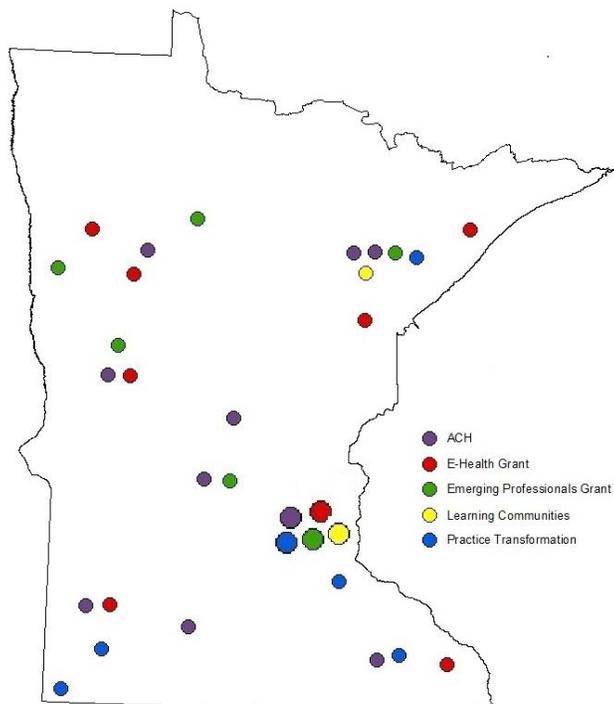


MINNESOTA ACCOUNTABLE
HEALTH MODEL
SIM MINNESOTA

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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. 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 is using the grant money to test new ways of delivering and paying for health care using the Minnesota Accountable Health Model framework. Thanks to SIM funding, dedicated programs are now in place to improve health in Minnesota communities, provide better care to our state's residents, and lower health care costs by expanding 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.

Practice Transformation

Zumbro Valley Health Center Incorporates Primary Care

JULY 2015

Over the course of the last several years, and with the support of a legislative appropriation, Zumbro Valley Health Center has integrated primary care into their mental health center. Those efforts made it possible for them to seek certification as a Health Care Home (HCH); making them the first community mental health center in Minnesota to do so. By integrating primary care services into their mental health center Zumbro is able to provide patients with the services they need to improve their overall health.

A health care home, also known as a medical home, is an approach to health care in which primary care providers, families, and patients work together to improve individual health outcomes and quality of life. Using teams to coordinate care is a hallmark of health care homes.

In order to become a health care home, Zumbro Community Health Center made significant changes to current procedures by:

- Transforming their clinical staffing model from program-specific to team-based multidisciplinary care teams.
- Developing a patient registry for co-occurring &/or co-morbid conditions.
- Soliciting client/caregiver feedback through the use of focus groups.
- Developing a centralized care plan that incorporates all health services received at Zumbro Valley.

Zumbro Valley was awarded a Practice Transformation grant through Minnesota's Statewide Innovation Model (SIM) initiative to help them implement the necessary changes and seek health care home certification. Results of their efforts have been positively received by Zumbro clients. One patient said, "Things get done so much faster here. You're not a number like in a large system. From the front desk to walking in the halls, people here know you."

SUCCESS

The Health Care Home Model

The health care home model requires that primary care services be comprehensive and include the full spectrum of preventive, acute, and chronic care. For example, at a health care home, a patient's care team will coordinate preventive care during annual exams as well as managing chronic concerns like high blood pressure or diabetes care needs and any acute concerns such as a sore throat, earache, or back pain.

Patients with more complex needs may have a written care plan. Care plans are an individualized document developed with and for the patient to guide their care.

Patients use care plans as action plans to reach health goals, quick reference for emergencies, and for communication with service providers. Care teams use care plans to promote active patient self-management, engage patients in personal goal planning, set the stage for a collaborative relationship, improve patient outcomes, increase patient satisfaction, and to reduce cost.

What does coordinated care look like?

- Chronic disease is managed.
- Prevention of emergency room visits.
- Prevention of hospitalizations.
- Smoother transitions with increased communication.
- Reduction of errors.
- Screening and follow-through completed.

The role of the care coordinator.

The care coordinator is a key figure in educating patients, verifying records, assuring complete, up-to-date care, communicating needs to the medical home provider and care team members, and accessing appropriate care/resources for the patient.

A care coordinator can be a Registered Nurse, Social Worker, Dietician, LPN, Community Health Worker, Advanced Practice Nurse, Physician Assistant, Physician, or Medical Assistant. Regardless of the certifications, the care coordinator will have skills in providing patient and family centered care, including:

- Listening to and understanding patient/family needs.
- Helping patient maneuver through the health system.
- Facilitating access to needed services.
- Advocating for appropriate care based on identified gaps in care.
- Tracking a patient through health care encounters.
- Developing care plans with patients and their family.

As a certified Health Care Home, Zumbro Valley Health Center is providing their clients with comprehensive and individualized care dedicated to whole health. As one patient stated, his "care plan is vital to his life and if he did not have his provider and RN care coordinator, he 'probably wouldn't be around'".