emerging Professions grants in mind.
- Jennifer DeCubellis commented that there are many different projects going on in the health sphere, and wondered whether there was a strategy in place to begin creating a shared view of projects across the healthcare and welfare spectrum. Rather than doing traditional one-offs with people building different models, can we identify best-practices? Jennifer Fritz (MDH) commented that the State was beginning to look at how to provide a broad-ranging overview.
- Jennifer DeCubellis asked whether Privacy, Security and Consent Management work would line up with work for the upcoming legislative session to see if legislative changes are needed. The State responded that this work would not line up with the upcoming legislative session.
- Renee Frauendienst seconded Jennifer DeCubellis' comment about bringing the medical and health together and learning from best practices. Jennifer Lundblad stated that it may be helpful at the next meeting to revisit the MN SIM driver diagram. That would help to ensure that investments are mutually reinforcing, not a series of one-offs with gaps between them.
- Jennifer DeCubellis noted that technology was of particular concern, because development costs are so high. She hears in the community that "we can't afford to get connected," but if the state can get behind one or two systems rather than tailored systems for everyone, the development costs could be minimized.
- Rahul Koranne recommended making "collection of best practices" a formal part of the RFP process. He noted that one of the first concerns from community paramedics was to avoid duplicating existing Home Health structures in the community.
- Renee Frauendienst stated that communities that were interested in applying for Accountable Communities for Health but did not are still very interested in what comes out of the program. There is a critical need to push best practices out to the wider community. Jennifer Blanchard noted that the MN SIM Community Engagement work will be critical to spreading that knowledge, and that Sida Ly-Xiong, MDH will be seeking input during this meeting.

**Minnesota Accountable Health Model: Looking back/looking forward on task force accomplishments**

Commissioner Lucinda Jesson, DHS, provided her thoughts on the Accountable Health Model and the work the Task Forces have done over the past year:

- Commissioner Jesson thanked the Task Force for their engagement, participation, and willingness to do homework. She noted that she has learned a lot through reading through the homework assignments, and how the homework builds on the entire process. Commissioner Jesson has begun using homework for a task force on child protection services, and said they know who they can blame.
- Accountability matrix: The State made a lot of changes based on Task Force input, making it more patient-focused and talking more broadly about health.
- There is a lot of work ahead of us – we're in the middle of the process, and beginning to see results. Commissioner Jesson mentioned that she is excited to see the implementation of community paramedics at North Memorial and the changes that are taking place as a result of this project.
- Commissioner Jesson provided her thoughts on the Task Force's future work:
    - Reexamining Assumptions: Are we pushing the right levers and overcoming previously identified barriers? What are the barriers now?
    - Sustainability: There is excitement about the potential for this project, but how do we take what we're learning and use that to drive better healthcare for Minnesota in the future? We need to make this work sustainable. Also, there is a tension between providing cookie-cutter "this is how it should be done" solutions, and the fact that different things work in different parts of the state. The SIM approach has been open to many ideas, but best practices (particularly in technology) are good.
- The end of Governor Dayton's term and beginning of a new one is an opportunity to reflect on the work being done in SIM. This work can be the most important thing we do, but only if we determine how to move forward.

Task Force members commented on the Task Force process:

- Jennifer Lundblad stated that she has thought of work in the first year as planning, and that now we're in implementation, then we'll learn, then lead right back into planning, then implementation. She hopes this is a continuous cycle, which will have the greatest positive effect.
- Nathan Moracco noted that he spent a lot of meetings trying to figure out why we're here. Now, it feels like everything is much tighter, and it is fun to see it come together. This could be one of the signature pieces for this group of policy people. Nathan also noted that the community is well-represented in these meetings, which is something he doesn't often see.
- Manny Munson-Regala said that the amount of work the Task Force has done has been impressive, particularly in providing coherence to an incoherent vision. How do you recognize the diversity of Minnesota, but in a way that acknowledges best practices? He is optimistic for the continuing work of the group.

**Update and Discussion: Data Analytics Subgroup**

Dr. Rahul Koranne, HealthEast and Chair of the Data Analytics Subgroup, provided an update on the Subgroup and its first meeting on November 17:

- Dr. Koranne thanked the individuals and organizations who volunteered individuals for the Subgroup, including George Klauser; Cathy VonRueden and Monica Hurtado (Subgroup members) and Dave Cook and Jennifer DeCubellis (for sending senior leaders from their organizations).
- 14 individuals applied for membership in the Subgroup, and they have their eyes and ears open for feedback from their organizations and the community at large. The first of three meetings is complete, which means only six hours of meetings remain before Phase One is completed, we must focused on "what we can create today".
- The Subgroup is comprised of a good continuum of leaders across healthcare system: some come from organizations that are experimenting with ACOs, both with DHS and commercial payers,

while some come from innovative social services community-based agencies that are starting into the ACO world, or thinking about total cost of care (Wilder and others).

- Dr. Koranne noted that part of the work is to think about how to wear hats in the room – keeping your own organization's hat on, but also thinking collectively for the State. He thanked Krista O'Connor, Heather Petermann, Chris Heiss and Diane Stollenwerk for their help keeping those frames in mind.
- Key topics at the first meeting:
    - Good discussion about "are we starting from square 1, or are there other organizations that can come in and give us a baseline?" Presentations from outside organizations (ICSI, MNCM, Stratis, SHADAC) provided some of this flavor. But this was a structured discussion – the Subgroup realizes that we need all the help we can get, but wants to gather feedback and move on, because we need to take the plane off the ground then land it in a short amount of time.
    - Phase One vs. Phase Two discussion – guardrails for Phase One around what can be done today in terms of ACOs, Phase Two will focus on ACHs and the further integration of medical and social services data.
    - There was a good dialogue between the medical, integrated delivery ACO types and the social service agencies about where the focus should lie in Phase One. How do we go from today to tomorrow so that we don't forget about social elements in Phase One?

Task Force members commented on Dr. Koranne's presentation:

- Jennifer DeCubellis noted that true improvements on the medical side cannot be achieved without social services. How closely can we tie Phase One and Phase Two together? Can we have a bit of a parallel track, to fast-track improvements by ensuring that community providers have social services data? Dr. Koranne responded that the composition of the group (with a wide range of both provider organizations and social service organizations) means that this question is being kept front and center in the conversations, throughout Phase One.
- George Klauser provided comments on his experience within the Subgroup. He said it is enlightening to get a group together that connects with this, and believes that we are more connected than in the beginning, and beginning to understand the task at hand. From the standpoint of correlating medical and social data – for half the group, they are already thinking about that and it is a natural. It is pretty amazing to have this type of blended group that can start talking about common elements, driving outcomes for key factors for people served. All agree that the person is at the center of the output and outcomes, something that George was pleased to see. He is looking for the opportunity for carry-over of the person-centered approach to Phase Two.
- Cathy VonRueden noted that in Phase One the conversation will include the social elements that an ACO would need to capture to be successful. The conversation in Phase Two will be much broader when speaking of data elements for ACHs.

Dr. Koranne commented on the spectrum of themes that emerged during the first meeting:

- How can we make sure what we come up with applies to small and large organizations, urban and rural, medical and social?
- The Subgroup will come up with guiding principles, and hope they will stand the test of ACO and ACH – who will use? Will Medicaid ACOs automatically use these? Will others use these? If the product is robust enough, it will have a gravitational pull to use rather than duplicate. The Subgroup will include the intended audiences as part of the recommendations to the Task Forces.

Dr. Koranne described the work that Subgroup members will expect to complete outside of the Subgroup meeting:

- Expecting 100% participation, the homework will emerge from themes that Chris Heiss and Diane Stollenwerk are working on. What are the data elements that are a must-have vs. a nice-to-have? May be homework around what is missing. Also may be whether you see a guiding principle emerging.

- Diane Stollenwerk commented that we knew with the diversity of people coming, there would be a range of perspectives; that some people would come to the meeting with broad concepts or specific data elements. Homework will focus on:
    - What question we are looking to answer?
    - For those that come with data analytics elements, what question is that trying to answer?
    - What information will help answer questions?
    - What data analytic elements will provide that information?
    - What are the sources of data?
- Need to hold people's feet to the fire about the value stream, to help answer "who is going to use this" through the clear value of the work.
- Dave Cook noted that the data analytics work gets back to the comment about getting organizations connected, so that they can get the data.
- Diane Stollenwerk said that we know there are groups that are already doing a lot of work in this, but also know from the provider panel, held in spring, that some are not receiving information, and some don't know what to do with it.
- Jennifer DeCubellis mentioned that core standardization is important to ensure that when an individual changes plans 5 times, their providers have a complete picture of their care.
- Diane Stollenwerk said that the Subgroup will need to come up with a product to think about the business case for why this is in everyone's best interest to follow principles to get better alignment.
- Renee Frauendienst noted that the conversation has been a lot about data and individuals. Will this workgroup be looking at what it means to improve population health/ measurements to improve health? Dr. Koranne replied that one of the themes that arose was whether we want to make this data patient-specific vs. population, and that it probably needs to do both. For an ACH, need to know the health of the population, but drill down to individuals. Jennifer Lundblad agreed that the work is both, and may dovetail with SIM evaluation work.
- Jennifer Stevens stated that as a tribe, the White Earth Nation finds it really difficult to find data on the population, as data is based on county someone lives in or zip code, not whether they are affiliated with a tribe. The tribe is trying to find data on drug-related births, but there are no hospitals on the reservation. Jennifer asked that the Subgroup keep in mind other ways to break out the data. Dr. Koranne replied that Mónica María Hurtado was keeping the Subgroup on point to look broadly at population and all types of population.

**E-Health Advisory Committee Activities**

Alan Abramson, HealthPartners, provided an overview of the E-Health Advisory Committee:

- The E-health initiative was established by statute in 2004 to equip providers with inter-operable records by 2015. The committee is a broad-based group of stakeholders that has advised the Commissioner of Health for the past 10 years.
- Accomplishments over the past 10 years include:
    - Working with the Minnesota Legislature to recognize the existence of Electronic Health Records (EHR).
    - Creating a three-phase plan for establishing inter-operable records by 2015 (equipping with records, effective use, and then exchange of data across the state) that the Federal government borrowed heavily from.

- Conducted an audit survey in June 2014 and found that Minnesota hospitals have achieved 99% installation, public health 97%, most providers 96-97%. Long Term Care providers asked to be included, and though not reimbursed for the work, stand at 70% installation of EHR.
- The Committee is beginning to talk about population health, accountable health and how EHRs coordinate with that work.
- The Committee is scheduled to sunset in 2015, but Alan think that there are reasons to renew the charter, particularly as organizations determine how to use EHRs.

Jennifer Fritz, MDH, provided an overview of Committee workgroups and their activities, and invited Task Force members to participate:

- The workgroups dive deeper into E-Health topics than the broader committee. Each year there are between two and four active workgroups (right now there are four).
- Health Information Exchange (HIX) workgroup: will hold its first meeting on December 4, to discuss how HIX can be used to achieve accountable care. A panel of ACOs will be presenting. The first couple of meetings will focus on gathering emerging needs. The remainder of year will be focused on what transactions need to be in place to meet the 2015 mandate, and that may be relevant to accountable care. Final activity of the year will be to update resources.
- Standards and Inter-Operability workgroup: has some interesting ties to the work of the Data Analytics Subgroup. There was a meeting a couple of weeks ago on capturing social determinants of health on EHRs, drawing off of a recently-published document from the Institute of Medicine. Minnesota was the first state to recommend that all providers adopt the same terminology as provided by the Omaha System for Public Health. The next conversations will be around inter-operability in state government, as the Commissioner of Health has responsibility for recommending standards.
- Privacy and Security workgroup: all of the SIM privacy and security work will go through this workgroup. The workgroup will provide advice on approaches to patient and provider education, consumer-based education to better explain how data is used/ stored/ disclosed, and legal analysis around privacy and consent policies. It will develop resources and guidance on resources, particularly for those not part of the bigger health systems. Work will continue through the duration of SIM.
- E-prescribing workgroup: Most of this workgroup's work is already done, but it may still meet later this year to take deep-dives on specific instances of e-prescribing.
- The Committee also has a couple of ad-hoc workgroups in place to address Consumer Engagement and Workforce issues.

Task Force members commented on the presentations from Alan Abramson and Jennifer Fritz:

- Jennifer DeCubellis asked if part of the work on collecting social determinants of health through the Standards and Inter-Operability workgroup was looking at metrics captured through social service agencies, and not just through EHRs. Rahul Koranne noted that the Minnesota Senior Options program has a new assessment screening with medical and social data that may be of value to the workgroup. Cathy VonRueden noted that we need to ensure the onus is not just on the providers, but that there is sharing between providers and social service agencies.
- Commissioner Jesson asked whether there is any record interoperability for dentistry. Jennifer Fritz replied that anecdotally they have heard that there is adoption of EHR among dentists, but that there are many barriers. The state has not done a formal survey of dentists on this question.
- Jennifer Lundblad said that as the E-health advisory committee has added members in recent years, it has done so with a lens towards what sectors we don't have information. Dental, chiropractic, and mental/behavioral health have all been areas where there has been renewed focus. Alan Abramson noted that Mark Jurkovich is representing dentistry on the committee, and

that at Health Partners there are clinics where patients can enter and turn left for dental, or turn right for medical. Certain medical symptoms are often diagnosed first by the dentist, and he likes how Epic is creating an integrated medical/ dental record. Rahul Koranne noted that it would be good to include social service agencies such as Catholic Charities, Lutheran Social Services, Wilder, and adult day care and care givers in the Committee.

- Jennifer Fritz noted that a key question for the Committee, assuming it is extended beyond 2015, is how to update their charter.
- Regarding the Privacy and Security workgroup, Jennifer DeCubellis asked if part of the initiative is to educate providers. Organizations have given access to EHRs to a bunch of case managers, but the case managers may be scared to death to use it for fear of legal issues. Jennifer Fritz said the workgroup did a study on unauthorized access and made recommendations that will be part of their work. Jennifer DeCubellis noted looking at the welfare statute regarding consent for data connection; Jennifer Fritz replied that it is in the scope of the Privacy and Security workgroup's RFP. Renee Frauendienst asked about how the workgroups are getting information to providers to help them understand what they are trying to do.
- Commissioner Jesson asked what was meant by community engagement in context of the ad-hoc workgroup. Jennifer Fritz noted that the purpose of the workgroup is to define scope of how we want to engage consumers around e-health. May include how to access data, understanding privacy of data, and literacy of explanations. Alan Abramson added that they are looking for recommendations about how consumers would use data.
- Jennifer Fritz noted that the dates for the next E-health summit are set for Tuesday, June 16th & Wednesday June 17, 2015 at the Double Tree Hotel, St. Louis Park. The call for abstracts is due 12/15 – some of the SIM e-health grantees will showcase their work. Jennifer encouraged anyone working on innovative things to consider submitting an abstract.
- Jennifer Stevens asked how communities are handling e-prescribing for drugs requiring wet signature. Rahul Koranne commented that the wet signature issue is also a big issue for the Indian Health Service and urgent care. Alan Abramson said that it is on the list of issues for discussion at the Committee, but that it brought up a bigger issue: if the E-Health Advisory Committee sunsets as scheduled in 2015, where will the work continue? For example, Minnesota statute enforces a fragmented sort of care – what changes to statute are needed to support the Accountable Health Model? How should the Committee's charge change to incorporate population and accountable health?
- Task Force members asked whether the Committee has to sunset. The response was that it will sunset unless there is legislation to renew it.
- Rahul Koranne asked if Epic is part of the Committee. Alan Abramson replied that no vendors are part of the Committee, as they would have to be appointed by the Governor, but a number of meetings have included testimony from the vendors, and they have also been involved in the workgroups. Rahul proposed that Epic be integrated into conversations so that everyone knows what direction things are moving and rework could be minimized. Alan replied that Epic is very intentional on improving the health care system through technology, but resistant to complying to specific government requests (e.g. certifying at the Minnesota level). Somewhat resistant to partnership except through customers. Rahul asked whether enough of the systems and Long Term Care customers could come together in a forum to work with Epic. Alan replied that the forum already exists through the Minnesota Epic User Group. Jennifer Lundblad commented that a number of organizations use Epic, but that there are a number of other vendors that the Committee wants to ensure are being engaged collectively.

Diane Stollenwerk, CHCS, facilitated a discussion with the Task Force around the opportunity to recommend continuation of the Committee past its scheduled sunset in June 2015. If the Committee continues, what might be useful in an updated charge to the Committee?

- Diane Rydrych noted that the Minnesota Department of Health is interested in the Committee extending, but it never hurts for legislators to hear from community that it should continue providing resources, support and TA to providers. The conversation here is whether the Committee will look the same when renewed, and how it could do its work more effectively.
- Jennifer Lundblad noted that the statute requires representation from particular groups, and that this is an opportunity to think about those lists if statute renewed to ensure the right people are around the table.
- Rahul Koranne noted that current Information Systems are focused on the limited interaction with medical facilities. There is a lot outside of that – is there something that can ensure social service agencies can tap into the data? We as a community should push for that.
- Dave Cook noted that it was said that mental health is included on the list, in the person of Tricia Stark from the Minnesota Mental Health Association. However, it is not in statute that mental health should be included, and maybe it should be. Most community mental health centers have an EHR, and should be included in the conversation.
- Renee Frauendienst noted a need to engage policy makers in what is happening. Legislators often become the barrier even though the community is interested in moving forward – it is critical to engage them in these discussions.
- Cathy VonRueden asked how the Privacy and Security Workgroup of the Committee will connect with the SIM Privacy and Security RFP. Jennifer Fritz said that it is anticipated that the workgroup will be the main external group advising the RFP. Jennifer Lundblad noted that whomever is selected under SIM, their primary linkage to the State will be through the E-health workgroup. Diane Rydrych concurred, saying the workgroup will be an advisory group to the grantee.
- Jennifer Lundblad noted that anyone can join the E-health workgroup, and asked whether there is anyone that the Task Force wants to make sure is engaged. Rahul Koranne recommended having someone from a community-based social services organization on the workgroup, such as George Klauser from Lutheran Social Services. Jennifer noted that now that the Task Force has seen the charges to the workgroups, they can give more specific thought to nominations or figure out good connections.
- Jennifer Fritz concluded by noting that membership in the workgroups is quite large – up to 70 participants in one of them. Anyone can sign up for the e-list to receive materials, and the staff to contact for each of the workgroups is in the slides. Contact that staff to sign up for the workgroups at any time.

**Minnesota Accountable Health Model Evaluation**

Lynn Blewett, SHADAC, provided an overview of the Minnesota Accountable Health Model Evaluation:

- This evaluation is a "formative evaluation," meaning that it is a joint, collaborative project, where SHADAC will be working with State staff and the evaluation committee to get the best information possible. It is not the type of evaluation where the evaluator shows up three years later to say what was done wrong.
- The evaluation contract was finalized his summer. Part of the work since then has focused on establishing working relationships between team leads. SHADAC is also working with Hennepin Health evaluators, who have similar goals.
- SHADAC submitted the draft evaluation plan on 10/31/2014 and received the first feedback on the plan on Monday, November 17. The final plan is due in early 2015. The draft plan is very complex, and is 70 pages long. Once feedback and edits are received and compiled, the draft plan will be made available to the committees. The plan outlines the five evaluation goals, with

evaluation questions for each goal, and cross-driver evaluation activities. Part of the work is to identify and leverage existing data sources, then seeing where there are gaps.

Task Force members asked a range of questions:

- Jennifer DeCubellis asked whether there was a timeframe for how long the evaluation would go on. After 1.5 years, will need a good idea of how things are going to implement a sustainability plan. Lynn Blewett replied that SHADAC currently has a 1 year contract, but that there is potential for additional time. She also mentioned that the evaluation plan includes timeframes for the work. Diane Rydrych noted that interim findings will be reported as they become available.
- Rahul Koranne noted that through SIM there is something different in how community-based stakeholders, DHS and MDH are working together. There is value in articulating what Minnesota does best (grass-roots task forces, listening sessions, etc.) that could be useful for other states.
- Commissioner Jesson reminded the group to think about those that aren't involved or engaged in SIM. The SIM model is currently focused on the Integrated Health Partnerships, but there are some major players who aren't participating in IHPs. Why aren't they? What are their reservations? She hopes that these questions are part of the evaluation. Lynn Blewett replied that key actor interviews will be included as part of the evaluation.
- Renee Frauendienst asked how the evaluation work will be conducted at the local level, to inform how the work is going state-wide. Lynn Blewett replied that part of the state-wide evaluation will be to look at the deliverables and evaluation components for the many local grants that are going out, and providing input on what worked well and what could have been done better. Another connection to the local level will be connections with patients, providers, and payers as part of the interview component of the evaluation.
- Diane Rydrych noted that the evaluation will be both qualitative and quantitative, and a big piece of the evaluation will be to share stories of grantees in various ways. As we move forward, the State will be looking for guidance from the Task Force on how best to share what we're learning. Presentations at meetings, white papers, webinars? Also, the State acknowledges that it is making investments in specific communities, on a deep level, but that there are other communities unfunded but interested in this work – how can we learn from and share with them?
- Shannon McMahon, CHCS asked Lynn Blewett to outline the distinction between the state evaluation and the federal evaluation, and highlight any places of potential synergy. Lynn Blewett noted that the federal evaluation looks across all of the SIM projects across the country, while Minnesota is doing a self-evaluation with a Minnesota-specific approach. However, SHADAC participates on the federal calls, getting their reports and trying not to duplicate federal efforts. SHADAC is working "on-the-ground," participating in meetings and workgroups. They will try to reduce duplication (avoiding asking the same individual the same questions), but there may be some bumps along the way.
- Jennifer Lundblad asked if the other five SIM model testing states are doing local evaluations, and if SHADAC is connecting with them. Lynn Blewett agreed that connections between the evaluators was a good idea, though they had not made that connection yet.
- Rahul Koranne asked if the evaluation had targeted some number of papers in Health Affairs as a way to get the news out about Minnesota's work. Diane Rydrych said that Health Affairs is one good audience/ approach, but that we should be looking in all directions, identifying what SIM is learning that can inform policy levers for sustainability. Jennifer DeCubellis raised the potential of creating videos; Diane Rydrych noted the videos of the three Community Care Team pilots, which were powerful stories. Lynn Blewett noted that SHADAC is part of an academic institution (UMN), and as academics they love to write peer-reviewed papers. If such papers align with the needs of the State, that would be great.

- Jennifer Lundblad asked if the evaluation will help answer the question of whether SIM is improving the health of the population. Lynn Blewett replied that is hard to show real change in a short period of time. The evaluation will be able to show changes in process measures (engagement, etc.), but effects on mortality and morbidity take a much longer time. It will be important to "keep an eye on the ball," establishing baseline measures and continuing to monitor over time. Renee Frauendienst noted that the population health discussion (identifying what we are trying to do 10-15 years out to set up the measures, establish where we are moving) is critical to planning for sustainability. Cathy VonRueden agreed, particularly in how an evaluation can gain more reliable information than the anecdotal one-off stories that are often heard.

**Community Engagement**

Sida Ly-Xiong, MDH and Shannon McMahon, CHCS, facilitated a discussion on recommendations to expand SIM community engagement:

- Sida Ly-Xiong noted that community engagement under SIM is intended to be a two-way discussion to inform the public about what is going on in SIM, but also receive feedback as well. People are excited/ pleasantly surprised about the amount of work going on. SIM has begun using an expanded definition of providers, including medical, behavioral, and social services.
- A number of questions that SIM is trying to answer through community engagement:
    - SIM is one of many health initiatives people are hearing about. How is SIM advancing health equity?
    - What are the additional resources that can advance equitable partnerships?
    - Authentic community engagement – how to encourage spill-over. Help State to understand what technical assistance providers may need?
- Shannon McMahon asked Sida Ly-Xiong to point to a specific example of talking to a provider that has said "this is what we've done to engage a specific population around population health"? Sida noted one provider that had done good work around changing the stigma around mental illness – engaging stakeholders in the community about what mental illness meant, to reframe the options for mental health care. This helped the community understand the real vs. perceived needs for care.
- Jennifer Blanchard noted that communities have then reached out to the Public Health side to ask what their goals are, and informing how to address in a specific way to more effectively reach a prevention goal for a population. Renee Frauendienst noted that public health agencies have done community engagement for many years, so it is critical for SIM to connect with them.
- Jennifer DeCubellis noted that reaching out to public health doesn't mean just getting a letter of support. How do the goals of accountable health match with public health goals? Need to do better messaging to ensure public health agencies are ready, staffed appropriately, but that organizations are also educated about why involving public health is important.
- Renee Frauendienst noted the Research to Action work in Minnesota, which focuses on how primary care is collaborating with global public health. Good information has been received about how patients are initially connected with a provider and what worked well getting those connections. That's where the connections start – when primary care and local public health get together. Beth Gilstrom at the Office of Performance Improvement at MDH did key informant interviews on that project.
- Diane Rydrych noted that when you think about the ACHs, e-health grantees, and others, there are many different facets of what we want to learn from them. What can we pull from the applicants (not just the grantees) on how they included marginalized populations in their planning efforts? Then we can share learnings or best practices.

Sida Ly-Xiong stated that a set of questions would be sent out to the Task Force after the meeting, perhaps in survey form for ease of response, to inform SIM as TA needs develop and inform the State's community engagement work. Jennifer Lundblad cautioned that the team be clear on what they mean by "community engagement."

**Review Next Steps/Future Meetings**
Jennifer Lundblad wrapped up the presentations, noting that this was the last meeting of 2014, and in 2015 the plan is to move to a quarterly schedule, including one or two joint meetings with the Multi-Payer Alignment Task Force. Short conference calls or webinars may also be scheduled to prepare members for in-person meetings, to make the most of in-person time. The next in-person meeting is scheduled for March 18, 2015, from 9 a.m. to 12 p.m., likely at Wilder in St. Paul.

**Public Comment**
George Klauser, Lutheran Social Services noted that the meeting was very enlightening with constructive feedback on evaluation and community engagement, but he sees a gap: there are a whole group of individuals that are not getting the benefit of the dialogue. The project should work to build a better bridge between community providers (community engagement) and feedback they can provide on the evaluation approach.