

# Minnesota Accountable Health Model: Community Advisory Task Force

WEDNESDAY, NOVEMBER 18, 2015  
WELLSTONE CENTER  
179 ROBIE STREET, ST. PAUL  
9 A.M. – 12 P.M.



# Agenda

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- Welcome, Introductions, and Overview of Agenda
- Update: Minnesota Accountable Health Model
- Update: SIM Evaluation
- Data Analytics: Phase One & Phase Two
- Sustainability of SIM MN
- Next Steps/ Future Meetings
- Public Comment

# Update: Minnesota Accountable Health Model

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## Aim

### Minnesota Accountable Health Model

By 2017, Minnesota's health care system will be one where:

The majority of patients receive care that is patient-centered and coordinated across settings;

The majority of providers are participating in ACO or similar models that hold them accountable for costs and quality of care;

Financial incentives for providers are aligned across payers, and promote the Triple Aim goals; and

Communities, providers and payers have begun to implement new collaborative approaches to setting and achieving clinical and population health improvement goals.

## Primary Drivers

1. Providers have the ability to exchange clinical data for treatment, care coordination, and quality improvement.  
--HIT/HIE

2. Providers have analytic tools to manage cost/risk and improve quality.  
--Data Analytics

3. Expanded numbers of patients are served by team-based integrated/coordinated care.  
--Practice Transformation

4. Provider organizations partner with communities and engage consumers, to identify health and cost goals, and take on accountability for population health.  
--ACH

5. ACO performance measurement, competencies, and payment methodologies are standardized, and focus on complex populations.  
--ACO Alignment

## Secondary Drivers

Provide funding, technical assistance (TA) and other resources to increase community, provider and setting engagement in secure Health Information Exchange (HIE).

Develop roadmap and provide tools/resources to promote Electronic Health Records (EHR) adoption and effective use.

Provide investment in state technical infrastructure to support population health improvements through standards-based clinical health information exchange.

Provide enhanced data analytics, reporting and technical assistance.

Provide resources and training on quality improvement.

Provide direct provider support/TA for practice transformation/transition to team based, patient centered coordinated care.

Support adoption of emerging provider types (e.g. community health worker, community paramedic, dental therapists).

Establish models for Accountable Communities for Health.

Develop a methodology/ roadmap for incorporating ACH activities into payment models.

Align and evolve ACO payment methodologies.

Establish ACO core competencies and regulatory structures.

Develop community core measures for ACO cost and quality.

Develop integrated ACO financial models and measures for complex populations.

# Updates: Community Engagement Regional Meetings

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- Four Regional Events in Fall 2015

Date	Location	Topic
November 2	Fergus Falls	County Health Rankings
November 17	Minneapolis	Community and Health: Stories of Impact and Collaboration
November 19	Rochester	Framing Your Impact Story and Message
December 3	Bemidji	Resilience and Healing Community Conversation

- Launched Storytelling Project with starter questions and jumpstart video
- Awarded Community Engagement Initiative contract to Community Blueprint to develop a plan for leveraging stories to encourage health partnerships

# Updates: Practice Facilitation Services

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- **The National Council for Behavioral Health** conducted initial in-person meeting on **November 10<sup>th</sup>** with organizations with priority needs in:
  - Accelerating behavioral health and primary care integration
  - Data use related to analytics and interoperability
  - Identifying and assessing service costs
  - Whole health programs
- **ICSI/Stratis Health** conducted initial in-person meeting on **November 17<sup>th</sup>** with organizations with priority needs in:
  - Chronic care management
  - Health IT
  - Health Care Home certification
  - Integration of behavioral health or alternative models of care
  - Quality Improvement
  - Total Cost of Care (TCOC)

# Save the Date: 2016 Health Care Homes/ State Innovation Model Learning Days Conference

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## On the Road: Patient Centered Care to Healthy Populations

- April 26-27, 2016
- Marriott Northwest, Brooklyn Park, MN
- Registration opens January 2016

Proposals sought for sessions by health care providers and community organizations on:

- Community Partnerships
- Population Health
- Quality Improvement
- Team Based Care

# ACO Baseline Assessment: Findings

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- Highest ratings are in clinical decision support
- Lowest ratings are in community partnerships and coordination
- About 50% of clinics, physicians & hospitals are part of an ACO model
- However half report only 0 – 10% of revenue is at risk

# ACO Baseline Assessment: Recommendations

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- Consistent leadership
- Investment in technology and core infrastructure
- Involvement with the broader community, including non-clinical providers
- Population health management to include broader population outside of the clinic walls
- Provide training and leadership in ACO and population health concepts
- Provide access to meaningful data and resources
- Investigate regulatory solutions and simplifications
- Continue to refine data collection and monitoring of ACO activity

# MINNESOTA ACCOUNTABLE HEALTH MODEL - STATE EVALUATION

Task Force Meetings  
November 18, 2015

Donna Spencer and Christina Worrall



# Presentation Overview

- Evaluation Update
- Continuum of Accountability Assessment Tool
  - Overview
  - Preliminary Results
- ACH Characteristics
  - Preliminary Findings

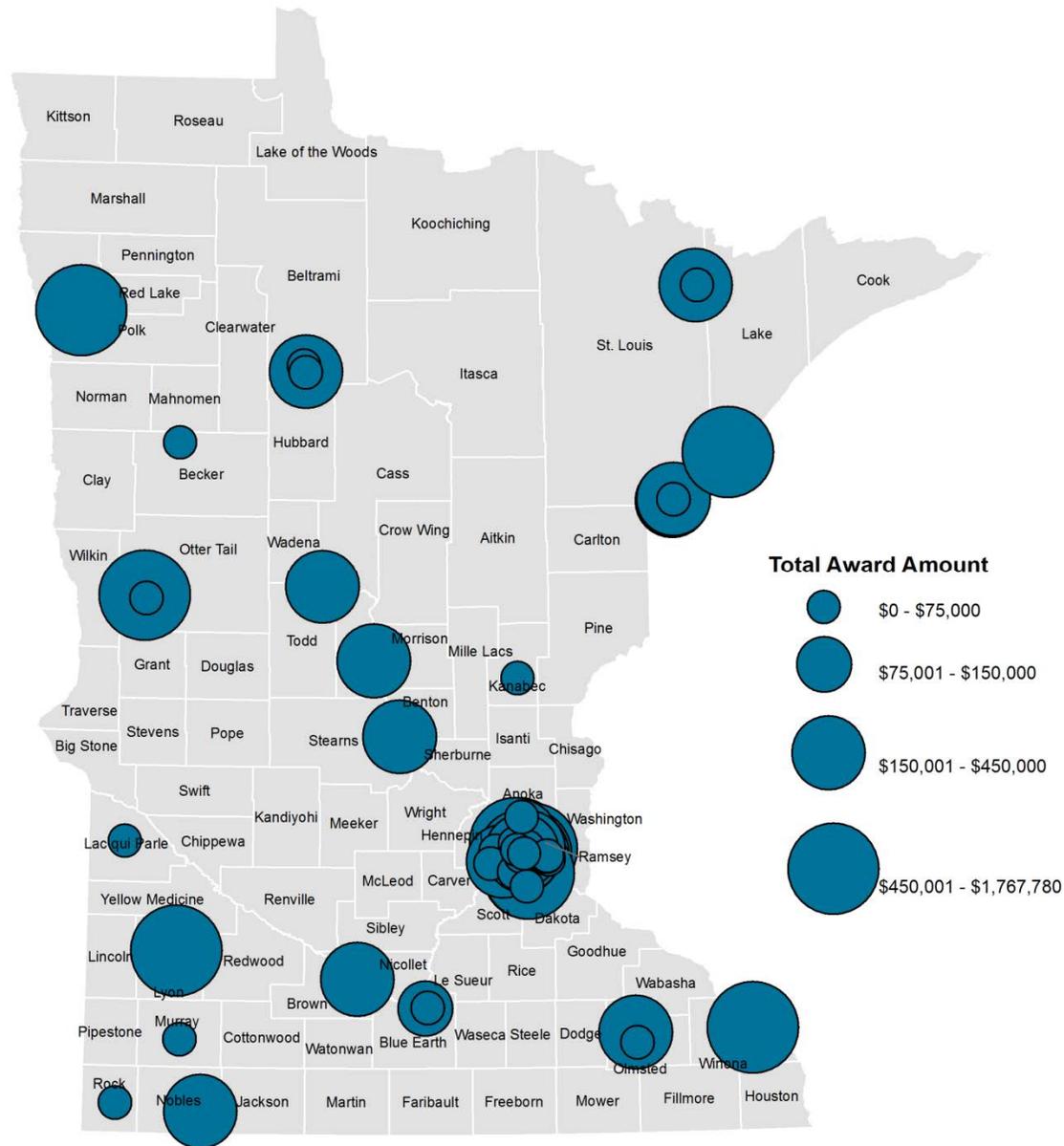
# Evaluation Update

- Qualitative interviews (~140 individuals to date)
  - e-Health Collaboratives and Roadmaps
  - IHPs
  - ACHs
  - Practice Transformation
  - Emerging Professions
  - Assessment Tool
  - Executive Other State Leadership and Staff
- Assessment tool database and analysis
- Access to APCD
- Contract with Rainbow Research for community engagement evaluation task
- Administration of tool to assess partnership, leadership, decision-making, resources among ACHs
  - Partnership Self-Assessment Tool
- Systematic document reviews
- Ongoing partner organization database

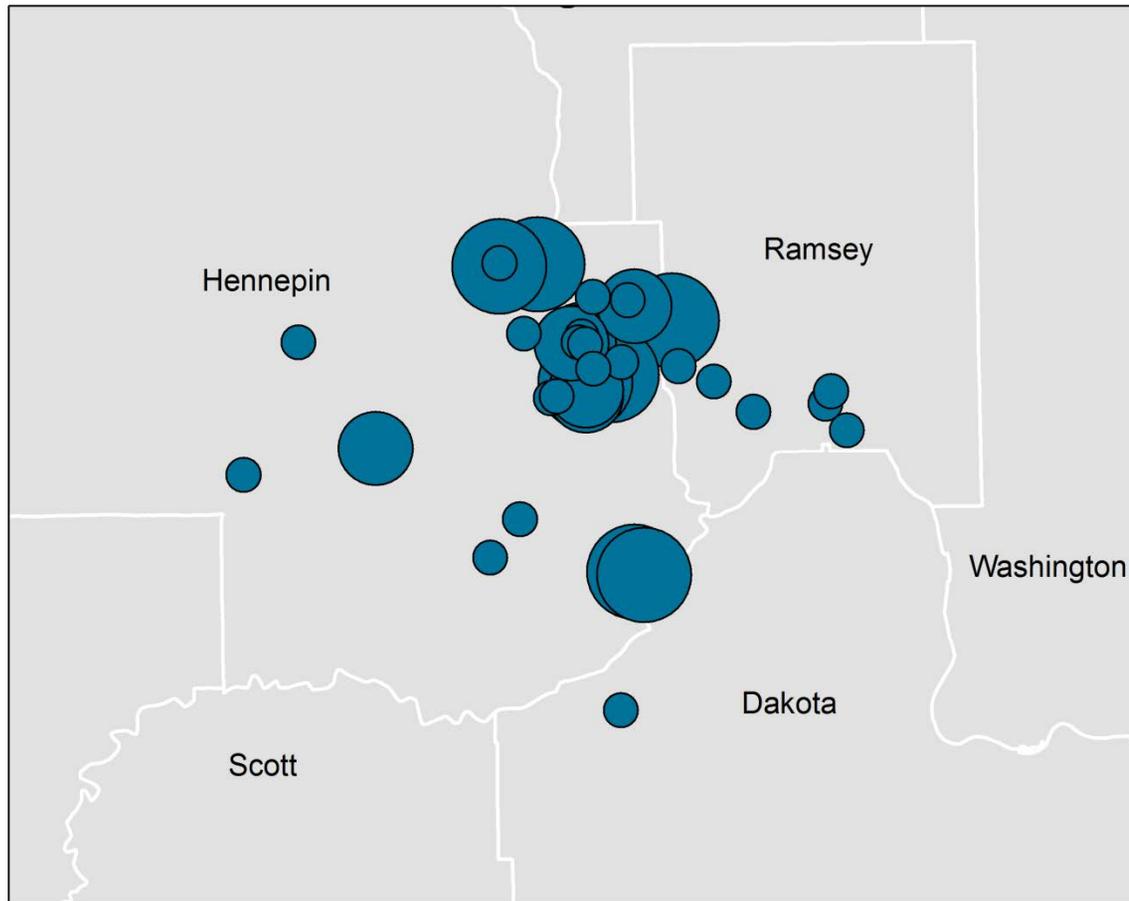
# Evaluation Update (cont.)

- Interim deliverables to date
  - Preliminary findings from initial interviews and document reviews
    - e-Health
    - Practice Transformation
    - ACHs
  - Preliminary assessment tool analysis
  - Updated data for and displays of ACHs and e-Health collaboratives
- Forthcoming
  - 1<sup>st</sup> annual report

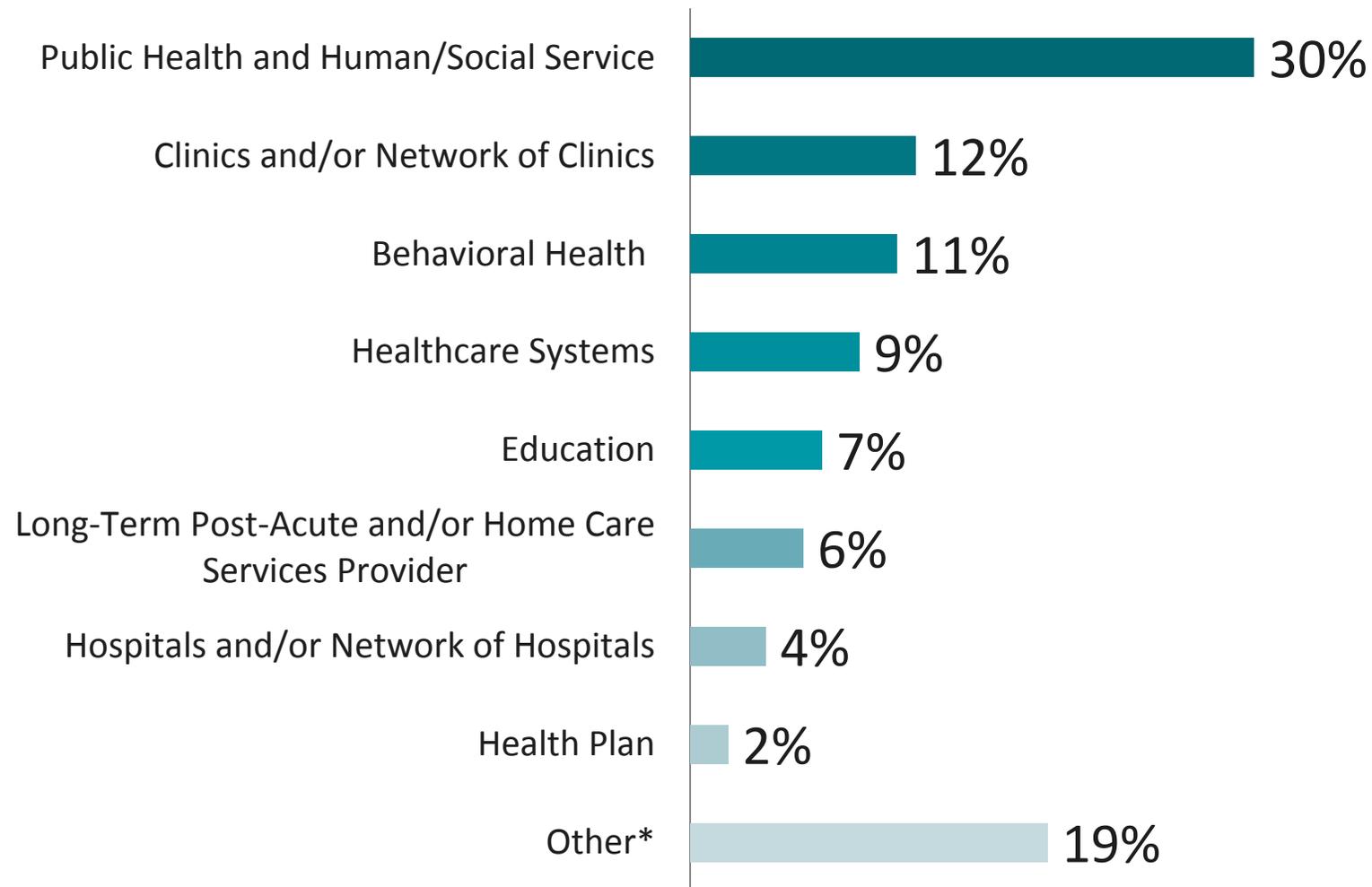
# Total MN Model Awards per Fiscal Agent



# Total MN Model Awards: Metro Counties



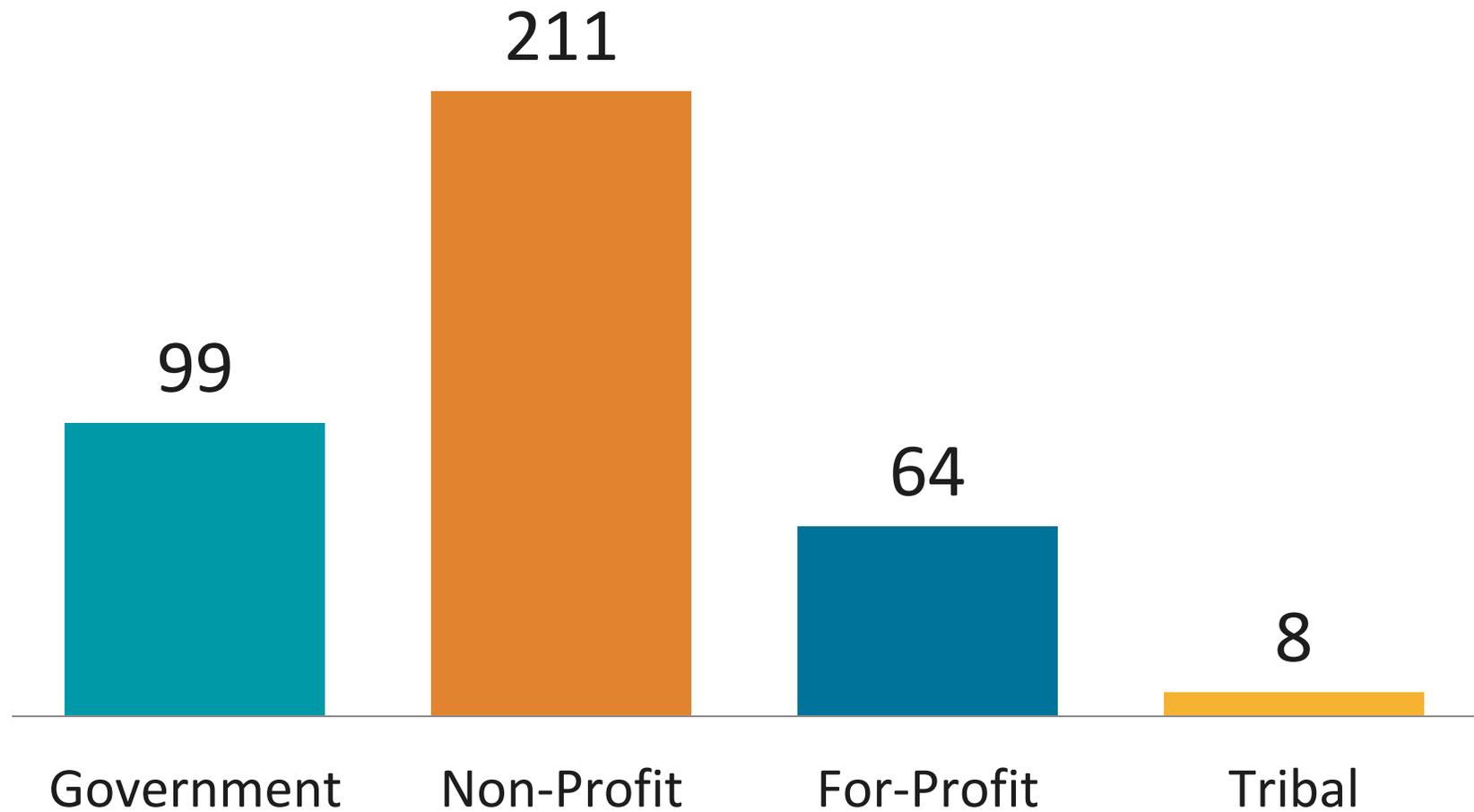
# Types of Organizations Participating in SIM in Minnesota



11/17/2015

\*e.g. Consultant, IT vendor, EMS, Advocacy, Legal, Pharmacy

# Sector of Organizations Participating in SIM in Minnesota



# Changes in Organization Grant Participation

- E-Health
  - 199 active organizations
  - 7 organizations proposed but not/no longer participating
  - 2 organizations added
- ACH
  - 180 active organizations
  - 57 organizations proposed but not/no longer participating
  - 62 organizations added

# Overview of Continuum of Accountability Assessment Tool

- Self-assessment of organization status on 31 capabilities and functions within seven categories:
  - Model Spread and Multi-Payer Participation (1 item)
  - Payment Transformation (1 item)
  - Delivery and Community Integration and Partnership (14 items)
  - Infrastructure to Support Shared Accountability Organizations (2 items)
  - Health Information Technology (7 items)
  - Health Information Exchange (4 items)
  - Data Analytics (2 items)

# Example Question from Tool

## Payment Transformation Section

2. What types of alternatives to fee-for-service (FFS) payment arrangement(s) do you participate in? Select the level that best represents your organization, and within that level choose the appropriate response by checking the box.

<u>Pre-Level</u>	<u>Level A</u>	<u>Level B</u>	<u>Level C</u>	<u>Level D</u>
We only receive payment for delivered services in the form of fee-for-service without any incentives.  <input type="checkbox"/> Beginning <input type="checkbox"/> In progress <input type="checkbox"/> Mostly done	We have little or no readiness to manage global costs, but may be willing to assume fixed payment for some ancillary services. Examples include: Health care home or similar coordination fees, quality improvement/incentive payments.  <input type="checkbox"/> Beginning <input type="checkbox"/> In progress <input type="checkbox"/> Mostly done	We are ready to manage global costs with upside risk. We participate in shared savings or similar arrangement with both cost and quality performance with some payers; may have some financial risk (e.g. episode-based payments).  <input type="checkbox"/> Beginning <input type="checkbox"/> In progress <input type="checkbox"/> Mostly done	We are ready to manage global cost with upside and downside risk. We participate in shared savings and some arrangements moving toward risk sharing through Total Cost of Care or partial to full capitation for certain activities; may include savings reinvestments and/or payments to community partners not directly employed by the contracting organization.  <input type="checkbox"/> Beginning <input type="checkbox"/> In progress <input type="checkbox"/> Mostly done	We are ready to accept global capitation payments. Community partners are sharing in accountability for cost, quality and population health are included in the financial model in some form.  <input type="checkbox"/> Beginning <input type="checkbox"/> In progress <input type="checkbox"/> Mostly done

Enter any comments you have about Payment Transformation: [Click here to enter text.](#)

# Analysis of Assessment Tool Data

- Received pre-grant assessments for 205 organizations\*

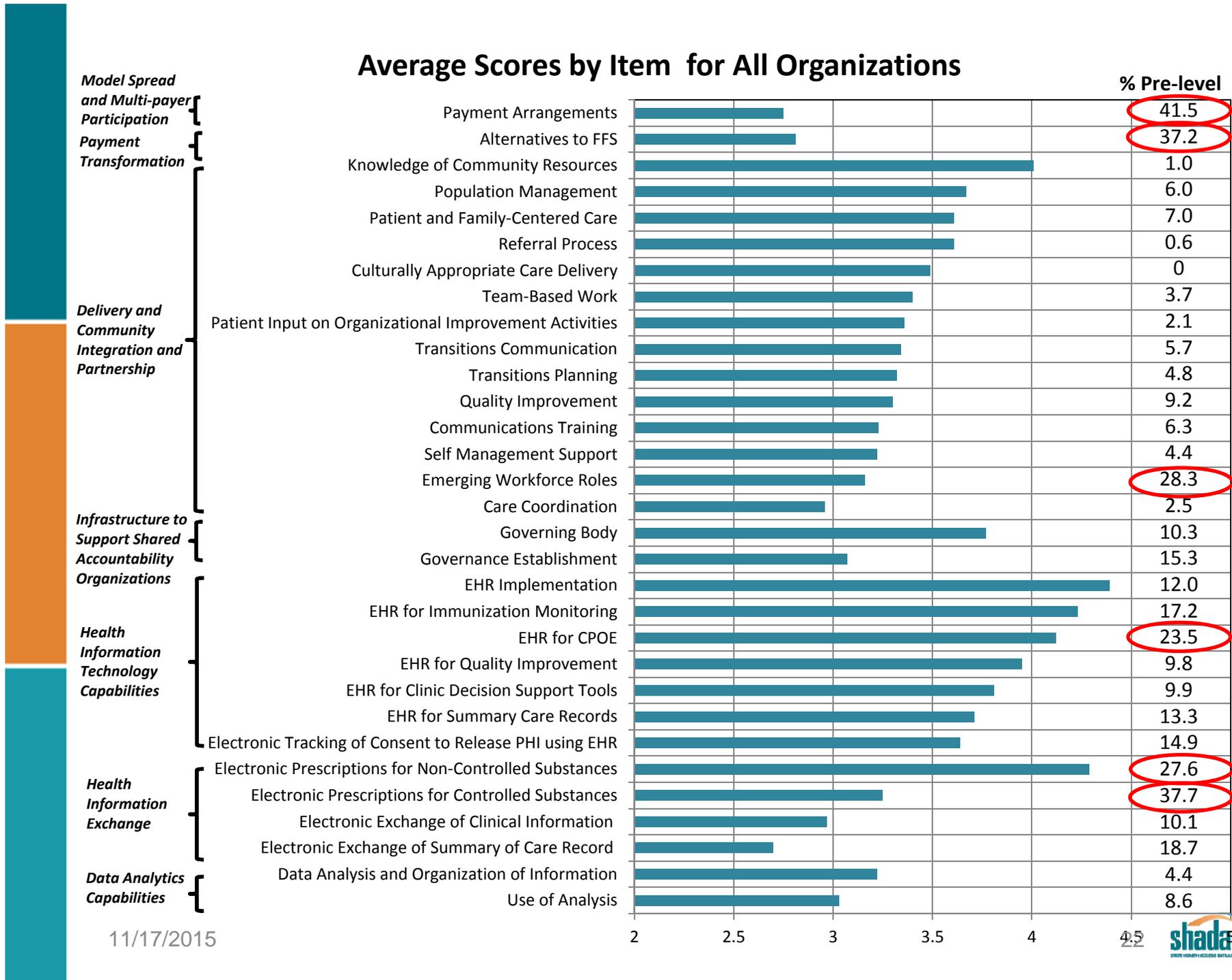
Grant Program	# of Tools
E-Health	84
ACH	78
Practice Transformation	21
Emerging Professions	13
IHP Data Analytics	9

Organization Type	# of Tools
Public Health and Human Services	59
Clinics	46
Health System	39
Behavioral Health	21
Long-Term Care	14
Hospitals	12
Other	10
Health Plan	2
Education	2

\*includes only active organizations

# Average Scores by Item for All Organizations

% Pre-level



11/17/2015



# Preliminary Results for Items with Higher Average Scores - EHR Implementation

Organization Type	Mean	Location	Mean	HCH Certification	Mean
Hospitals	4.80	Urban	4.47	Yes	5.00
Clinics	4.98	Rural	4.23	No	4.16
Health Systems	4.86				
Behavioral Health	4.82				
Public Health and Human/Social Services	3.25				
Long-term Post-Acute/Home Care	3.86				

## Q19

2 (Level A) = We do not use an EHR but are in the planning and/or implementation process.

3 (Level B) = We have an EHR in use for 1%-50% of staff and providers at our practice.

4 (Level C) = We have an EHR in use for 51%-80% of staff and providers at our practice.

5 (Level D) = We have an EHR in use for more than 80% of staff and providers at our practice.

# Preliminary Results for Items with Higher Average Scores – e-Prescriptions for Controlled Substances

Organization Type	Mean	Location	Mean	HCH Certification	Mean
Hospitals	3.14	Urban	3.17	Yes	3.66
Clinics	3.61	Rural	3.44	No	3.03
Health Systems	3.48				
Behavioral Health	3.00				
Public Health and Human/Social Services	2.27				
Long-term Post-Acute/Home Care	2.80				

## Q30

2=We do not e-prescribe but are beginning the planning and/or implementation process.

3=Use for 1%-50% of prescriptions for controlled substances

4=Use for 51%-80% of prescriptions for controlled substances

5=Use for more than 80% of prescriptions for controlled substances

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# Preliminary Results for Items with Higher Average Scores – EHR for Immunization Monitoring

Organization Type	Mean	Location	Mean	HCH Certification	Mean
Hospitals	4.55	Urban	4.26	Yes	4.65
Clinics	4.67	Rural	4.18	No	4.02
Health Systems	4.69				
Behavioral Health	3.00				
Public Health and Human/Social Services	3.47				
Long-term Post-Acute/Home Care	4.22				

## Q 25

2=We do not monitor immunization information with our EHR.

3=We do not use the EHR to monitor immunizations but are in the planning and/or implementing.

4=We use the EHR to monitor immunizations for 1%-50% of patients/clients.

5=We use the EHR to monitor immunizations for 51-80% of patients/clients.

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# Preliminary Results for Items with Higher Average Scores – EHR for Computerized Provider Order Entry (CPOE)

Organization Type	Mean	Location	Mean	HCH Certification	Mean
Hospitals	4.40	Urban	4.20	Yes	4.70
Clinics	4.77	Rural	3.92	No	3.80
Health Systems	4.44				
Behavioral Health	3.75				
Public Health and Human/Social Services	2.58				
Long-term Post-Acute/Home Care	3.45				

## Q21

2=We do not use our EHR for CPOE but are in the planning and/or implementation process.

3=The CPOE function is enabled and in use as part of the workflow for 1-50% of provider orders.

4=We use CPOE for 51%-80% of provider orders.

5=We use CPOE for more than 80% of provider orders.

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# Preliminary Results for Items with Higher Average Scores – Knowledge of Community Resources

Organization Type	Mean	Location	Mean	HCH Certification	Mean
Hospitals	3.90	Urban	4.04	Yes	4.02
Clinics	3.96	Rural	3.97	No	4.01
Health Systems	3.81				
Behavioral Health	4.26				
Public Health and Human/Social Services	4.16				
Long-term Post-Acute/Home Care	4.00				

## Q11

2=We have limited knowledge or working relationships with community resources or agencies.

3=We make referrals to community resources but have limited knowledge of how they operate.

4=We have established mutually beneficial community partnerships for referrals and we work actively with partners in problem solving and communications.

5=We have formalized partnership supported by an infrastructure where partners plan together, measure outcomes together, and share information together.

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# Preliminary Results for Items with Lower Average Scores –Electronic Exchange of Clinical Information

Organization Type	Mean	Location	Mean	HCH Certification	Mean
Hospitals	3.64	Urban	3.10	Yes	3.27
Clinics	3.14	Rural	2.74	No	2.85
Health Systems	3.48				
Behavioral Health	2.40				
Public Health and Human/Social Services	2.47				
Long-term Post-Acute/Home Care	2.64				

## Q27

2=We do not currently exchange health information electronically but are in the planning and/or implementing process (e.g., identifying use cases).

3=We electronically push (send) information (i.e., test results, care plan) to affiliated organizations (e.g. practicing within the same health system).

4=We electronically push (send) information (i.e., test results, care plan) to unaffiliated organizations (e.g., not practicing within the same health system).

5=We electronically pull (query) information from organizations.

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# Preliminary Results for Items with Lower Average Scores – Care Coordination

Organization Type	Mean	Location	Mean	HCH Certification	Mean
Hospitals	3.22	Urban	2.86	Yes	2.92
Clinics	2.63	Rural	3.15	No	2.97
Health Systems	3.07				
Behavioral Health	3.31				
Public Health and Human/Social Services	2.88				
Long-term Post-Acute/Home Care	3.60				

## Q4

2=We have internal care coordination and management where patients/clients and families have direct involvement in establishing patient centered goals.

3=We regularly ask our patients if they have external care coordinators by service provider. Names of external care coordinators and other service provider are included on the patients care plan and staff members communicate across locations with patient and family as partners.

4=We have developed collaborative relationships with external care coordinators, and appropriate components of external care plans are incorporated into the patients' care plan and families understand who is involved in their care and participate as partners.

5=External care managers, care coordinators, and patients and families are working together in a patient centered, coordinated care environment. Roles are defined, communication systems are in place and information is shared and updated in shared care plan. There is integration on all levels. <sup>29</sup>

# Preliminary Results for Items with Lower Average Scores – Alternatives to FFS

Organization Type	Mean	Location	Mean	HCH Certification	Mean
Hospitals	3.17	Urban	2.89	Yes	2.93
Clinics	2.83	Rural	2.63	No	2.75
Health Systems	3.20				
Behavioral Health	2.17				
Public Health and Human/Social Services	2.24				
Long-term Post-Acute/Home Care	3.00				

## Q2

2=We have little or no readiness to manage global costs, but may be willing to assume fixed payment for some ancillary services.

3=We are ready to manage global costs with upside risk. We participate in shared savings or similar arrangement with both cost and quality performance with some payers; may have some financial risk.

4=We are ready to manage global cost with upside and downside risk. We participate in shared savings and some arrangements moving toward risk sharing through Total Cost of Care or partial to full capitation for certain activities; may include savings reinvestments and/or payments to community partners not directly employed by the contracting organization

5=We are ready to accept global capitation payments. Community partners are sharing in accountability for cost, quality and population health are included in the financial model in some form.

# Preliminary Results for Items with Lower Average Scores – Payment Arrangements

Organization Type	Mean	Location	Mean	HCH Certification	Mean
Hospitals	2.67	Urban	2.86	Yes	2.70
Clinics	2.70	Rural	2.50	No	2.77
Health Systems	3.23				
Behavioral Health	2.18				
Public Health and Human/Social Services	2.39				
Long-term Post-Acute/Home Care	2.63				

Q1

2=We have alternative types of payment arrangements with at least one payer that represents less than 20% of our total consumer base, OR participation in at least one performance-based or value-based incentive system representing less than 5% of our total revenue.

3=We have alternative types of payment arrangements with at least one payer that represents 20% to 50% of consumers, OR participation in at least one performance/value-based incentive system representing 5% to 15% of revenue.

4=We have alternative types of payment arrangements with at least one payer that represents 50% to 75%, of consumers OR participation in a performance/value-based incentive system representing 15% to 30% of revenue.

5=We have alternative types of payment arrangements with at least one payer that represents > 75%, of consumers OR participation in a performance/value-based incentive system representing > 30% of revenue..

11/17/2015

# Preliminary Results for Items with Lower Average Scores – Electronic Exchange of Summary Records

Organization Type	Mean	Location	Mean	HCH Certification	Mean
Hospitals	2.40	Urban	2.83	Yes	2.98
Clinics	3.00	Rural	2.42	No	2.58
Health Systems	3.03				
Behavioral Health	2.36				
Public Health and Human/Social Services	2.38				
Long-term Post-Acute/Home Care	2.36				

## Q28

2=We are not electronically exchanging the summary care records but are in the planning and/or implementing process.

3=We electronically exchange the summary care records for 1%-50% of patients/clients who require transition, referral or sharing with another provider.

4=We electronically exchange the summary care records for 51%-80% of patients/clients who require transition, referral or sharing with another provider.

5=We electronically exchange the summary care records for more than 80% of patients/clients who require transition, referral, or sharing with another provider.

# Discussion Questions

- Based on your knowledge of Minnesota and the organizations participating in SIM, what are your reactions to these preliminary results?
  - Are they what you expected?
  - Are there any surprises?
  - Are there any illogical results?
- How can these early findings inform SIM priorities for 2016?
- Where should ongoing technical assistance be focused in 2016?

# ACH Characteristics – Preliminary Findings

- Based on systematic document review
  - ACH proposals, updated work plans, quarterly reports
- Focus on:
  - ACH structure
  - ACH care coordination
  - Barriers to partnership/care coordination implementation
- In-person interviews underway with ACHs to update and build on preliminary findings from document review

# ACH Structure – Preliminary Findings

- Size of ACHs
  - From 5 to 20+ partners
- ACO Partners in ACHs
  - All have an ACO partner (a few have multiple ACO or ACO-like partners)
  - 13 ACHs have an IHP partner
- Role of ACO in ACHs
  - For 6 ACHs (40%), ACO is the fiscal agent
  - ACO is on leadership team (LT) of nearly all ACHs
  - In about half of ACHs, the ACO partner is on the care coordination team

# ACH Structure – Preliminary Findings

- Participation and Role of Public Health
  - 12 ACHs (80%) include a PH partner
  - PH is fiscal agency: 2 ACHs
  - PH on the LT: 9 ACHs
  - PH on care coordination team: 8 ACHs
  - PH on both leadership and coordination teams: 7 ACHs
- Participation and Role of Target Population

Role of Target Population	# (%) of ACHs
<b>Leadership Team</b>	
Individual is leadership team member	6 (40%)
Agency representing target population is leadership team member	2 (13%)
<b>Other Involvement</b>	
(e.g., participation in workgroup, focus groups)	13 (87%)

# ACH Care Coordination – Preliminary Findings

Types of Care/Services Included in ACH Care Coordination Model	# (%) of ACHs
Primary/medical care	12 (80%)
Mental health/behavioral health care	11 (73%)
Substance abuse prevention/treatment	3 (20%)
Health education/promotion resources (includes health coaching)	5 (33%)
Immunizations/well-child care	1 (7%)
Dental care	3 (20%)
Vision care	1 (7%)
Public health services	1 (7%)
Community resources/services	8 (53%)
Social services	5 (33%)
Housing services	3 (20%)
Employment services	3 (20%)
Financial services	1 (7%)

# Key Interview Care Coordination Topics

- Mechanisms for identifying/reaching target population
- Entry points into care coordination
- Services being coordinated and directories of services/providers
- Staff dedicated to care coordination and roles
- Agreements within and among participating organizations
- Communication protocol for care coordination team
- Patient/consumer consent/release of information
- Patient/consumer needs assessment
- Care plans
- Work flows
- IT and data sharing
- Referral, transition, follow up and tracking protocols
- Provider/patient orientation and education about care coordination

# Barriers in ACH Implementation – Preliminary Findings

- Organizational capacity and resources
- Engaging community members
- Engaging ACH organization partners
- Sharing data between partners
- Facilitating collaboration
- Resources for the non-clinical needs of patients/consumers
- Selecting/and or collecting data
- Other

# ACH Discussion Questions

- Given Minnesota's practice transformation and payment reform aims, what are the most important areas or indicators of progress to examine among the ACHs next year?
- What constitutes meaningful change?

# Contact Information

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# Data Analytics: Phase One and Phase Two

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# Data Analytics Purpose and Phased Approach

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- Purpose: “Develop recommendations and identify top-priority data analytic elements, to motivate and guide greater consistency in data sharing...”
- Subgroup work divided into two phases:
  - Phase One: What can be done now, given current data availability, infrastructure, and analysis skills and staffing
  - Phase Two: What is essential for effective shared accountability (ACO, ACH), with a focus on social determinants of health

# Data Analytics Phase One Update

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- The AUC's new "ACO Data Analytics TAG" has met once
  - Wide group of participants from provider and payer organizations
- Currently compiling examples of member file record layouts, data dictionaries, etc., as well as best practices
- Goal to produce recommendations by **February 2016**



# TheoryLand

*Where dreams come true*

# Data Analytics Phase Two: Practical Use Case

## A Tale of Two Scenarios – Ben Alvarez

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- **Current:**
  - Dr. Jackson assesses Ben’s medical needs: pediatric asthma and obesity
  - She prescribes inhaler and advises Ben’s mother to help him lose weight
  - Over time, Ben continues to show up at the E.R. (and miss school)
  
- **Future:**
  - Dr. Jackson assesses Ben’s medical needs and identifies other influential factors (minority family living in poverty in a food desert)
  - She prescribes inhaler and provides Spanish-language support materials
  - Essential information also becomes available to other service providers to inform their support for Ben and his family (school, housing, food bank)

# Data Analytics Phase Two: A Tale of Two Scenarios – Ben Alvarez

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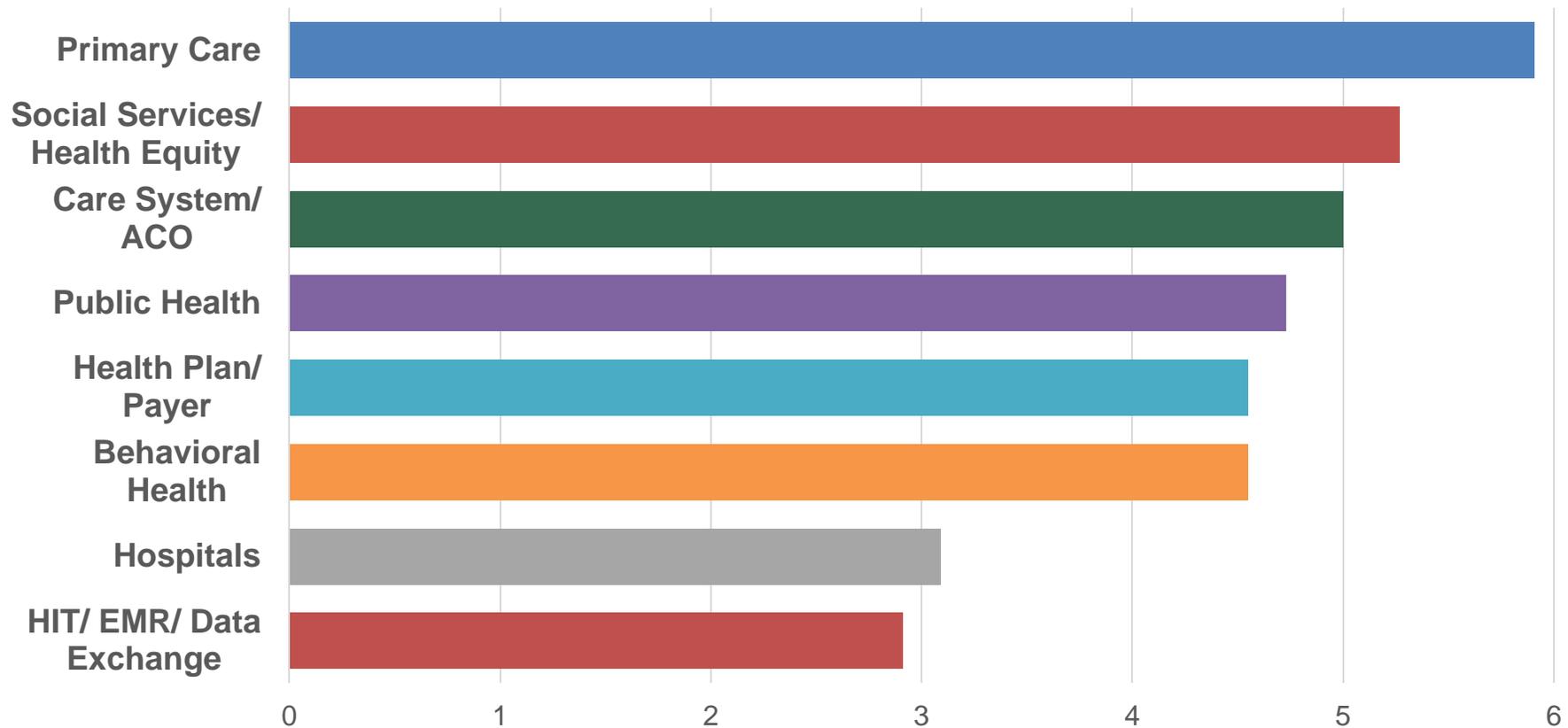
- Focus on Practical Needs and Information to Spur Action
- Types of Questions the Subgroup Might Discuss
  - What information is important for medical and other service providers to know? (e.g., essential data associated with key determinants of health)
  - For each type of information:
    - Is that information already collected and aggregated in some way?
    - Who holds that information now and who already has access to it?
    - What types of individuals or organizations likely have a “need to know” to coordinate support efforts and share accountability for improving health outcomes?
  - What other issues must be addressed to enable this kind of data sharing?

# Data Analytics Phase Two: Charter

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- Identify data analytic elements that would be essential for effectively sharing accountability for improving individual and population health status, but are not feasible in the current environment. This [should involve fully operational Accountable Communities for Health (ACHs) and a broader set of partners and services within ACO models more generally.]
- Define a set of use cases for the data analytic elements identified above . . .
- Suggest Minnesota organizations active in data collection and improvement of social determinants of health that could be approached for future administration and support of the data analytic elements identified by the Subgroup.

# Data Analytics Phase Two: Suggested Membership Categories



# Data Analytics Phase Two: Timeline

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- **Timeframe:** November 2015 to May 2016
- **Proposed Meeting Dates**
  - Meeting 1: January 13
  - Meeting 2: March 3
  - Meeting 3: April 28

# Data Analytics Phase Two: Highlights from Survey Respondents

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## Outcomes to Achieve in Phase 2:

- Identify and prioritize social determinants of health
- Identify measures and a measurement framework for social determinants
- Engage in alignment activities to integrate SDH with the current health care system
- Create a data collection methodology
- Create consensus among stakeholders around the value of sharing data

## Recommendations for Improvement of Phase 2 Charter:

- Narrow the focus and scope of work - attempting to accomplish too much in too short a time; need a clear definition of how success will be measured
- Define what will be done with deliverables
- Involve professionals from both the medical and social continuum in this work

# Data Analytics: Discussion

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What are your suggestions for:

- Phase Two Subgroup members?
- Existing materials that can inform this work?
- Community groups and other stakeholders who should be involved in some way to inform this work?
- Other key considerations?

# Sustainability of SIM MN

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## Sustainability Goals

## Strategic Planning Sessions

## Three Priority Areas

1. Continued efforts with health information exchange, data analytics
2. Value Based Purchasing; Alignment of incentives with desired outcomes
3. Community connections, partnerships and authentic engagement

# Sustainability of SIM MN (continued)

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## Guidance

- SIM Task Force
- Health Care Financing Task Force
- Regional Meetings
- Evaluation Findings
- Other Advisory Bodies

Final Sustainability Plan: Q4, 2016

# Sustainability of SIM MN: Discussion

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- Given its importance, how do we support greater adoption of accountability models? What are the barriers?
- How do we encourage alignment across approaches to accountability?
- How would we know that we're succeeding, and what an ongoing monitoring approach might look like?
- What are other sustainability-related challenges and opportunities?
- What should be Task Forces' role in improving the likelihood of the long-term sustainability of this work?

# Next Steps/ Future Meetings

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Joint Task Force Meeting

February 17, 2016

1:00 pm – 4:00 pm

Shoreview Community Center, Shoreview, MN

# Public Comment

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# Task Force Contact Information

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## Task Forces

- Jennifer Lundblad ([jlundblad@stratishealth.org](mailto:jlundblad@stratishealth.org)), Chair
- Diane Rydrych ([Diane.Rydrych@state.mn.us](mailto:Diane.Rydrych@state.mn.us)), MDH
- Jennifer Blanchard ([Jennifer.Blanchard@state.mn.us](mailto:Jennifer.Blanchard@state.mn.us)), DHS

## Facilitation Team

- Diane Stollenwerk ([diane@stollenwerks.com](mailto:diane@stollenwerks.com))
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# Minnesota Accountable Health Model

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## Public Website

[www.mn.gov/sim](http://www.mn.gov/sim)