

EVALUATION OF THE MINNESOTA ACCOUNTABLE HEALTH MODEL: First Annual Report

FULL REPORT

FINAL

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Prepared for:

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Prepared by:

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This program is part of a \$45 million State Innovation Model (SIM) cooperative agreement, awarded to the Minnesota Departments of Health and Human Services in 2013 by The Center for Medicare and Medicaid Innovation (CMMI) to help implement the Minnesota Accountable Health Model.

Table of Contents

1. INTRODUCTION	1
Minnesota’s State Innovation Model: The Minnesota Accountable Health Model	1
Background	1
Minnesota’s Accountable Health Model	2
Evaluation of the SIM Initiative.....	4
Scope of Minnesota’s State Evaluation	5
Evaluation Methods.....	6
Focus of the 2015 Evaluation Report.....	6
2. OVERVIEW OF SIM INVESTMENTS IN MINNESOTA THROUGH DECEMBER 2015	7
Introduction	7
State Governance and Structure.....	7
Engagement of Stakeholders	9
External Task Forces	9
Regional Meetings	11
Communications	11
Grant Programs and Contracts	11
Participating Organizations	14
Continuum of Accountability Assessment Tool	18
3. E-HEALTH	22
Introduction	22
Background	23
Minnesota e-Health Initiative	23
Federal E-Health Activities.....	25
Interoperability and Health Information Exchange (HIE)	25
Minnesota’s HIE Landscape	27
Privacy, Security, and Consent Management Program	27
Key Activities.....	28
E-Health Roadmap Program	29
Key Activities.....	29

This program is part of a \$45 million State Innovation Model (SIM) cooperative agreement, awarded to the Minnesota Departments of Health and Human Services in 2013 by The Center for Medicare and Medicaid Innovation (CMMI) to help implement the Minnesota Accountable Health Model.

Early Outcomes 31

Facilitators..... 34

Challenges 34

Sustainability Insights 35

E-Health Collaboratives Grant Program..... 36

 Key Activities..... 39

 Early Outcomes 42

 Facilitators..... 44

 Challenges 46

 Policy Considerations..... 49

 Sustainability Insights 51

4. ACCOUNTABLE CARE ORGANIZATIONS.....53

 Introduction 53

 Background 55

 Integrated Health Partnerships..... 56

 Key Activities..... 57

 Early Outcomes 63

 Continuous Improvement Feedback 67

 Sustainability Insights 69

5. TEAM-BASED INTEGRATED/COORDINATED CARE73

 Introduction 73

 Background 75

 Emerging Professions Integration Grant Program..... 76

 Key Activities..... 76

 Emerging Professions Toolkit Program 77

 Learning Communities Grants 77

 Practice Facilitation Grants 78

 Practice Transformation Grant Program, Round One 78

 Key Activities..... 80

 Outcomes..... 81

 Facilitators..... 82

This program is part of a \$45 million State Innovation Model (SIM) cooperative agreement, awarded to the Minnesota Departments of Health and Human Services in 2013 by The Center for Medicare and Medicaid Innovation (CMMI) to help implement the Minnesota Accountable Health Model.

Challenges	83
Continuous Improvement Feedback	86
Sustainability Insights	87
6. ACCOUNTABLE COMMUNITIES FOR HEALTH (ACH)	89
Introduction	89
Awarded ACHs	89
ACH Learning Collaborative	90
Accountable Communities for Health.....	93
Key Activities.....	93
Early Outcomes.....	104
Facilitators.....	106
Challenges.....	108
Continuous Improvement Feedback	111
Sustainability Insights	111
7. DISCUSSION.....	114
Findings.....	114
Progress	115
Gaps and Challenges.....	118
Continuous Improvement Feedback to State	122
Insights for Sustaining the Model in the Future	123
Conclusion.....	127
APPENDIX A State Staff Training Sessions	A-1
APPENDIX B Task Force Meetings.....	B-1
APPENDIX C Overview Of Grant Applicants And Awards, By Sim Component And Grant Program	C-1
APPENDIX D Continuum Of Accountability Assessment Tool Additional Findings.....	D-1
APPENDIX E E-Health (Driver1) Investments	E-1
APPENDIX F E-Health Roadmap Community Engagement Report By Rainbow Research	F-1
APPENDIX G Team-Based Integrated/Coordinated Care Investments	G-1

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1. INTRODUCTION

The State Innovation Model (SIM) Program is sponsored by the Centers for Medicare and Medicaid Services (CMS) and administered by CMS's Center for Medicare and Medicaid Innovation (CMMI). SIM provides funding and support to states to transform their public and private health care payment and service delivery systems with the aims of lowering health system costs, maintaining or improving health care quality, and improving population health. In 2013, Minnesota received a SIM award to implement and test the Minnesota Accountable Health Model. Between October 2013 and December 2016, the Minnesota Department of Human Services (DHS) and the Minnesota Department of Health (MDH) are implementing the Model across the state of Minnesota.

This report describes the activities conducted during and the results from the first year of a two-year evaluation of Minnesota's SIM initiative. The State Health Access Data Assistance Center (SHADAC) is conducting the state evaluation during 2015 and 2016 under a contract with DHS and in collaboration with both DHS and MDH.

Minnesota's State Innovation Model: The Minnesota Accountable Health Model

Background

The Affordable Care Act of 2010 (ACA) established CMMI within CMS as a vehicle to test payment and service delivery models through pilot programs designed to lower costs for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) while maintaining or improving the quality of care for beneficiaries. CMMI is currently engaged in the following three priorities: 1) testing new payment and service delivery models; 2) evaluating results and advancing best practices; and 3) engaging a broad range of stakeholders to develop additional models for testing.¹

A major program of CMMI is the SIM initiative, which provides funding to states to design and test innovative and multi-payer health care delivery and payment systems. The goal of the program is to improve the quality of care and lower the costs of care for public programs including Medicare, Medicaid, and CHIP. CMS is relying on states to administer the program, to facilitate multi-payer involvement and eventual transformation of the delivery system, and to improve the health of state populations. States were seen as the appropriate vehicle because they have the right policy levers and

¹ "About the CMS Innovation Center." *Centers for Medicare and Medicaid Services*. Web. 25 Jan 2016. <<https://innovation.cms.gov/About/index.html>>

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administrative structure to involve multiple payers, as well as the state innovation needed for health system transformation to improve population health.²

In 2013, CMMI awarded its first round of SIM cooperative agreements (totaling nearly \$300 million) to 25 states. States received funding to design or test a State Health Care Innovation Plan. In 2013, 19 states received design or pre-test funding (CA, CO, CT, DE, HI, IA, ID, IL, MD, MI, NH, NY, OH, PA, RI, TN, TX, UT, WA), and six received test funding (AR, MA, ME, MN, OR, VT). Of the initial six test states, Minnesota was awarded the largest funding amount at just over \$45.0 million over the course of a three-year project. In December 2014, CMMI announced a second round of SIM funding recipients, with cooperative agreements awarded to 11 new test states (CO, CT, DE, IA, ID, MI, NY, OH, RI, TN, WA), 17 new design states (AZ, CA, HI, IL, KY, MD, MT, NH, NJ, NM, NV, OK, PA, UT, VA, WI, WV), and three new design territories (American Samoa, Northern Mariana Islands, and Puerto Rico). In addition, the District of Columbia received a design award. In total, the SIM program has funded 38 states/territories, representing 61% of the US population, for a total of almost \$1 billion.³

There is increasing interest in multi-payer initiatives and payment reform strategies that influence provider behavior and work to transform the health care delivery system by aligning incentives and payment strategies to facilitate high quality care at reduced costs.⁴ The SIM program is one of several initiatives developed and administered through CMMI to test and refine innovation around health care payment and delivery models with the goal of improving the health of state populations.⁵

Minnesota's Accountable Health Model

In Minnesota, the SIM cooperative agreement is being used to advance the Minnesota Accountable Health Model. The model builds upon the state's previously established Medicaid Accountable Care Organization (ACO) demonstration projects and other payment and delivery reform efforts including Health Care Homes (HCH), the e-Health Initiative, Community Care Teams (CCTs), the Statewide Health Improvement Program (SHIP), Community Transformation Grants, and standardized quality measurement and reporting across payers. Under SIM, Minnesota is working to support the Triple Aim – improve patient experience, improve population health, and reduce health care costs – by expanding the percentage of Minnesotans receiving care under shared savings/shared risk payment models and developing patient-centered integrated community service delivery models and coordinated care models. Minnesota's aims are that, by 2017, the state's health care system will be one where:

² Van Vleet, Amanda and Julia Paradise. "The State Innovation Models (SIM) Program: An Overview." *The Henry J. Kaiser Family Foundation*. Dec. 2014. Web. 11 Jan. 2016. <<http://kff.org/medicaid/fact-sheet/the-state-innovation-models-sim-program-an-overview/>>

³ "State Innovation Models Initiative: General Information." *Centers for Medicare and Medicaid Services*. Web. 25 Jan. 2016. <<https://innovation.cms.gov/initiatives/state-innovations/>>

⁴ "The State Innovation Models (SIM) Program: A Look at Round 2 Grantees." *The Henry J. Kaiser Family Foundation*. Sep. 2015. Web. 11 Jan. 2016. <<http://kff.org/medicaid/fact-sheet/the-state-innovation-models-sim-program-a-look-at-round-2-grantees/>>

⁵ "Data and Reports." *Centers for Medicare and Medicaid Services, CMS Innovation Center*. Web. 11 Jan. 2016.

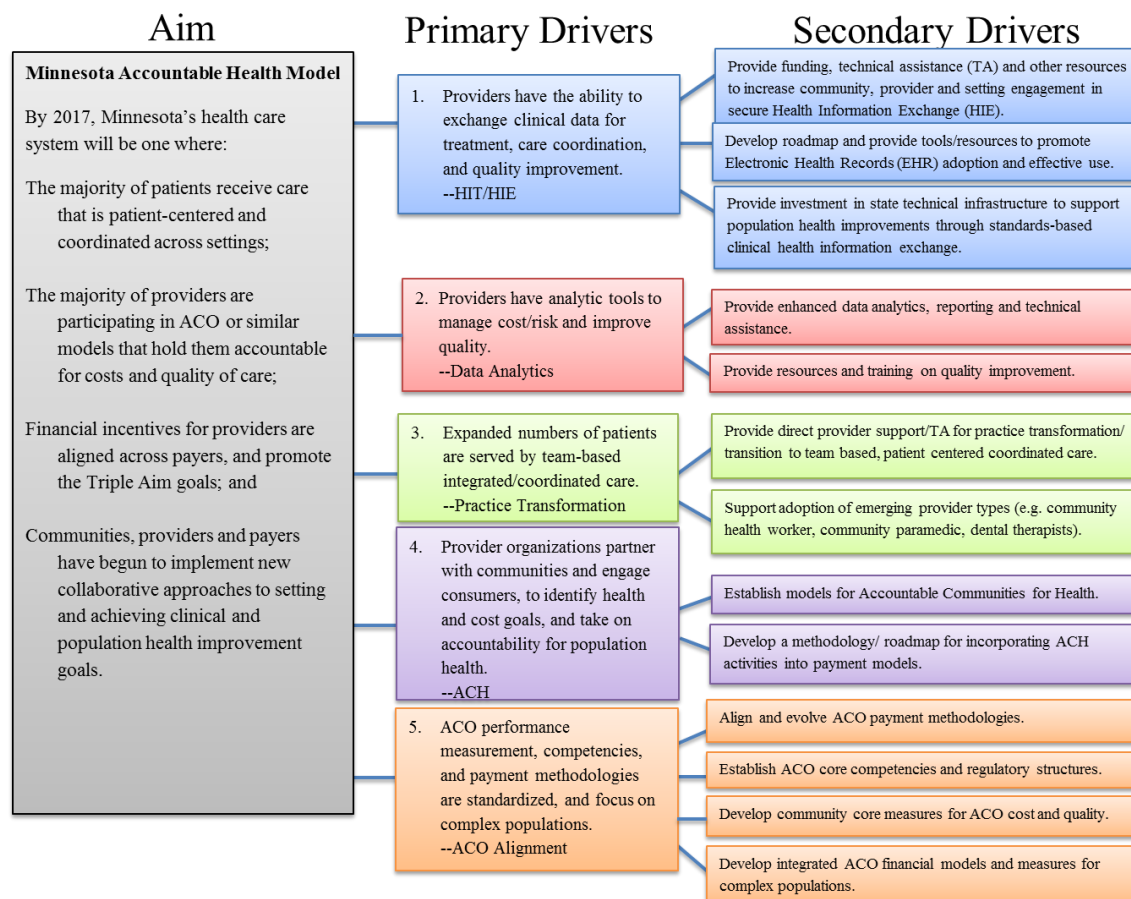
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- The majority of patients receive care that is patient-centered and coordinated across settings;
- The majority of providers are participating in ACO or similar models that hold them accountable for costs and quality of care;
- Financial incentives 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.

These four aims are supported by five primary drivers, under which most activities have been organized in Minnesota. These drivers are 1) the expansion of e-Health; 2) improved data analytics across the state's Medicaid ACOs (i.e., Integrated Health Partnerships); 3) practice transformation to achieve interdisciplinary, integrated care; 4) implementation of Accountable Communities for Health (ACHs); and 5) alignment of ACO components across payers related to performance measurement, competencies, and payment methods. Exhibit 1.1 below summarizes Minnesota's aims and the primary drivers to achieve Model aims. Depicted as secondary drivers within this exhibit, the key mechanisms the state is using to execute its primary drivers are grants and contracts, technical assistance, and other resources for providers and other organizations in the state.

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Exhibit 1.1. Minnesota's Driver Diagram



Source: Resources. *State of Minnesota*. Web. Dec. 2015.

Evaluation of the SIM Initiative

CMMI is requiring and supporting two levels of evaluation of the SIM initiative: 1) a federal multi-state evaluation, and 2) individual state evaluations. CMMI has issued a contract with RTI International to conduct the federal evaluation of the SIM initiative. The federal evaluation is being conducted for CMS and its federal partners so they may assess the success and sustainability of the models being tested and identify cross-state themes and findings that may have broader implications for all states, including states that have not been awarded SIM funding. The CMS evaluation started in 2013 and is scheduled to last until 2018. The individual state evaluations, directed by individual states, are intended by CMMI to be a more formative evaluation for each respective state and its in-state stakeholders, allowing for internal review and continuous improvement of state activities along the way. Overlap and duplication between the two evaluations may occur in some instances.⁶ DHS executed a contract with SHADAC in

⁶ "SIM Test State Self-Evaluation: Guidelines and Resources. Webinar for Test States." *Center for Medicare and Medicaid Innovation*. June 2014.

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July 2014 to design and conduct the Minnesota state evaluation as well as assist in the state's collaboration and participation in the federal evaluation.

Scope of Minnesota's State Evaluation

In collaboration with DHS and MDH, SHADAC identified five goals for the state's evaluation. These goals, along with the key evaluation questions, are as follows.

Goal 1. Document the activities carried out under the Minnesota Accountable Health Model.

- What activities have been completed under the Minnesota Accountable Health Model? Which activities were anticipated but not completed? Why?

Goal 2. Document the variation in design, approaches, and innovation in Minnesota Accountable Health Model activities and programs.

- What forms or models have emerged out of the activities and programs under the Model? How are they similar? How do they differ?

Goal 3. Identify opportunities for continuous improvement in Minnesota Accountable Health Model activities and programs.

- What have been barriers/facilitators to implementation/completion of activities and programs under the Model? What support is needed? What gaps exist under these activities and programs? Have there been unintended results or consequences? How has the state used evaluation results for continuous improvement?

Goal 4. Examine how the Minnesota Accountable Health Model has contributed to advancing the state's goals.

- What are key outcomes of the activities and programs under the Model? Which approaches are associated with more success? How do the key outcomes relate to the Model goals?

Goal 5. Identify lessons learned for sustaining the Minnesota Accountable Health Model beyond the SIM award.

- What are key policy and operational implications from the SIM test?

The evaluation design addresses these questions for each of the five primary drivers comprising Minnesota's Model as well as aims to synthesize findings and lessons learned across the SIM initiative in Minnesota. The evaluation design includes two main components. The first component is focused on documenting and investigating the activities carried out under each of the drivers of the Minnesota Accountable Health Model. The second component of the evaluation is a collection of four "cross-driver" evaluation activities aimed at addressing topics that span the driver framework. These include: 1) a tracking of providers and organizations engaged in the Minnesota Accountable Health Model; 2) an

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analysis and assessment of statewide data resources for monitoring ACO and ACO-like models; 3) an assessment of the Continuum of Accountability Assessment Tool (discussed more below); and 4) a review of community engagement and partnerships under the Model.

Evaluation Methods

In line with our primarily formative goals, the design of the Minnesota evaluation focuses on initial and interim markers of implementation, process, and outcomes across the drivers and seeks to collect information to inform sustainability of the model beyond the cooperative agreement. The evaluation design calls on both existing and new data sources and incorporates both quantitative and qualitative methods.

This report on Minnesota's Accountable Health Model in 2015 draws on several key evaluation data sources:

- A database of organizations participating in the Model, including organizations that have been awarded grants or contracts by the state or that are otherwise participating in these awards;
- Semi-structured qualitative interviews with grantees and contractors (227 individuals to date) engaged in the SIM initiative;
- Semi-structured qualitative interviews with state leadership and staff (23 individuals to date);
- Document review of state, grant, and contract materials; and
- Data collected from the Continuum of Accountability Assessment Tool, a tool designed and implemented by the state to assess organizations' capabilities related to multi-payer participation, payment transformation, care delivery, community integration and partnership, health information technology (HIT), health information exchange (HIE), and data analytics.⁷

Focus of the 2015 Evaluation Report

The balance of this report is organized into seven chapters. Chapter 2 presents a summary of the investments Minnesota has made under the SIM initiative, including both investments internal to state government and external investments. Chapters 3 through 6 present activities and findings through 2015 in the key areas of e-Health (Driver 1), ACOs (Drivers 2 and 5), investments in team-based, integrated/coordinated care (Driver 3), and ACHs (Driver 4). It is important to note that, as of December 2015, different components of the Minnesota Accountable Health Model are in different stages. For this reason, a chapter may not address all investments made under a key area, and a chapter may address initial outcomes whereas another chapter may not. This report closes with a chapter summarizing key findings from SIM investments in the state. Appendices providing supporting or more detailed information are included at the end of the report.

⁷ The tool is available on the Request for Proposals page of the health reform Minnesota SIM website under Tools.

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2. OVERVIEW OF SIM INVESTMENTS IN MINNESOTA THROUGH DECEMBER 2015

Introduction

Since receiving the State Innovation Model (SIM) award in the fall of 2013, the Minnesota Department of Human Services (DHS), in collaboration with the Minnesota Department of Health (MDH), has made significant investments within state government and throughout the state of Minnesota to implement the Minnesota Accountable Health Model. An award of this size requires a specific governance and management structure as well as mechanisms for engaging stakeholders and participants including payers, providers, organizations, and consumers.

In this section, the State Health Access Data Assistance Center (SHADAC) provides a high level description of the structure built to lead and manage the initiative and the mechanisms the state has implemented to engage stakeholders. In addition, this chapter reviews the multiple grant programs and contracts established with providers and organizations across the state under each of the state's five Model drivers: 1) the expansion of e-Health; 2) improved data analytics among the Integrated Health Partnerships (IHPs); 3) practice transformation to achieve interdisciplinary, integrated care; 4) implementation of Accountable Communities for Health (ACHs); and 5) alignment of Accountable Care Organization (ACO) components across payers related to performance measurement, competencies, and payment methods. Key characteristics of the organizations engaged in these efforts are summarized. At the end of this chapter, SHADAC presents baseline findings from the Continuum of Accountability Assessment Tool, an instrument designed by the state to collect information on capabilities and functions related to accountable care models among organizations participating in SIM in Minnesota. Evaluation data sources informing this chapter include: SHADAC's database of organizations participating in the Model; review of the state SIM summary documents; interviews with state leadership and staff; and SHADAC's Continuum of Accountability Assessment Tool database.

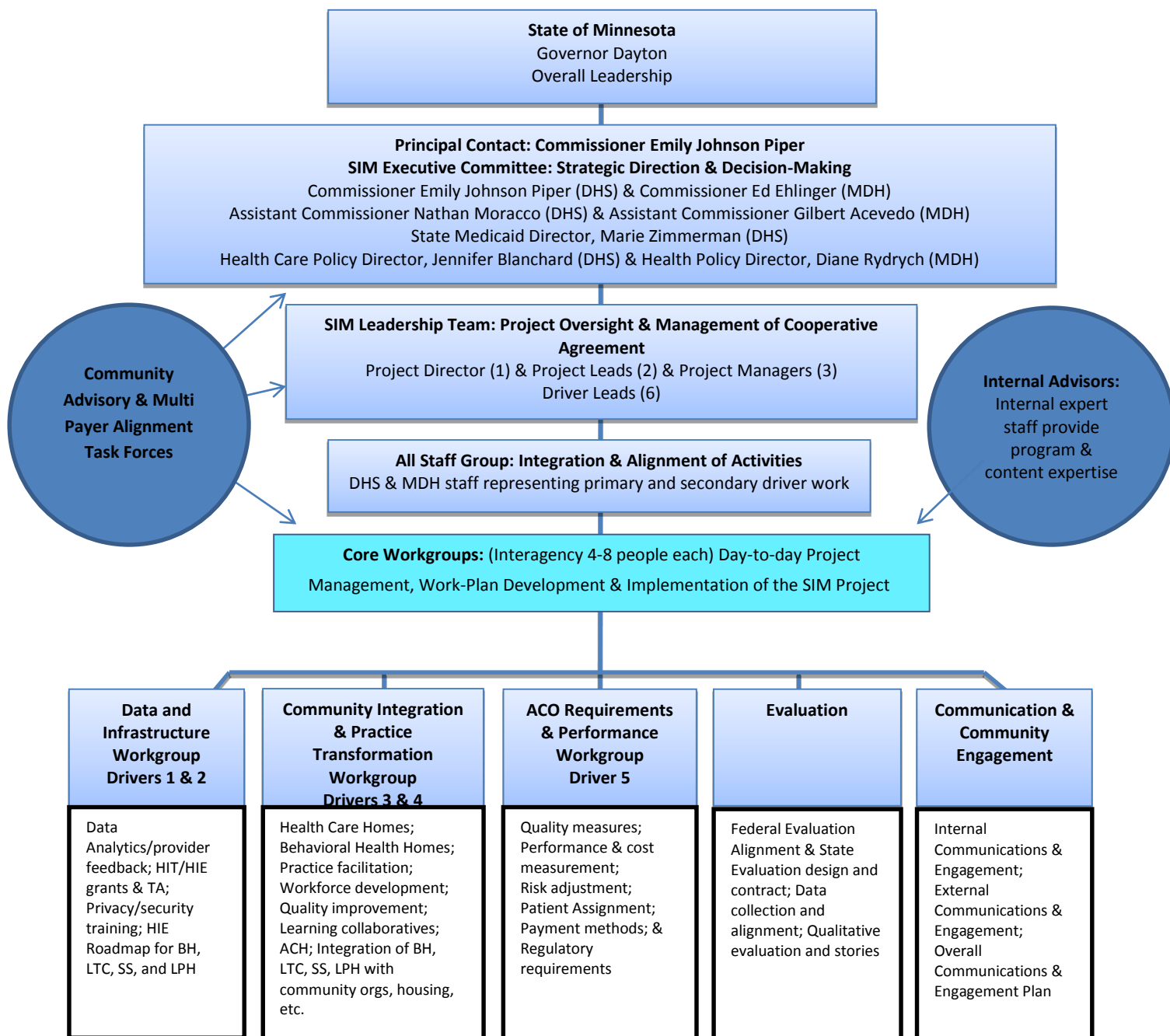
State Governance and Structure

To implement the Minnesota Accountable Health Model, DHS and MDH established a cross-agency organizational governance structure, including an Executive Committee providing strategic direction and decision-making, a Leadership Team responsible for day-to-day project oversight and management, and workgroups in charge of executing components under each of the five primary drivers. See Exhibit 2.1 for a summary of the state's governance structure for the initiative.

The Leadership Team regularly briefs the Executive Committee, which is made up of Commissioners from both DHS and MDH as well as the State Medicaid Director. While the Governor of Minnesota is represented at the top of the organizational chart, having endorsed the state's SIM application to the Center for Medicare and Medicaid Innovation (CMMI), his office's involvement has been limited to date.

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Exhibit 2.1. Minnesota's SIM Governance Structure



Source: Minnesota Accountable Health Model Operational Plan (updates). *State of Minnesota*. Web. Oct. 2015.

Members of the Leadership Team include policy directors from both agencies, a cross-agency project director, a project manager responsible for internal and external communications and SIM operations, and staff leads for community engagement and the state-led evaluation. In addition, the Leadership Team includes state staff directing each of the three Workgroups (discussed below).

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The Leadership Team formed three core Workgroups that are developing and implementing the core components of the Model. Activities under Drivers 1 (e-Health) and 2 (IHP data analytics) are being managed by the Data and Infrastructure Workgroup; Driver 3 (practice transformation or team-based, integrated/coordinated care) and 4 (ACH) activities by the Community Integration and Practice Transformation (CIPT) Workgroup; and Driver 5 (alignment of ACO components) activities by the ACO Requirements and Performance Workgroup. Each Workgroup is led by co-chairs representing both agencies.⁸ According to interviews with members of the Leadership Team, a noteworthy change in Leadership Team membership took place a year into the SIM award when the co-chairs of each of the three Workgroups were invited to serve on the Leadership Team. Guidance is provided to the state team by two external Task Forces, the Community Advisory Task Force and the Multi-Payer Alignment Task Force. Both of these are described later in this chapter.

According to Minnesota's Operational Plan submitted to CMMI annually, the Leadership Team recognized early during implementation the importance of educating state staff engaged in the SIM initiative, beyond providing background materials. Appendix A lists the training events.

Engagement of Stakeholders

Minnesota proposed to engage a variety of stakeholders in the Minnesota Accountable Health Model, including, but not limited to, the state's four priority setting providers (behavioral health, long term/post-acute services and support, local public health, and social services), medical providers, payers, quality measurement bodies, employers, and advocacy groups. DHS hired a project manager to oversee stakeholder communications; MDH hired a coordinator to oversee community engagement. Strategies for reaching stakeholders documented in early Operational Plans prepared by the state for CMMI consist of Request For Proposal (RFP) input provided or coordinated by the MDH community engagement manager, the formation and maintenance of the two external Task Forces and subgroups, state- and community-led regional meetings, and the SIM website and listerv maintained by the DHS manager. Additionally, Learning Day activities have targeted grantees and stakeholder groups in order to enhance and share knowledge and partnerships; Learning Days are referenced in the team-based care chapter of this report. In this section, SHADAC provides brief descriptions of three stakeholder engagement strategies: Task Forces, regional meetings, and communications.

External Task Forces

Minnesota seeks input on the SIM initiative and the Minnesota Accountable Health Model on a regular basis from two Task Forces whose membership includes prominent players and stakeholders in the health care delivery and payment system in Minnesota. The Community Advisory Task Force consists of 14 representatives of many care settings (e.g., health, behavioral health, social service, long-term care, education), including a consumer, and is responsible for advancing community and patient engagement across the continuum of care. The Multi-Payer Alignment Task Force consists of 15 provider and payer

⁸ Many of the Workgroup members are also responsible for implementing other state activities not funded by SIM.

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representatives, and supports alignment across payers as well as the development of ACOs. Many of these representatives' organizations (19) are directly involved in a SIM grant or contract. Three organizations (Stratis Health, Minnesota Hospital Association, and Medica) have representatives on both Task Forces. After two year terms, the state required reappointment of the Task Force members. SHADAC researchers observed a decline in Task Force meeting attendance, which may be due in part to some turnover in Task Force membership in mid-2015.

The Task Forces have met 15 times each between July 2013 and December 2015, which included four joint meetings. As detailed in Appendix B, meeting topics range from Accountable Communities for Health (ACH) to overall SIM sustainability. Many of the earlier Task Force meetings focused on seeking input for initial design work, such as the Minnesota's Continuum of Accountability Assessment Tool and the ACH grant program RFP. In later Task Force meetings, the state and its contractors provided updates on Minnesota Model activities, including the state-led evaluation, showcased grantees, and facilitated sustainability discussions.

An ACH Advisory Subgroup was formed by the Community Advisory Task Force in the winter of 2014 to provide guidance on strategies to engage stakeholders and communities in ACH planning. This subgroup, whose membership extended beyond Task Force members (n=16), met three times (February 2014, twice in March 2014) and developed recommendations on the criteria and implementation of ACHs. The final subgroup recommendations focused on topics such as populations to be served, leadership structure, care coordination teams, and sustainability. These findings informed the release of the ACH RFP in September of 2014.

A Data Analytics Subgroup also exists to develop recommendations to promote consistent sharing of data analytics reports between payers and providers that are part of ACO models such as the IHPs. Members represent various care settings and positions in care delivery and payment and are drawn from the two Task Forces as well as key state and other personnel, including foundation, community and association representatives. The Data Analytics subgroup work was divided into two phases. Phase 1, consisting of 14 representatives, met three times (November 2014, December 2014, February 2015) and focused on the current data analytic environment and possible immediate improvements in alignment of data analytic reports used by payers with the providers that they contract with in ACO or similar arrangements. The Phase 1 subgroup identified five high priority data elements in their final report where greater alignment would be beneficial, including:

1. Contact information and identified primary care provider;
2. Health status and risk level;
3. Total cost of care;
4. Health status, grouped by demographics; and
5. Patterns of care within and outside of ACO providers.

This work was institutionalized, in part, by the Administrative Uniformity Committee (AUC), a voluntary group working to improve health care administrative processes in the state. In September 2015, the AUC

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voted to establish a Technical Advisory Group to address the need for consistent contact information and identified primary care provider data elements across payers.

Phase 2 of the Data Analytics Subgroup is now underway and is focusing on social determinants of health data components. The Phase 2 subgroup consists of 15 representatives, six of which were a part of the Phase 1 subgroup. During Phase 2, the subgroup will develop guiding principles that will inform future data collection and sharing within arrangements such as ACHs. Phase 2 is expected to be completed by the end of summer 2016.

Regional Meetings

There have been three waves of regional meetings to spread the word about SIM and the Minnesota Model throughout the state. First, DHS and MDH initially convened three open community meetings to seek input for the SIM proposal, as well as a fourth meeting during the funding period to engage additional stakeholders. In the second wave, from July to August 2014, nine regional meetings were held across the state to inform the public about the SIM vision, including the ACH opportunity. In the final wave (fall of 2015), regional meetings took on a slightly different format: six communities planned and hosted meetings on behalf of the state to share stories and network on topics related to SIM.

Communications

The Leadership Team, which includes the communications project manager, directs the Minnesota Accountable Health Model internal and external communications, with support from MDH and DHS communication staff. According to the state's Operational Plan, these staff replaced an initial interagency communications workgroup that was established in 2013. The Task Force members are also considered to be vital in communicating SIM-related information to stakeholder groups.

External communications are executed utilizing a website, an email listserv (788 subscribers as of January 2016); a monthly newsletter; updates to Task Force members and leadership; social media; and events such as the Task Force meetings, webinars, and presentations. The public SIM website is the primary communication vehicle for the state (1,017 users in January 2016). In addition to the public website, the communications team uses an internal SharePoint website and holds quarterly briefings on SIM activities for state staff.

Grant Programs and Contracts

In order to achieve the goals of the Minnesota Accountable Health Model by 2017, the state made investments in e-Health (Driver 1); ACOs (Drivers 2 and 5); Team-based, Integrated, Coordinated Care (Driver 3); ACHs (Driver 4); and Community Engagement (all drivers). Exhibits 2.2 and 2.3 list the names, number of awards, and total dollars awarded for grant programs and selected contracts, respectively, under each of these SIM components. We describe each of these investments in subsequent chapters. See Appendix C for additional information on grant program applicants, awards, and rounds of funding.

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Exhibit 2.2. Grant Investments

Grant Program by SIM Component	Number of Grants Awarded	Total Dollars Awarded
E-Health: Collaboratives (Rounds 1 and 2)	16*	\$4,863,396
E-Health: Privacy, Security, and Consent Management (A and B)	2	\$499,137
ACO: Integrated Health Partnerships Data Analytics	11	\$4,063,472
Team-based Care: Emerging Professions (Rounds 1, 2, and 3)	14	\$418,061
Team-based Care: Learning Communities (Rounds 1 and 2)	5	\$398,095
Team-based Care: Practice Facilitation	2	\$966,601
Team-based Care: Practice Transformation (Rounds 1, 2, and 3)	46	\$716,082
Accountable Communities for Health	15	\$5,543,160
Total Number of Awards	111	\$17,486,004

*Three awards were to the same collaboratives for a total of 13 e-Health Collaboratives.

Source: SHADAC, *Database: Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative*, University of Minnesota, School of Public Health. Minneapolis, Minnesota. April 2016.

Notes: Database is based on state documentation, grant applications and agreements, select progress reports, organization websites, and consultation with the state.

Exhibit 2.3. Selected Contract Investments

Contract by SIM Component	Number of Contracts Awarded	Total Dollars Awarded
E-Health: Roadmap	1	\$596,726
ACO: Integrated Health Partnerships (Rounds 1, 2, and 3)	16	n/a
ACO: Integrated Health Partnerships Data Analytics Vendor	1	\$1,750,000
ACO: Baseline Survey	1	n/a
Team-based Care: Emerging Professions Toolkit	3	\$297,480
Team-based Care: Learning Days	3	\$80,756
Cross-cutting: Community Engagement	2	Pending
Cross-cutting: Evaluation	1	\$3,635,713
Cross-cutting: SIM Task Force Facilitation	1	\$719,754

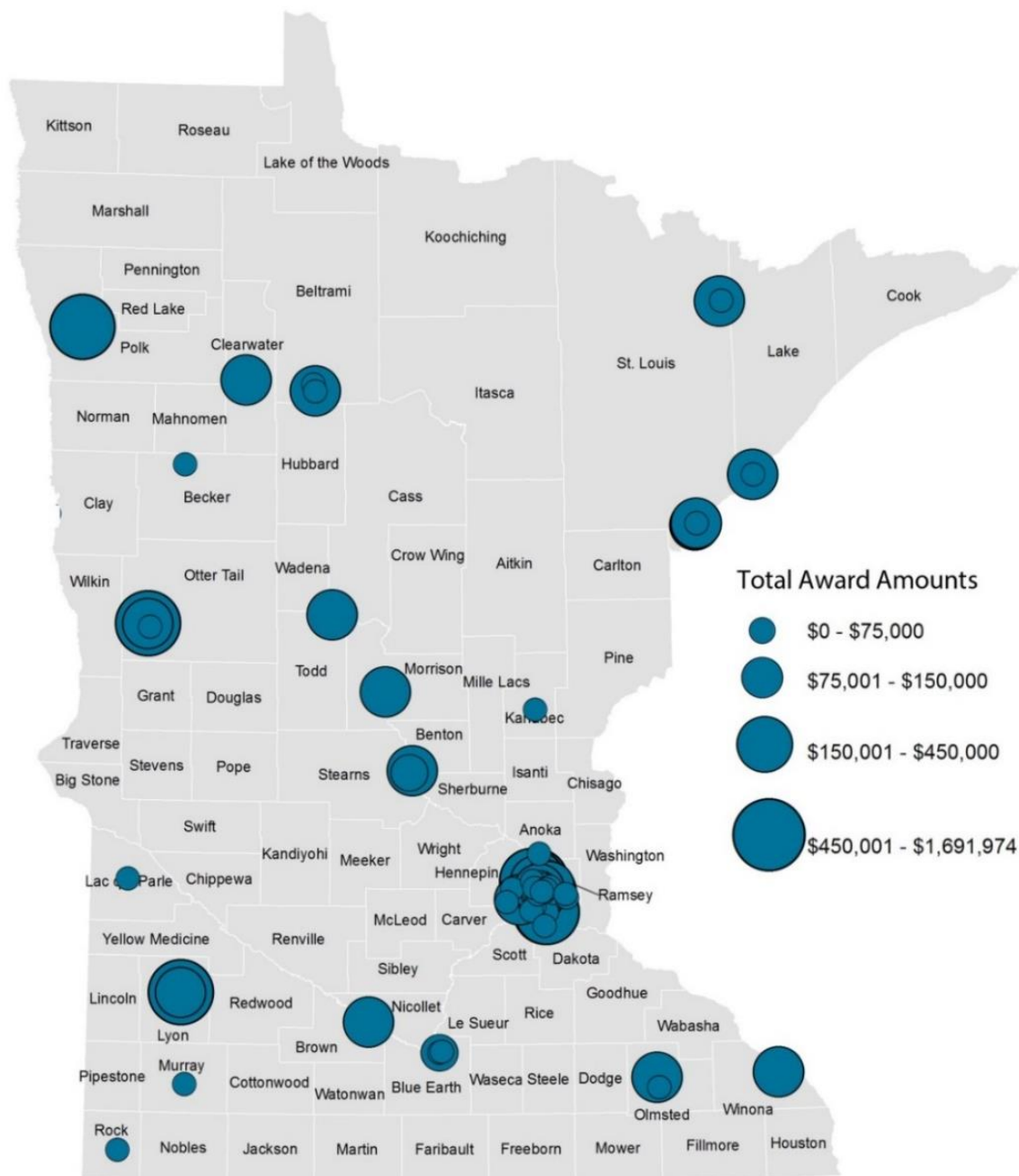
Source: SHADAC, *Database: Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative*, University of Minnesota, School of Public Health. Minneapolis, Minnesota. April 2016.

Notes: Database is based on state documentation, grant applications and agreements, select progress reports, organization websites, and consultation with the state. Contract investments represent many but not all of the state's engagements.

The map below illustrates the geographic spread of the SIM grant and contract investments in Minnesota, according to the fiscal agent or the entity that has received funding. Fiscal agents are usually the lead organization for a particular grant or contract, but it is important to note that grant and contract awards involve other organizations. Exhibit 2.4 plots 95 awards to 73 fiscal agents, according to their geographic location and the size of their grant or contract award. Many fiscal agents have received more than one award, and the size of their dot reflects their total awards across all grants and grant programs. Exhibit 2.5 presents a closer look at the 48 awards to 38 fiscal agents in Hennepin, Ramsey, and Dakota counties.

This program is part of a \$45 million State Innovation Model (SIM) cooperative agreement, awarded to the Minnesota Departments of Health and Human Services in 2013 by The Center for Medicare and Medicaid Innovation (CMMI) to help implement the Minnesota Accountable Health Model.

Exhibit 2.4. Minnesota Accountable Health Model Awards per Fiscal Agent

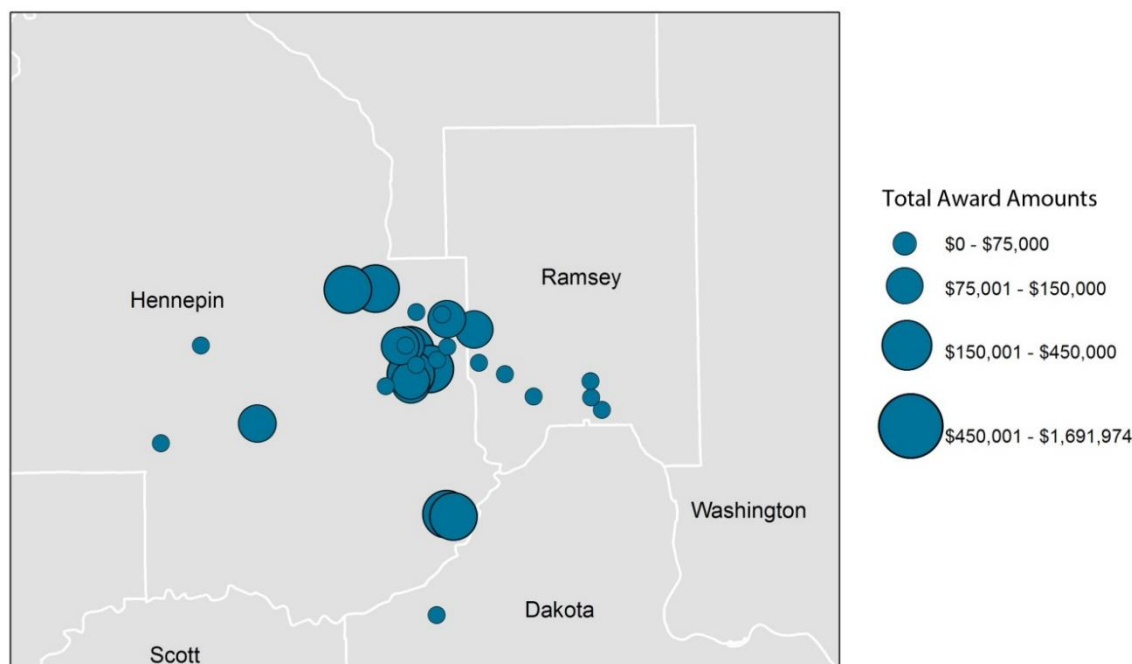


Source: SHADAC, *Database: Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative*, University of Minnesota, School of Public Health. Minneapolis, Minnesota. April 2016.

Notes: Database is based on state documentation, grant applications and agreements, select progress reports, organization websites, and consultation with the state. Three fiscal agents are not plotted on the map due to their out of state location.

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Exhibit 2.5. Minnesota Model Awards per Fiscal Agent: Metro Counties



Source: SHADAC, *Database: Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative*, University of Minnesota, School of Public Health. Minneapolis, Minnesota. April 2016.

Notes: Database is based on state documentation, grant applications and agreements, select progress reports, organization websites, and consultation with the state.

Participating Organizations

This section provides characteristics on the 424 currently active organizations (as of April 2016) participating in the SIM initiative in Minnesota.⁹ These organizations include fiscal agents as well as other organizations participating in grant programs and contracts, such as partner organizations or vendors. Exhibits 2.6 and 2.7 summarize the organizations by type, sector, and urban/rural status. (Organizations were assigned a type according to their primary service.) Among the participating organizations, 27% are traditional medical providers, 45% are priority setting providers, and 28% are other types of organizations. The representation of non-traditional medical providers is indicative of the nature of the Minnesota Accountable Health Model, which emphasizes coordination of primary care and other community services. Although SIM grants and contracts span the entire state, there is an agglomeration of participating organizations in the Twin Cities metro area, with approximately 67% of organizations located in urban counties. Organizations representing the non-profit and government sectors make up the majority of participants; 16% of participating organizations are for-profit, and only 2% of participating organizations are tribal entities. In addition, 33 organizations, or 8% of all active organizations are certified Health Care Homes (HCHs).

⁹ The organization count of 424 does not include the Integrated Health Partnerships participating providers unless they are active in another grant program or contract tracked in SHADAC's organization database.

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Exhibit 2.6. Types of Participating Organizations

Organization Type	# Organizations (% of Total)
Hospitals and/or Network of Hospitals	15 (4%)
Clinics and/or Network of Clinics	46 (11%)
Health Care Systems	42 (10%)
Health Plan	8 (2%)
Behavioral Health	53 (12%)
Social Services	49 (11%)
Local Public Health	24 (6%)
Human and Other Public Health & Social Services*	45 (10%)
Long-Term Post-Acute and/or Home Care Services	24 (6%)
Education	35 (8%)
Other**	83 (20%)
Total	424 (100%)

*Includes local public health and human service agencies

**E.g. consultant, IT vendor, EMS, advocacy, legal, pharmacy

Source: SHADAC, *Database: Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative*, University of Minnesota, School of Public Health. Minneapolis, Minnesota. April 2016.

Notes: Database is based on state documentation, grant applications and agreements, select progress reports, organization websites, and consultation with the state. For mutually exclusive organization type, organizations were assigned a category according to their primary service.

Exhibit 2.7. Other Characteristics of Participating Organizations

Sector Location	# Organizations (% of Total)
Government Sector	109 (26%)
Non-Profit Sector	238 (56%)
For-Profit Sector	68 (16%)
Tribal Sector	8 (2%)
Total*	423 (100%)
Location	# Organizations (% of Total)
Urban Status	269 (67%)
Rural Status	134 (33%)
Total*	403 (100%)

*Totals vary due to missing data

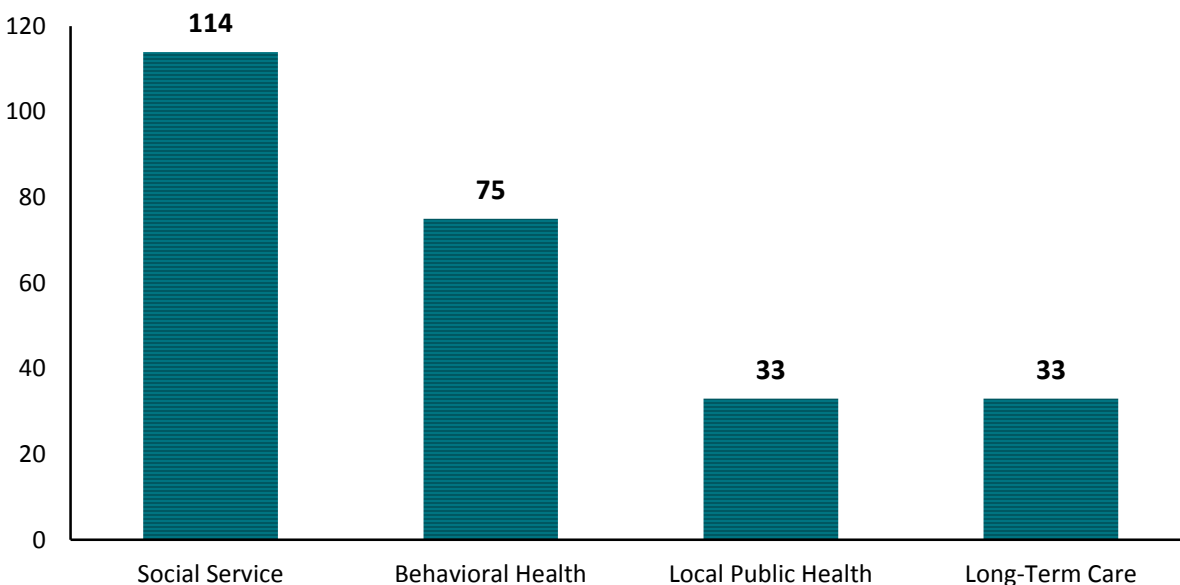
Source: SHADAC, *Database: Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative*, University of Minnesota, School of Public Health. Minneapolis, Minnesota. April 2016.

Notes: Database is based on state documentation, grant applications and agreements, select progress reports, organization websites, and consultation with the state. Location and sector categories are mutually exclusive.

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The state put particular emphasis on certain settings that provided opportunities for care coordination, specifically for complex and diverse populations. Behavioral health, long-term/post-acute services and supports, social service, and local public health were all identified as priority setting providers for SIM investments. Almost half (45%) of the organizations involved in grant programs or contracts work in these settings (see Exhibit 2.8). Organizations providing social and behavioral health services have strong representation in SIM grants and contracts in Minnesota.

Exhibit 2.8. Participating Organizations by Service Offerings



Source: SHADAC, *Database: Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative*, University of Minnesota, School of Public Health. Minneapolis, Minnesota. April 2016.

Notes: Database is based on state documentation, grant applications and agreements, select progress reports, organization websites, and consultation with the state. Categories are not mutually exclusive; participating organizations may provide services in more than one area.

Exhibit 2.9 below details the number of unique organizations participating either as a lead/fiscal agent or as a partner or vendor for select Minnesota Accountable Health Model programs. In line with the collaborative nature of the e-Health and ACH grant programs, these efforts reach over 100 unique organizations each. For example, the 16 e-Health Collaborative grants involve 160 organizational partners and vendors. The 15 ACHs are made up of 214 participating organizations. In total, the 16 Integrated Health Partnerships list over 350 clinic locations, hospitals, outpatient facilities, and physician and other provider groups that are participating in their ACO models.

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Exhibit 2.9. Participating Organizations by Select Program

Select Program	Number of Organizations
E-Health: Collaboratives	160
E-Health: Privacy, Security, and Consent Management	2
ACO: Integrated Health Partnerships	354*
ACO: Integrated Health Partnerships Data Analytics	220*
Team-based Care: Emerging Professions	65
Team-based Care: Learning Communities	13
Team-based Care: Practice Facilitation	26
Team-based Care: Practice Transformation	54
Accountable Communities for Health	214

* Participating providers in the Integrated Health Partnerships program are not included in the 424 active organization count presented earlier unless they are participating in another grant program.

Source: SHADAC, *Database: Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative*, University of Minnesota, School of Public Health. Minneapolis, Minnesota. April 2016.

Notes: Database is based on state documentation, grant applications and agreements, select progress reports and grantee interviews, organization websites, and consultation with the state. Organization counts include fiscal agents, other partners, and vendors. For e-Health Collaboratives, some, but not all, collaboratives identified HIE vendors or consultants.

Organizations may be the recipients of multiple rounds of funding within a particular grant program or may be the recipient of an award under more than one grant program or activity, and this is true for a subset of organizations participating in the Minnesota Accountable Health Model. Although there are 424 active unique organizations, many of them are in several programs, leading to over 500 organization “connections.” One out of four organizations is involved in more than one program; 29 of those organizations are involved in three or more programs (see Exhibit 2.10).

Exhibit 2.10. Organization Participation in Multiple Programs

Number of Programs	Number of Organizations
2+ programs	104
3+ programs	29

Source: SHADAC, *Database: Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative*, University of Minnesota, School of Public Health. Minneapolis, Minnesota. April 2016.

Notes: Database is based on state documentation, grant applications and agreements, select progress reports and grantee interviews, organization websites, and consultation with the state.

Exhibit 2.11 lists the organizations involved in three or more programs by their organization type. For example, the Essentia Health Ely Clinic is the lead organization for the Ely Community Care Team ACH, but also participates in the Emerging Professions and Practice Transformation grant programs as a partner. Lutheran Social Services of Minnesota, a private non-profit social service agency, leads an e-Health Collaborative, as well as participates in two ACH grants and a Practice Transformation grant. Stratis Health is a popular vendor for e-Health Collaboratives, but also participates in the e-Health Roadmap, Practice Facilitation, and Learning Communities programs.

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Exhibit 2.11. Organizations that Participate in 3+ Programs, by Organization Type

Organization Type	Name of Organizations Participating in 3+ Programs
Clinics	Bluestone Physicians, Stillwater Essentia Health Ely Clinic Federally Qualified Health Center Urban Health Network (FUHN) Native American Community Clinic West Side Community Health Services Open Door Health Center
Health care systems	Essentia Health Hennepin County Medical Center (HCMC) Hennepin Health Lake Region Health Care North Memorial Health Care Southern Prairie Community Care
Behavioral health	Greater Minnesota Family Services Guild Incorporated Lakeland Mental Health Center Range Mental Health Center Southwestern Mental Health Center Vail Place Western Mental Health Center Woodland Centers Stellher Human Services, Inc.
Social services	Lutheran Social Service of Minnesota
Local public health	Otter Tail County Public Health
Human and other public health & human services	Otter Tail County Human Services
Long-term post-acute and/or home care services provider	Pioneer Care Ely Bloomensen Community Hospital Home Health Care
Education	Vermillion Community College
Other	Halleland Habicht Stratis Health

Source: SHADAC, *Database: Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative*, University of Minnesota, School of Public Health. Minneapolis, Minnesota. April 2016.

Notes: Database is based on state documentation, grant applications and agreements, select progress reports and grantee interviews, organization websites, and consultation with the state.

Continuum of Accountability Assessment Tool

With Task Force input, the state invested resources to develop and require all organizations applying for grant funding under the Minnesota Accountable Health Model to complete a Continuum of Accountability Assessment Tool. The tool allows organizations to self-assess their status on 31 capabilities and functions related to participation in accountable care models and the Triple Aims of improved care, improved population health, and lower health care costs. The state administers the tool at the proposal stage of a grant program or activity and at the end of an award. Results presented in

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this section include findings from tools completed pre-award by organizations participating in the Model. See Appendix D for additional baseline assessment results, specifically for care coordination and electronic health record (EHR) implementation, as well as preliminary analysis of pre- and post-award information for one grant program that ended in the fall of 2015.

The assessment tool is organized into seven categories:

- Model Spread and Multi-Payer Participation
- Payment Transformation
- Delivery and Community Integration and Partnership
- Infrastructure to Support Shared Accountability Organizations
- Health Information Technology
- Health Information Exchange
- Data Analytics

For each of the 31 questions within the tool, organizations were instructed to choose a level (Pre-Level, Level A, Level B, Level C, Level D) that best represents their status related to a particular capability or function and then, within that level, they were to select a progress indicator (beginning, in progress, or mostly done). For this analysis, only the five status levels were used. Each status level was recoded into a numeric value (1-5), with 1 being the lowest (pre-level) and 5 being the highest level of status (Level D). Generally, higher scores indicate more regular, established, and formalized capabilities/functions within an organization. Organizations with multiple status levels recorded for a particular question or with missing data on a particular question were excluded from the baseline analyses.

To date, SHADAC has reviewed and analyzed data for 248 completed tools for 172 organizations. This represents approximately 42% of the organizations currently involved in SIM. Completed tools were not required of new partners who joined SIM work post-award or of some organization types, such as health plans and vendors. Exhibit 2.12 provides counts of tools received at the time of application by program. The ACH and e-Health grant programs submitted the most assessment tools, in part due to the collaborative nature of their grants and the number of partners involved. The characteristics of organizations submitting the tools are similar to the characteristics of organizations participating in SIM overall.

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Exhibit 2.12. Completed Assessment Tools by Program

Program	Number of Completed Tools
E-Health	79
IHP Data Analytics	9
Emerging Professions	16
Practice Transformation	44
Practice Facilitation	21
ACH	73

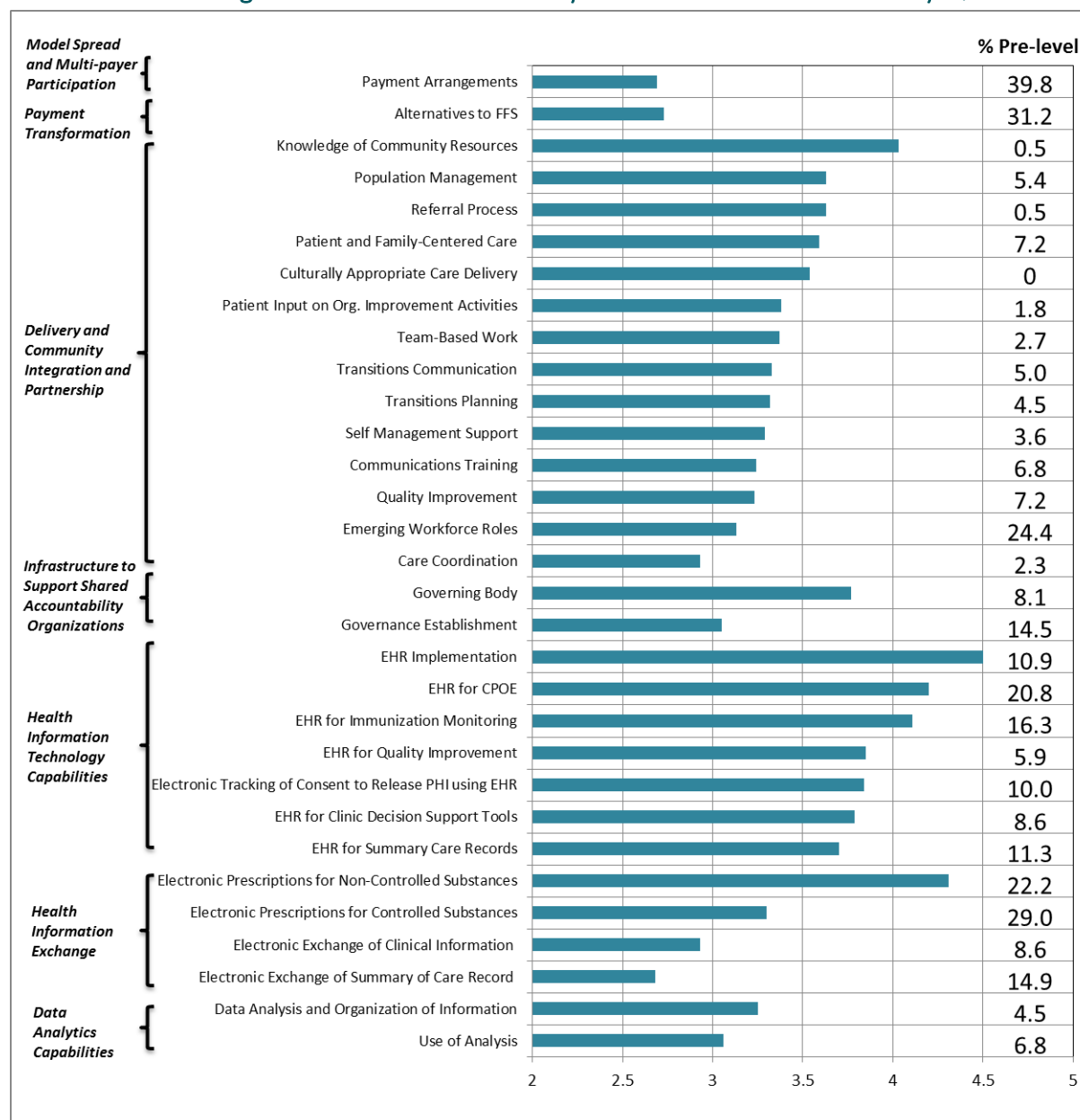
Source: SHADAC, *Database: Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative*, University of Minnesota, School of Public Health. Minneapolis, Minnesota. April 2016.

Notes: The same organization may have submitted more than one tool due to participation in more than one program.

Exhibit 2.13 details the average scores for all organizations for all questions organized by each of the seven tool categories. The column on the right indicates the percent of organizations reporting “pre-level” for that question. A response of “pre-level” generally indicates that an organization has either not started implementing a function, or is not even planning to, whereas responses 2 (Level A) through 5 (Level D) generally indicate stepwise movement towards complete and successful implementation of the function. Pre-level responses were excluded from average scores for each question shown as sideways bars in Exhibit 2.13. The two questions in the tool related to alternative to fee-for-service (FFS) or movement toward value-based payment arrangements for care delivery have the highest percentages of pre-level responses. Even among those organizations who self-reported progress on these items, average scores fall between 2.0 and 3.0. Overall, the highest scores were reported for health information technology capabilities.

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Exhibit 2.13. Average Pre-SIM Award Scores by Continuum of Accountability Question



Source: SHADAC, *Assessment Tool Database: Continuum of Accountability Assessment Tools Submitted by Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative*. April 2016.

Notes: “% Pre-level” indicates the percent of organizations answering that they have not begun or are not planning to begin implementing the function.

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3. E-HEALTH

Introduction

The Minnesota Accountable Health Model includes significant investments in areas of e-health,¹⁰ Driver 1 of the Model, all intended to increase providers' ability to securely exchange data for treatment, care coordination, quality improvement, and population health pursuant to state and federal law. Driver 1 investments are viewed as fundamental components that are necessary for supporting providers' movement to shared cost, shared savings, or total cost of care (TCOC) arrangements. To this end, Minnesota's State Innovation Model (SIM) funding has supported three areas of e-health investment (presented here in order of the status of the grant period, from the most recent to the furthest along):

- **Technical Assistance and Education: Privacy, Security and Consent Management.** The goals of this program are multifold: to ensure that health care professionals have access to education and technical assistance on privacy, security, and consent management practices; to identify opportunities for improvement in current patient consent processes for the release of protected health information required for health information exchange; and to provide technical assistance and education to ensure health care professionals across various settings have the access to the knowledge and tools required to use, disclose, and share health information in a safe and secure manner that is consistent with both state and federal law. This 18 month grant was awarded to Gray Plant Mooty and Hielix, Inc. in August 2015.
- **E-Health Roadmap to Advance the Minnesota Accountable Health Model.** The purpose of this project is to provide recommendations and actions to support and accelerate the adoption and use of e-health in four priority settings: behavioral health, long-term and post-acute care, local public health, and social services. Through the process of collecting and identifying stories that illustrate how an individual moves through the various health and care systems, the Roadmap will emphasize how supporting and accelerating the adoption and use of e-health in these priority settings could improve health outcomes. This is an 18 month grant program, and was awarded to Stratis Health in January 2015.
- **E-Health Grant Program.** The goal of this grant program (referred to in this report as the e-Health Collaboratives) is to support the secure exchange of medical or health-related information between organizations for: a) developing a plan to participate in the Minnesota Accountable Health Model; or b) implementing and expanding e-health capabilities for participation in the Minnesota Accountable Health Model. Eligible awardees are community

¹⁰ The Minnesota e-Health Initiative defines e-Health as follows: The adoption and effective use of electronic health record (EHR) systems and other health information technology (HIT), including health information exchange, to improve health care quality, increase patient safety, reduce health care costs, and enable individuals and communities to make the best possible health decisions.

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collaboratives that have at least two or more organizations participating in an accountable care organization (ACO) or similar health care payment model (i.e., payment arrangements involving shared risk, shared savings, or total cost of care). Development grants are 12 months in duration and were awarded to six community collaboratives in October 2014. Implementation grants are 18 months in duration and were awarded to six community collaboratives in October 2014, and to four community collaboratives in July 2015.

Work under each of the three e-health investment areas is overseen by the Minnesota Department of Health (MDH), and is ongoing. The Privacy, Security, and Consent Management (PSCM) grant is still early in its implementation; thus analysis of outcomes of this grant program will be forthcoming in subsequent evaluation reports. The focus of this chapter will be on the other two components, the e-Health Roadmap and e-Health Collaboratives, but relevant insights related to the PSCM work will be noted throughout this report. Additional detailed information about the three e-health investment areas and the individual awarded grantees is provided in Appendix E.

The findings included in this report were identified through the State Health Access Data Assistance Center's (SHADAC) review of grant program materials and grantee submitted reports, observations of e-Health Roadmap Steering Team meetings, interviews with state staff, and interviews with Roadmap and Round 1 e-Health Collaborative grantees.

Background

Driver 1 investments build on significant e-health work that has occurred in Minnesota over the past 12 years. The ability to securely share health care data across all health care settings, in compliance with patient preferences and state and federal law, has become a high-priority objective at both the state and national levels. With providers increasingly at risk for quality and costs of their patients, the need for access to information that supports the delivery of high quality care is driving the adoption and use of electronic health records (EHRs). Minnesota has long been a leader in e-health, and consistently ranks as one of the states with the highest rates of hospital and ambulatory clinic EHR adoption in the country (100% and 97%, respectively).¹¹ Providers are recognizing, however, that in addition to simply adopting an EHR, the key to successfully accessing and sharing needed health information is interoperability – the seamless, bi-directional, standards-based communication across settings.

Minnesota e-Health Initiative

Since 2004, e-health activities in Minnesota have been coordinated by MDH through the Minnesota e-Health Initiative, a public-private collaborative of health care providers, payers, and professional associations. Guided by a 25-member advisory committee, the Initiative fulfills the statutory role of the Minnesota e-Health Advisory Committee.¹² (For additional information on the other e-Health laws and

¹¹ "Minnesota e-Health Profile." *Minnesota Department of Health, Office of Health Information Technology*. Web. Nov. 2015. <<http://www.health.state.mn.us/ehealth/assessment.html>>

¹² Minnesota Statutes §62J.495.

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mandates that guide activities in the state, see Exhibit 3.1.) The Initiative has worked to pursue policies and practices to accelerate e-health with a focus on achieving interoperability (the ability to share information seamlessly) across the continuum of care. Examples of Minnesota's pre-SIM e-health initiatives include the establishment of the e-Health Connectivity Grant Program (after which the SIM e-Health Collaboratives grant program is modeled) and the Minnesota Revolving EHR Loan Program.

Exhibit 3.1. Minnesota's E-Health Laws

A number of unique Minnesota laws and mandates have been put in place that guide e-health activities in the state. Four significant e-health-related laws include:

- **Minnesota Interoperable Electronic Health Record Mandate.**¹³ In 2007, Minnesota enacted legislation that requires all hospitals and health care providers (other than nursing homes) in the state to implement an interoperable electronic EHR system by January 1, 2015. The mandate was updated in 2015 to exempt individual health care providers in a solo, private practice, and those who do not accept reimbursement from a group purchaser. There is no fine or state-administered penalty for not complying with the mandate.
- **E-prescribing mandate.**¹⁴ In 2008, Minnesota enacted a mandate that requires prescribers, pharmacists and pharmacies, and pharmacy benefit managers to be e-prescribing (capable of electronic prescribing through a secure bidirectional electronic information exchange) by January 1, 2011.
- **Health Information Exchange (HIE) Oversight.**¹⁵ Established in 2010 and updated in 2015, this law provides a framework for health information exchange in Minnesota. It establishes two separate certification options for organizations conducting HIE: 1) Health Information Organization (HIO) - An organization that oversees, governs, and facilitates health information exchange among health care providers that are not related to health care entities to improve coordination of patient care and the efficiency of health care delivery; and 2) Health Data Intermediary (HDI) - An entity that provides the technical capabilities or related products and services to enable health information exchange among health care providers that are not related health care entities. This includes but is not limited to: health information service providers, electronic health record vendors, and pharmaceutical electronic data intermediaries. The law also requires that all Minnesota health care providers have an interoperable electronic health record system that is connected to a State-Certified HIO, either directly or indirectly through a connection established with a State-Certified HDI by 2015.
- **Minnesota Health Records Act.**¹⁶ This state law provides guidance for the management of health related information, and outlines standard elements that must be present in the patient consent form. Minnesota's law is more stringent than the Health Insurance Portability and Accountability Act (HIPAA) with respect to the rights of individuals, as it prohibits exchange of information for treatment purposes unless the patient has provided a signed, written permission (consent). The 2013 Minnesota Health Records Access Study found that Minnesota is nearly unique among states in requiring patient permission to disclose any type of health information to other providers for treatment purposes. Only Minnesota and New York do not align their requirements with HIPAA.¹⁷

¹³ Minn. Stat. §62J.495

¹⁴ Minn. Stat. §62J.497

¹⁵ Minn. Stat. §62J.498-.4982

¹⁶ Minn. Stat. §144.291-.298

¹⁷ *Minnesota Health Records Access Study: Report to the Legislature*. Minnesota Department of Health. Feb. 2013. Web. Jan. 2016

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Additional information about Minnesota's current e-health landscape, including rates of EHR adoption by practice site, descriptions of the composition of the e-Health Advisory Committee, and summaries of the work of the e-Health Initiative can be found online at: <http://www.health.state.mn.us/e-health/>.

Federal E-Health Activities

Federal initiatives aimed at individual providers, hospitals, and the state have laid the groundwork for much of Minnesota's work to expand e-health capabilities. One of the most impactful federal e-health activities was the passage of the 2009 Health Information Technology for Economic and Clinical Health Act (HITECH Act), which authorized Medicare and Medicaid EHR Incentive Programs (also known as meaningful use¹⁸), the Beacon Community Program,¹⁹ the State Health Information Exchange (HIE) Cooperative Agreement Program, and other e-health related initiatives. Over the past six years Minnesota providers have received nearly \$500 million in meaningful use payments, as well as funding for health information technology policy and standards development, \$12.3 million for the Southeastern Minnesota Beacon Community Program, and \$2.8 million for individual provider, hospitals, pharmacies and community collaboratives through the e-Health Connectivity Grant Program for HIE. However, most of those federal funding supports (other than the meaningful use incentives) ended in 2014, or will end in early 2016.

Interoperability and Health Information Exchange (HIE)

As it carried out its work related to meaningful use, the Minnesota e-Health Initiative recognized that there was a continued need to support the goal of achieving interoperability, both across traditional health care organizations and across a broader set of providers and settings that had not been recipients of meaningful use incentive payments such as social service providers, local public health, home health settings, etc. In contrast to Minnesota's high rates of EHR adoption, interoperability goals have been more difficult to achieve, although significant progress has been made recently. In 2015, 77% of hospitals and 73% of clinics with EHR systems reported electronically exchanging health information with an unaffiliated partner. While this is significant progress (40% of clinics reported exchanging health information with unaffiliated partners in 2014), MDH's e-Health Profile report cautions that other than electronic prescribing, most of the health information exchange happening in Minnesota is primarily between hospitals and clinics in the same system or with affiliated partners.

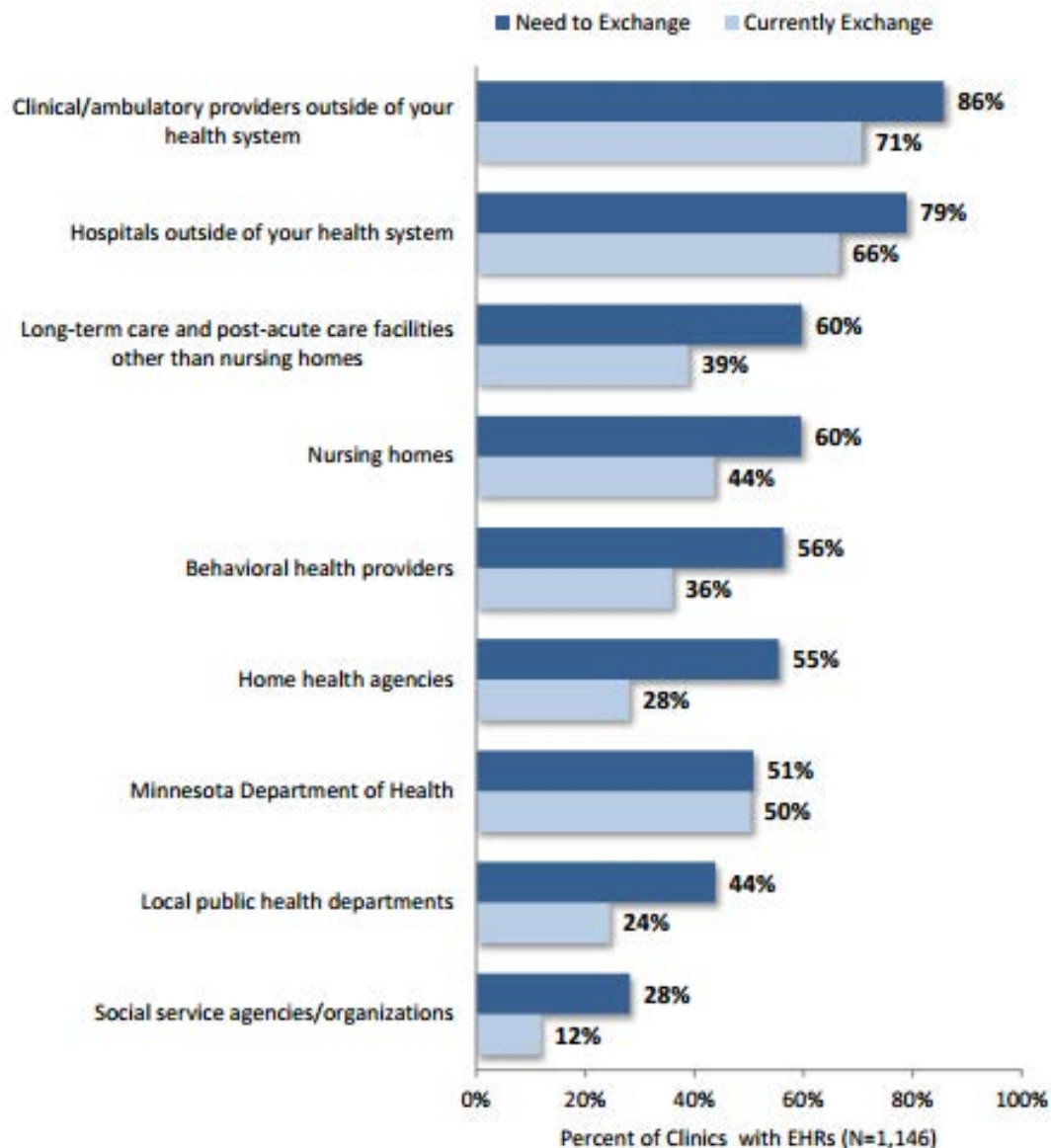
¹⁸ Meaningful use refers to the use of certified electronic health record technology to improve quality, safety, and efficiency and reduce health disparities; engage patients and families; improve care coordination; improve population and public health; and maintain privacy and security of patient health information as established by the Centers for Medicare and Medicaid Services and the Minnesota Department of Human Services.

¹⁹ In 2010, the Office of the National Coordinator for Health Information Technology (ONC) established the Beacon Community Program, awarding \$250 million across 17 communities to build and strengthen their health information technology (IT) infrastructure in support of clinical transformation efforts.

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Exhibit 3.2 below, from the 2015 Minnesota HIT Clinic Survey,²⁰ shows the reported gap between the types of HIE partners that clinics currently have, compared with their need to exchange with those partners.

Exhibit 3.2. Clinics' Need and Actual Electronic HIE by Type of Organization, 2015



Source: 2015 Minnesota HIT Clinic Survey.

²⁰ *Minnesota e-Health Report - Clinics: Adoption and Use of EHRs and Exchange of Health Information, 2015*. Minnesota Department of Health Office of Health Information Technology. Aug 2015. Web. Dec. 2015. <<http://www.health.state.mn.us/e-health/summaries/reportclinic2015.pdf>> This Report is part of MDH's Minnesota e-Health Profile, which is a method to uniformly collect and routinely share the results of MN's e-health assessment activities statewide and based upon multiple sets of assessment information.

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The survey found that, in general, there is high need among clinics to exchange with providers across the continuum of care but a significant lag in the actual ability to do so.

Minnesota's HIE Landscape

Minnesota's approach to health information exchange is to support a market-based strategy that allows for private HIE service-provider participation and provides government oversight to monitor fair practices and compliance with state privacy protections. As mentioned in Exhibit 3.1, Minnesota requires all HIE service providers to obtain a Certificate of Authority from MDH in order to operate as either an Health Information Organization (HIO) or Health Data Intermediary (HDI) in Minnesota.

The number and composition of State-Certified HIE service providers has been in flux as the State's HIE landscape has changed. For example, when the Round 1 SIM e-Health Collaboratives were applying for funding in the spring of 2014, Minnesota had one State-Certified HIO, Community Health Information Collaborative (CHIC), and six state-certified HDIs. However, in the spring of 2015, CHIC withdrew its application to be recertified as an HIO. This temporarily left the State, and e-Health Collaborative participants, with no State-Certified HIO option.

As of the writing of this report, however, the number of State-Certified HIE options has more than doubled. Currently there are three organizations certified as HIOs and 13 organizations certified as HDIs, with additional HIO and HDI certifications under review.

Privacy, Security, and Consent Management Program

Work under the Privacy, Security, and Consent Management (PSCM) grants began in August 2015. This report documents the activities that have been completed to-date based on SHADAC's review of contractor materials submitted to the state. Further analysis of the outcomes and insights of this work will be included in subsequent evaluation reports.

The PSCM investment area has two distinct parts, which were awarded through a Request for Proposal (RFP) process to two separate entities:

- **Part A: Review of e-health legal issues, analysis, and identification of leading practice.** The overall goal of this grant is to complete a legal review and analysis of the differences, barriers, and tensions between state and federal laws, regulations, rules and policies for HIE required for care coordination activities, and to identify leading practices and opportunities for standardization related to e-health privacy, security, and consent management issues. This grant was awarded to Gray Plant Mooty, a law firm based in Minneapolis.
- **Part B: Provide e-health privacy, security, and consent management technical assistance and education.** The goal of the Part B grant is to use information gained in Part A to develop and disseminate educational tools, tips, guides, and materials related to privacy/security of electronic health records and exchange of health information that meets the needs of health

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care providers across the state, e-Health Collaborative grant projects, and Accountable Communities for Health (ACHs). This grant was awarded to Hielix, Inc.

Key Activities

Part A

Work under Part A of the PSCM grant, led by Gray Plant Mooty, began in August 2015. Gray Plant Mooty began analyzing eight use case stories,²¹ including four of the use case stories identified by the e-Health Roadmap project, in order to identify practical challenges and implementation barriers related to privacy, security, and consent management issues and the exchange of health information. To inform this work, Gray Plant Mooty held an open mic town hall meeting in November 2015. The purpose of the meeting was to hear directly from a variety of stakeholders regarding the privacy, security, and consent issues or barriers they face when trying to facilitate care coordination and exchange health information. Preliminary participant results indicate that 140 individuals participated in the meeting. Gray Plant Mooty is currently analyzing the feedback, questions, and responses received at the town hall meeting and will complete a summary report of the findings, along with a summary of their use case and regulatory analysis, expected in the summer of 2016. (See Appendix E for additional information on the scope of Gray Plant Mooty's upcoming work.)

Part B

In August 2015, Hielix, Inc. completed an environmental scan designed to gain insight into the current or "as is" state of privacy, security and consent management knowledge and compliance in Minnesota. The goal of the scan was to set a benchmark from which progress toward project goals can be determined. The environmental scan analyzed, classified, and made recommendations for identified knowledge gaps including: materials that are useful in the current form; materials that are useful but need to be modified; and needed materials that do not exist and must be developed. Hielix will use the findings from the environmental scan, along with the findings from Part A work, to develop educational resources (web-based and in-person) for implementing privacy, security, and consent management tools in health care settings and SIM-funded communities across the state. This work is expected to continue through the end of 2016.

Throughout the evaluation interview process, a number of grant participants in other SIM-funded programs expressed interest in knowing more about the status of work being done under the PSCM grants. Participants are anxious to see the results of that work shared as soon as possible, as privacy, security, and consent management issues have been identified as major obstacles to HIE implementation across various SIM driver components. State staff report that they have been communicating with grantees about the status of the PSCM work on a number of occasions. For example, state staff shared an update on the status of the PSCM work with Accountable Community for

²¹ According to the Minnesota e-Health glossary, a use case is a methodology used in system analysis to identify, clarify, and organize system requirements. In HIT and HIE, it often refers to a special kind of scenario that breaks down system requirements into user functions; each use case is a sequence of events performed by a user.

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Health (ACH) grantees on an ACH cohort conference call in December 2015, and at an e-Health Roadmap Steering Committee meeting in January 2016.

E-Health Roadmap Program

The purpose of the e-Health Roadmap is to identify a path forward and a framework for providers in the four SIM priority settings (behavioral health, local public health, long-term and post-acute care, and social services) to effectively use e-health. These four settings were chosen as the focus for this work due to the challenges and disparities that these providers have historically faced in implementing e-health in their respective settings. While investments, such as meaningful use incentives, have helped build e-health capacity in primary and acute care settings, significant parts of the health system where patients and families receive care and support have not had access to the same resources. The Roadmap is expected to focus on recommendations that will advance each of the four settings' progress in EHR adoption and use, and health information exchange.

The following sections summarize the major Roadmap activities to-date, identify early outcomes, and identify continuous improvement and sustainability considerations for Roadmap work going forward. These findings were ascertained through SHADAC's review of grant program materials, grantee reports to the state, observation of Roadmap Steering Team meetings, and interviews with members of the Roadmap Project Oversight Team. (Telephone and in-person interviews took place in October 2015 and covered project accomplishments, community engagement, and continuous improvement and sustainability insights.) In addition, SHADAC contracted with Rainbow Research to conduct an assessment of how the Roadmap has engaged the community in its work. To conduct this assessment Rainbow Research held focus groups with members of the Project Oversight Team, the Steering Team, and workgroups from each of the four priority settings. For additional information on Rainbow Research's community engagement findings, see Appendix F.

Key Activities

Through an RFP process, Stratis Health, a non-profit quality improvement organization, was selected to engage stakeholders and implement a consensus-based approach to develop an e-Health Roadmap for all four of the priority settings. The project, which began work in January 2015 and will continue through June 2016, is a collaborative effort led by the MDH's Office of Health Information Technology and Stratis Health. According to the e-Health Roadmap July 2015 Progress Report,²² the project has three phases: plan, develop, and educate. These three phases are intended to support and accelerate the adoption and use of e-health, but will not include implementation guides or detailed directions for individual providers and organizations to implement an EHR or HIE.

Recruitment of Participants

²² *Progress Report and Proposed Next Steps. Minnesota e-Health Roadmap for Behavioral Health, Local Public Health, Long-Term and Post-Acute Care, and Social Services* (July 2015). Stratis Health and Minnesota Department of Health. Web. Dec. 2015. < <http://www.health.state.mn.us/e-health/ehealthdocs/roadmapprogress.pdf>>

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Participants from across the care continuum, with special focus on the four priority settings, were recruited by Stratis Health and MDH to participate in the project. An open participation call was distributed in January 2015 through MDH's email listserv and Stratis' contacts. Individuals were offered the opportunity to participate in the project as a member of one (or more) of the following four groups:

- **Community of interest.** Individuals interested in receiving periodic updates on the Roadmap process and related e-Health activities.
- **Reviewer/subject matter experts.** Individuals to provide targeted feedback via email on materials and deliverables.
- **Workgroup member.** Individuals to provide insight and experience from the priority settings. The four workgroups, one for each priority setting, were each led by two co-chairs, except social services which only had one chair, and have been meeting monthly.
- **Steering Team member.** Individuals to provide leadership and guidance to the overall direction of the Roadmap and assure alignment between the priority settings. Two co-chairs led the Steering Team, which has been meeting monthly.

A Project Oversight Team was also convened with members from MDH and Stratis Health to provide overall strategic direction for the project and the Steering Team. The Project Oversight Team articulated the goals, timeframe, framework, and scope of the effort of the project; identified team members for the Steering Team and the four workgroups; and monitored the overall project status and deliverables.

Development of Shared Understanding and Common Terms

Stratis Health developed charters for the Steering Team and the four setting-based workgroups that included information on the groups' charge, process, tasks, expectations, guiding principles, milestones, and membership. One of the groups' first tasks was to develop a shared understanding of the project and identify common terms among the four settings. In order to help develop that shared understanding and build a base of support for the need for e-health, the four groups identified ways their settings are interconnected in the support of an individual's care, as well as ways technology could be used to support that care.

Identification of Use Case Stories

The second major task of the four workgroups (and a requirement of the Roadmap RFP), was to identify and select specific stories from their respective settings that could be developed into use cases (scenarios) for implementing e-health. These use cases are real stories, with names and identifying information removed, that reflect scenarios of how people interact with a variety of entities and care settings as they try to manage their health and wellness. The workgroups identified over 70 stories, which were reviewed and synthesized by the Project Oversight Team, resulting in 56 unique stories.

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Ranking and Prioritization of Stories

A multi-step process was used for ranking the stories. Each workgroup identified criteria that they deemed important for their stories, setting, and populations served. Using the criteria from the four workgroups, the Steering Team identified additional ranking criteria.²³ Each workgroup rated the stories it developed as high, medium, or low. The highest rated stories from each of the workgroups (four stories from social services and five each from behavioral health, local public health, and long-term and post-acute care) were presented to the Steering Team. Each member of Steering Team was given 10 votes to identify priority stories, and 11 stories received the highest number of votes. Ultimately, the Project Oversight Team selected eight of the 11 stories (two from each priority setting) to develop into use cases and undergo a full gaps analysis. This work is ongoing, and will be included in the final Roadmap report expected in June 2016.

Early Outcomes

As of the writing of this report, the e-Health Roadmap project has completed the first of its three planned phases of work, the design phase, and is currently wrapping up the develop phase and beginning work on the education phase. Therefore, the following outcomes, identified through the review of contractor reports to the state and interviews with project staff, state staff, and steering committee and workgroup members, are mostly related to the Roadmap's design phase of work.

Robust Community Engagement of Priority Setting Providers

The ability to successfully engage organizations and community members in the project was an achievement cited by members of the Project Oversight Team, Steering Team, workgroups, and the SIM Leadership Team.²⁴ As of July 31, 2015, Stratis Health reported successfully engaging over 1,000 individuals in the Roadmap design process. Exhibit 3.3 below, prepared by Stratis Health, summarizes the Roadmap's community engagement milestones.

²³ For additional information on the ranking criteria used to prioritize the stories see: *Progress Report and Proposed Next Steps. Minnesota e-Health Roadmap for Behavioral Health, Local Public Health, Long-Term and Post-Acute Care, and Social Services* (July 2015). Stratis Health and Minnesota Department of Health. Web. Dec. 2015. < <http://www.health.state.mn.us/e-health/ehealthdocs/roadmapprogress.pdf>>

²⁴ For more detailed information on the e-Health Roadmap's community engagement model see Appendix F.

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Exhibit 3.3. E-Health Roadmap Community Engagement Milestones

Engagement Opportunities	Focus/Description	Number of Individuals Engaged*	Number of Meetings	Estimated Hours Contributed**
Community of Interest	Receive periodic emails	+900	3 (communications)	NA
Reviewers/Subject Matter Experts	Provide targeted feedback on materials	48	3 (communications)	NA
Workgroups	Identify stories	52	21	590
Steering Team	Provide overall direction and alignment	19	6	285

*Some individuals participated in multiple engagement opportunities.

**Only includes hours of participants in meeting, does not include outside of meeting hours contributed
Source: "Minnesota e-Health Roadmap – Progress Report and Next Steps." Stratis Health. July 2015.

As one participant commented, "Our most important achievement is how we have harnessed stakeholder interest and engagement. If you look at the numbers and who sits on the committees, there is a huge and diverse representation of stakeholders. This signifies a great need and the fact that we have tapped into something people want and value."

MDH's call for participation resulted in the submission of 180 names for consideration on a workgroup, on a steering committee, or as a reviewer/subject matter experts. A number of individuals commented that they felt that the demand to participate in the Roadmap reflected a pent up community desire to see work done in this area. Many Roadmap participants expressed that having an opportunity to discuss the needs of their priority setting was a benefit, as members felt that their priority settings were often overlooked in previous state HIE discussions and decision making.

Members of the Steering Team and workgroups not only participated, but were actively engaged throughout the design process. One project manager made note of the amount and quality of the feedback received; it was not uncommon to receive emails from participants at night with suggestions. Workgroup members were so passionate about their favorite use case stories that when it came time to vote for the priority stories that would be included in the Roadmap, members took it upon themselves to personally try to convince both their own and other settings' workgroup members to vote for their preferred stories.

Project participants did, however, identify categories of stakeholders that were not participating in the Roadmap work. Overall, the limited participation of payers and primary/acute-care providers was perceived as detrimental to the project. Participants were concerned about their ability to garner support for the Roadmap recommendations from those two key groups without having had their participation and input along the way. One participant remarked, "Primary care is still off doing its own thing. That's not the way it works if you're a patient – you're not just in one health care setting at time. We should all be working on this together. At what point will we try and ask primary care to integrate with the recommendations in our Roadmap? It's still unclear."

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Project Oversight Team members noted that they reached out to payers and providers, some of whom indicated that they were supportive and interested but not quite ready to commit to the Roadmap process. Additional categories of stakeholders who did not participate in the Roadmap planning process included: consumers/clients; EHR vendors; and representatives from oral health, home health, nutrition services; jails and correctional facilities (project staff were not successful in getting county social service representatives to participate in the Roadmap work); Indian Health Services; and the VA Health Care System. In addition, project staff were surprised at the lower than expected participation they received from areas outside of the Twin Cities, especially from northern Minnesota, where they know a great deal of e-health work is occurring. After reaching out to representatives from a number of these areas project staff eventually made the decision to not spend additional time trying to garner more participation, but rather to focus on the substantial task of communicating with existing participants.

Use of Compelling Patient Stories/Use Cases

A second achievement mentioned was the collection and development of impactful patient stories (and subsequent use cases) that can be used to demonstrate the benefit of data-sharing across the four priority settings. Roadmap project participants report that these patient-centered stories were a straightforward way to capture complex HIE needs, and have become powerful tools to tell the story of how e-health can facilitate integration of care among the settings. Project Oversight Team members reported that the use cases have already been disseminated more rapidly than first anticipated, and that the use cases, developed by individual workgroups, have clearly resonated with the Roadmap Steering Team and SIM Task Force members.

Workgroup members also noted the benefits of structuring their work around the use cases, as it was a good way for the four settings to better understand each other's work. There was a concern raised, however, that the approach oversimplified a complex issue. In addition, there were concerns that a patient-centered approach didn't adequately capture community or population level health issues. Some members noted that they may have included different information in the use cases if they had known how the process would work from the beginning.

Evolving View of the Definition of "Roadmap"

Participants remarked that initially they assumed that the patient stories would reveal which elements should be included in a Roadmap. However, the patient's stories themselves started to become the Roadmap, and many participants felt that this transformation in the overall approach of the Roadmap process was a positive one. As one participant commented, "It's easy to disengage when you talk about needing HIE. But when you present the Roadmap from a real patient's perspective you have a way to talk about it that no one can argue with. Rather than thinking conceptually about the idea of integration [of health services among the four settings], the use cases drive the point home."

Consensus Across Priority Settings

Project Oversight Team members also expressed surprise at the amount of consensus across the four settings they were able to achieve and how that will impact their final Roadmap deliverable. One project

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leader explained, “We brought to this project a logic model and premise that each of the four settings would say unique things in each of their areas. But we were surprised to find that all four settings are saying the same things. Although they may be starting from different places they have the same needs and demands. I think we have chosen use cases well because they don’t stand out by priority settings. They touch on so many care transitions and supports for patients and family. It’s all about integrated care, and our approach reflects that. In the end, we will deliver one, not four, Roadmap.”

Facilitators

Through interviews with Stratis Health project staff, state staff, and Roadmap Steering Team and workgroup members, SHADAC researchers heard the following facilitators (presented in this section) and challenges (presented in the next section) articulated in the Roadmap project’s planning and development work.

Trusted Facilitator in Stratis Health

Stratis Health’s relationships with stakeholders from each of the four priority settings, which predated the SIM work, was noted as a key facilitator to this project. At the time of the RFP application, Stratis Health had already documented stakeholder support and a list of potential participation names for the project. Stratis Health also had a track record of successful community engagement and capacity-building within the four priority settings. For example, Stratis had previously developed tool kits for nursing homes and other settings of care to implement e-health.

Building off Previous Work

Leveraging previous e-health work, including work done by the e-Health Initiative, was noted as key to accelerating the planning and development work of the Roadmap project. Many of the providers engaged in the Roadmap project had participated in e-Health Initiative workgroups and were familiar with the terminology, challenges, and needs. Additionally, as Stratis Health developed its charters for the Roadmap steering committee and workgroups, they were deliberate about building charter language off of previously defined values of the priority settings. One project leader commented, “Leveraging this existing language as a starting point helped the various representatives from the priority settings feel empowered and engaged.”

The project’s early success with harnessing community engagement in the development of use cases led some project participants to question the sequence of the SIM funding opportunities. Several project participants, both from Roadmap and the e-Health Collaboratives, lamented that the state was not able to complete the Roadmaps and Privacy and Security work prior to starting the e-Health Collaborative grants. One project participant noted that the e-Health Collaboratives would have been an ideal mechanism to have tested implementation of the Roadmap use cases.

Challenges

Unanticipated Investment of Time to Facilitate Stakeholder Participation

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Project Oversight Team members noted that the level of stakeholder communication needed to conduct the Roadmap work was not spelled out in the original RFP, and was extremely time consuming. In their original project proposal, Stratis Health’s vision for stakeholder engagement focused on engaging a set of key stakeholders on a core steering team. However, the subsequent decision (strongly encouraged by MDH) to solicit participation at four different levels (community of interest, subject matter experts, workgroups, and Steering Team) required the development of a new, broader communications structure to support the work. Project Oversight Team members indicated that a tradeoff was ultimately necessary - Stratis Health had to devote more time communicating with a broader audience than originally expected, and thus was not able to devote as much staff time to the technical analysis and development of the Roadmap document.

Delays Due to Federal Contracting Requirements

Federal contracting requirements related to the process of unrestricting grant funds delayed the start of the Roadmap project work. The need to develop detailed project deadlines and milestones for the unique grant project, one where the final product was unknown at the beginning due to the iterative development process envisioned, was a stumbling block for the project’s commencement. Project Oversight Team members were frustrated that they had to inform interested stakeholders who were anxious to get started that they were not ready to initiate the project.

Sustainability Insights

Many Roadmap participants raised concerns about the sustainability of their work going forward.

Lack of Funding for Roadmap Implementation

The lack of implementation funding is seen as a potential barrier to the adoption of the forthcoming Roadmap recommendations. Roadmap project leaders noted the ongoing challenges they have faced in communicating that implementation work related to the Roadmap falls outside the scope of the SIM funding. Participants were concerned that there is no plan in place to ensure that providers from the various settings, who do not qualify for meaningful use incentives, can afford to implement the recommendations that will be included in the Roadmap. One project leader commented, “If we lived in an ideal world, there would be follow-on funding to do a proof of concept [of the Roadmap] in different places across Minnesota. Otherwise it is left to individual communities to take this on and own it.” As mentioned, a number of interviewees also made note of what they felt was a missed opportunity by the state in releasing the e-Health Collaborative grant funding before the having the Roadmap completed. Several individuals remarked that the e-Health Collaboratives grant program could have provided that “proof of concept” for the Roadmap.

Lack of Non-Clinical Data Standards for Priority Settings

A second sustainability concern raised was the lack of data standards for those priority settings where standards do not yet exist. Data standards, as defined in Minnesota’s e-Health glossary, are documented agreements containing technical specifications to ensure that data is shared in a way that multiple systems can “talk” to each other. A number of national standards have been developed for the exchange

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of clinical information; however, similar data standards have not been developed for the exchange of non-clinical health data collected in settings like long term care. Roadmap participants expressed a desire to see work on those standards begin now in order to continue the momentum of the Roadmap, and to facilitate the eventual implementation of Roadmap recommendations by priority settings. As one participant noted, “The policies and standards are the things that need to happen now in order for any of the Roadmap work to continue. Organizations need to know what standards the state will land on before they commit time or resources to building any tools or technology that will enhance integration.” One suggestion was made to utilize Minnesota’s existing administrative uniformity infrastructure, as well as the e-Health Advisory Committee resources, to begin work of developing data standards for priority settings where those standards do not yet exist.

E-Health Collaboratives Grant Program

The overall goal of the e-Health Collaboratives grant program is to support the secure exchange of information across health settings for the purpose of more effective care coordination. Eligible applicants for the grant program were community collaboratives (not individual organizations) that had at least two or more organizations participating in, or planning to participate in, an accountable care organization (ACO) or similar health care delivery model that provides accountable care. Collaboratives were also required to include a partner organization from the four priority settings: local public health departments; long-term and post-acute care providers; behavioral health providers; and social service providers.

To date, there have been two rounds of funding under this grant program. Round 1 commenced in the fall of 2014 and funded 12 grantees, six of which were awarded development grants and six of which were awarded implementation grants.²⁵

- **Development grants.** Development grants were focused on creating a detailed development plan for the implementation of e-health that will advance the collaborative along the Minnesota Accountable Health Model. Development grantees completed their 12 month grant period in 2015.
- **Implementation grants.** Implementation grants focus on implementing the adoption and effective use of EHR systems and other health information technology including health information exchange. Implementation grants were initially 18 months long, although a number of grantees have received extensions. Most grants are expected to end in December 2016.

Round 2 began in the fall of 2015 and consists of four grantees (all implementation grants). Two of the four Round 2 implementation grantees are community collaboratives that had previously been awarded

²⁵ SHADAC prepared maps of each of the 12 Round 1 e-Health Collaboratives, which are publically available on the evaluation page of the State of Minnesota’s State Innovation Model website.

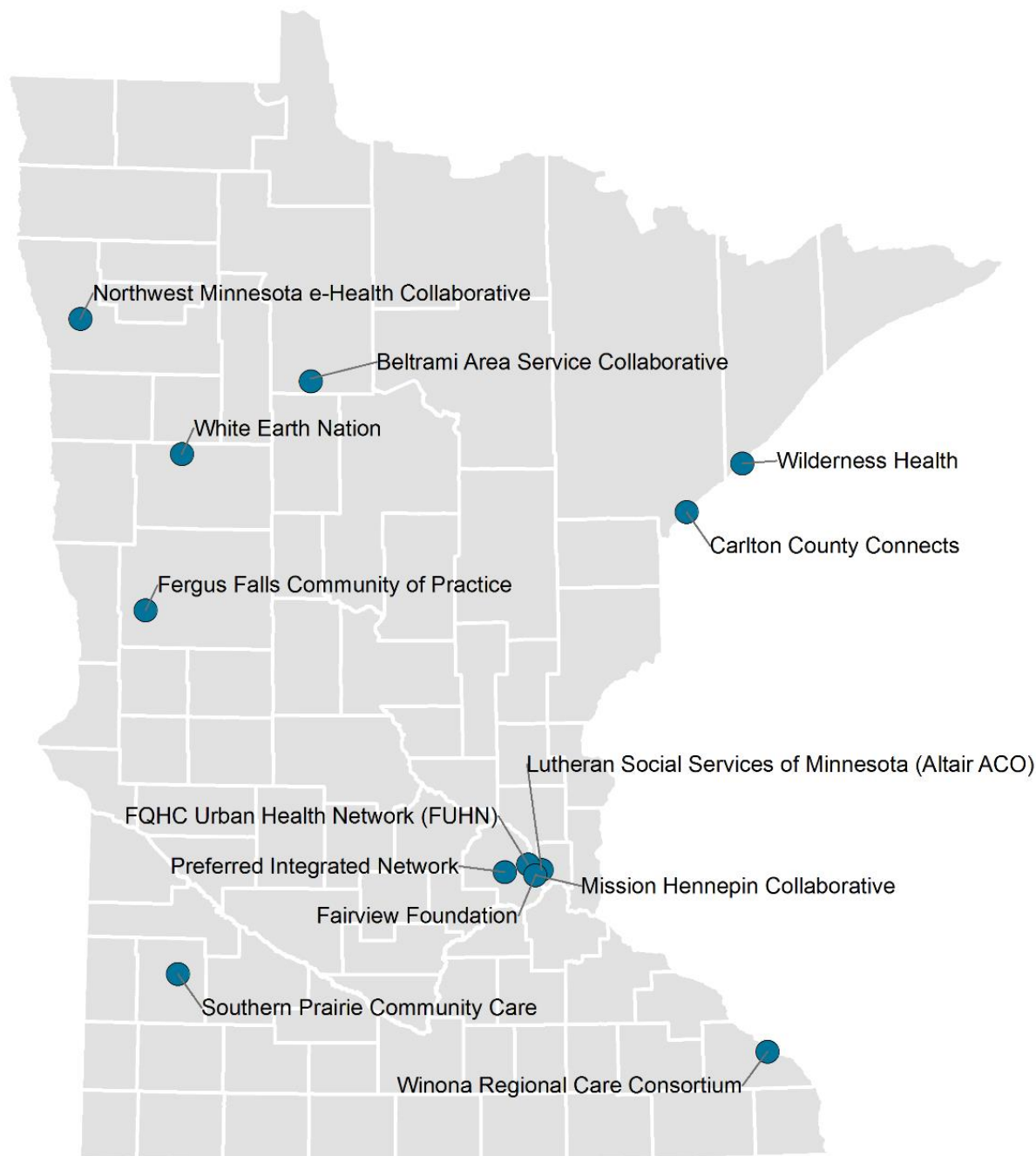
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development grants in Round 1; one grantee is a continuation of a Round 1 implementation grant; and one grantee was a new award under this grant program. In contrast to Round 1 grantees, Round 2 grantees were required to include two partners from the four priority settings (Round 1 grantees were only required to include one partner from the priority settings).

The following map (Exhibit 3.4) identifies the 13 e-Health Collaboratives (which represents 160 participating organizations, including vendors) that have received either Round 1 or Round 2 e-Health Collaborative grant funding (both development and implementation awards). It provides an overview of the 13 e-Health Collaborative grants totaling \$4.9 million, located according to the address of the applicant organization. These organizations span ten counties across both urban and rural areas of the state.

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Exhibit 3.4. E-Health Collaboratives



Source: SHADAC, *Database: Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative*, University of Minnesota, School of Public Health. Minneapolis, Minnesota. Dec. 2015.

Notes: Database is based on state documentation, grant applications and agreements, select progress reports, organization websites, and consultation with the state.

Individual e-Health Collaboratives range from five participating organizations in the White Earth Nation development grant in the city of White Earth, to 30 organizations in Southern Prairie Community Care

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implementation grant in southwestern Minnesota. Additional information on the award amounts, community collaborative participants, and individual grantee project descriptions can be found in Appendix E.

Because Round 2 e-Health Collaboratives recently began in fall of 2015, the focus of this report is on the activities and insights observed from Round 1 grantees. The following sections summarize the major activities undertaken by the Round 1 e-Health Collaboratives, identify early outcomes, and identify continuous improvement, policy and sustainability considerations for e-health HIE work going forward. These findings were ascertained through SHADAC's review of grant program materials and grantee reports to the state, and interviews with state staff and participants from all 12 of the Round 1 e-Health Collaboratives. Most of the interviews with e-Health participants (n=26) were face-to-face discussions that took place in August of 2015. SHADAC targeted representatives from the organizations that were recipients of the grant award for these discussions. Topics of discussion included: grant activities; barriers and facilitators to implementation of activities; accomplishments; relationship to other SIM or e-Health work; and sustainability insights. In future qualitative interviews, SHADAC and its contractor, Rainbow Research, will reach out to additional organizations involved with e-Health Collaboratives.

Key Activities

Round 1 e-Health development and implementation grantees began their work in the fall of 2014. While each of the grantees had different partners and project goals, many carried out similar work. The following is a summary of the common grant activities completed by the Round 1 development and implementation grantees, as indicated in grantee reports to the state and through interviews with each of the 12 collaboratives.

HIE Readiness Assessments

Seven of the 12 grantees reported that their collaborative partners completed an organizational readiness assessment for HIE as part of the kick-off of their work together. These assessments were often used to identify the capabilities of partners' current EHR or record systems, to identify current and future-desired data sharing elements, and to assess partners' knowledge and understanding of HIE in general. In many cases, grantees contracted with a vendor to design, facilitate, and summarize the findings from the readiness assessments. A number of grantees reported that the assessments confirmed what they had originally expected, that their collaborative partners' knowledge, understanding, and ability to move forward with HIE varied widely depending on the organization. Several grantees also noted that hospital partners tended to be the most ready to implement HIE. Participants built the knowledge gained from HIE readiness assessment results into their implementation plans and timelines, and in many cases tried to phase the work based on which organizations were ready to proceed first.

HIE Education and Communication

Both development and implementation grantees indicated that a significant amount of their grant time and energy was focused on the ongoing communication and education activities needed to keep the

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project partners engaged and active in the process. Even collaboratives that felt they had early stakeholder buy-in or a well-defined process for implementing HIE made note of the amount of education they had to provide at every level (from patients,²⁶ to providers, to high-level administrators) about the definition and capabilities of HIE, and what the project goals would entail. Grantees utilized a number of different education and communication tactics to share that knowledge, including hosting webinars, individual organizational meetings, joint collaborative partner training and educational sessions, and community stakeholder meetings.

Governance Issues

Many collaboratives reported investing significant time addressing governance, legal, policy, and business operational issues that would allow partners to share information in the ways desired. Five of the six implementation grantees have put a formal governance and decision-making process structure in place to oversee the e-health grant activities. Two of those collaboratives have agreements or Memorandums of Understanding in place among the collaborative members that address the grant obligations. Three implementation grantees either had previously established, or established as part of their grant activities, a new non-profit corporation that oversees the HIE work. One of those grantees, Southern Prairie Community Care, became certified as a State-Certified HIO provider. Through that process it has established a comprehensive suite of policies and procedures to govern the way health information exchange will work in its community. The sixth implementation grantee reported that they had established an informal governance body with representation from the various project stakeholders, but that they currently had no binding agreements among the partners. They are, however, in the process of exploring whether that step will be necessary for them.

Privacy and Security Legal Issues

Both implementation and development grantees spent considerable time addressing privacy and security issues among their collaborative partners. Some of the newly formed collaboratives spent up to the entire first year of the grant period going through and addressing a privacy and security risk assessment process. A number of the collaboratives, including both development and implementation grantees, reported that completing a privacy and security assessment was one of the most informative and worthwhile grant activities they completed. One grantee noted, "Putting together the privacy and security work plan was eye opening for both our board and IT subcommittees." Several collaboratives also reported spending significant time in the first grant year working through patient consent related issues, and ultimately drafting their own consent or release of information policies.

Care Coordination Model Development

Many grantees indicated that the goal of improving care coordination was the cornerstone of their HIE work. In some instances collaboratives reported that care coordination activities were already happening among the collaborative partners, although in informal ways and often by individual dedicated providers who felt it was just "the right thing to do." In other instances, collaboratives

²⁶ One community collaborative reported directly engaging patient stakeholders in their HIE development process.

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reported that new external forces, such as revelations from IHP data, were causing them to look at implementing new care coordination models. The work to define a care-coordination delivery model, and identify how HIE would support that model, was a major focus of many of the grantees. A number of grantees reported that they realized they needed to spend additional time addressing their care coordination work flow issues before they could get more precise about exactly what kind of information they needed to exchange and how they wanted that process to happen. Some collaboratives addressed those work flow issues through the development of use cases. Other collaboratives reported holding mock care coordination meetings.

Data Sharing Preparation

Deciding what data to share, and in some cases developing standards for non-clinical data sharing, are two of the main first steps several of the collaboratives took toward achieving their goal of sharing information electronically. Collaboratives varied in the types of data they focused on sharing. A number of collaboratives focused initially on exchanging hospital admission, discharge and transfer (ADT) data and summary of care records, such as Continuity of Care Documents (CCDs).²⁷ Other collaboratives worked on identifying data outside of the standard medical CCD structure that they wanted to exchange, such as mental health data or long term services and supports data. Some collaboratives focused on sharing information among collaborative partners via Direct²⁸ secure messaging.

HIE Vendor Selection

Almost all of the grantees reported spending considerable time evaluating and selecting a HIE service provider. While many of the grantees had originally proposed to connect to the Community Health Information Collaborative (CHIC) as their State-Certified HIE service provider, CHIC's withdrawal of its application to be recertified as a Health Information Organization (HIO) in Minnesota forced a number of the grantees to initiate a vendor selection process that they had not anticipated. The vendor selection process varied, but a number of collaboratives developed and distributed their own Request for Proposals to anywhere from three to 16 different vendors. In addition, many collaboratives reported setting up multiple live demonstrations from the vendors in order to gain a better understanding of the capabilities of the vendors' products. Grantees also reported spending significant time talking to references of the HIE service providers. Two of the six development grantees were ultimately able to select a HIE service vendor by the end of their grant period. Five of the six implementation grantees have also completed their HIE vendor selection process and have contracts in place as of the end of 2015.

²⁷ A Continuity of Care Document (CCD), also known as a Continuity of Care Record (CCR) is a patient health summary. It includes the core clinical, demographic and administrative information that one health care provider can forward to another health care provider, such as patient name and contact information, procedures, relevant past diagnoses, lab test results, vital signs, demographic information, care plan, and active medication list and allergy list.

²⁸ Direct is a standards-based way to send encrypted health information directly to known, trusted recipients over the internet.

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Early Outcomes

The main deliverable and achievement of the development grantees was the completion of an e-Health development plan. The work of Round 1 implementation grantees is ongoing, and most projects are expected to end in December 2016. The following sections summarize the preliminary outcomes and achievements as identified by both the development and implementation grantees in their work to-date.

Discussion of HIE in the Community Accelerated

Numerous interviewees commented that the SIM e-Health funding gave them an impetus and legitimacy to bring collaborative members together around a table and have conversations about using HIE to coordinate care in their communities that would have not been possible otherwise. One participant observed, “The SIM grants have made HIE a discussion topic on the table. If we didn’t have the SIM e-Health grants we’d have a market driven process, and it might have been 5 years before these organizations would have had this discussion.” Another participant explained, “The grant provided some visibility and authority to take on the project, and it provided a roadmap for undertaking the work. Even though we may have had difficulty engaging the right people in the necessary timeframe, the main accomplishment was in getting people even thinking about the issue.” A SIM Leadership Team member also noted the important role SIM funding has played to-date in shaping community HIE discussions, commenting: “The SIM process exposed problems with the [market-based] path we [the state] previously went down on HIE. It exposed gaps.”

Grantees also reported that the grant gave them a focused, structured way to articulate the components of information that should be the priorities for HIE among the various partners, and an opportunity to learn about what they were capable of doing in HIE. For example, one collaborative found that there were no technical data standards for long-term services and supports data, such as assessments and care plans, that they were interested in exchanging. As a result of the grant process, they were able to set aside time to work as a group to define the data domains and the elements for each domain.

Another participant commented that SIM’s overall focus on the social determinants of health has helped community based organizations gain a better understanding of what is happening in the health care market place, and how to be a viable player in health care settings. As one interviewee noted, “You never hear of people working together that don’t acknowledge social determinants. We’ve come a long way and that’s very exciting.”

Partnerships Deepened

A second commonly identified outcome of the e-Health grants was the formation, or deepening of, organizational partnerships. One participant explained, “We have been able to build a collaborative wrapped around an idea and come together. The implementing hasn’t happened yet, but coming together is no small feat, it’s a big accomplishment.” Another grantee noted that the grant process gave their collaborative the “time and space” to understand the complexities and challenges faced by other

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organizational partners. For example, one collaborative that was working with a Native American tribe reported gaining a new understanding of tribal governance processes and the importance of allowing sufficient time for information to be shared with different levels of tribal leaders. A number of grantees also commented that the SIM e-Health grants forced the issue of governance for their collaboratives. Several of the collaboratives had worked together for many years as a loose group of organizations, but through the grant program they were able to put a structure in place to identify and articulate priorities and share information.

Another grantee commented on the strengthening of business relationships that developed, and cost-efficiencies they discovered, by partnering with another organization that used the same information technology (IT) software to communicate with their public health agencies. By partnering, these two organizations were able to share the cost of software development and were able to structure their HIE interfaces in a way so that the local public health agency only had to connect to one HIE vendor. The organizations were also able to jointly select an attorney to assist them in the development of governance policies and procedures for how HIE would work in their communities.

Additional Opportunities for Partnerships and Funding

Grantees also cited success in their ability to leverage their e-Health grant to receive additional financial resources from other funding sources in order to support work for related projects, such as funding care coordination or integration model development work. One organization cited that its SIM e-Health Collaborative grant was a key contributing factor in its successful ability to enter into a new payment contract with a major health plan to pilot its new care coordination model.

Limited Electronic Exchange of Data

The overall goal of the grant program is to support the secure exchange of medical or health-related information between organizations and across settings. As of the writing of this report, two Round 1 implementation grantees have reported success in exchanging some type of electronic information across settings as a result of grant activities.

- **Fergus Falls Community of Practice:** Grantee progress reports generated for the date range of October 1, 2015 – December 31, 2015, indicate 167 messages sent through Direct enabled messages. That exchange is happening primarily between two project participants, a health care organization and a public health department.
- **Southern Prairie Community Care:** Grantee progress reports generated for the date range of October 1, 2015 – December 31, 2015, indicate 591 messages sent and 589 messages received using SPCLink (Southern Prairie Community Care's HIO) Direct enabled messages. In addition, six community organizations representing hospitals, clinics, county health and human services and public health departments, are actively transmitting data (ADTs and in some cases CCDs) to SPCLink's test and live environments. SPCLink reported 9,081 patients in the master patient index for SPCLink live environment as of October 30, 2015.

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Facilitators

Many collaboratives experienced successes or faced challenges in their planning and implementation work that were unique to their models. However, the focus of this and the next section is on the following common facilitators of success and challenges that were reported across the projects. Grantees were able to identify a number of factors that helped facilitate their planning and implementation work.

Committed Senior Leadership

Several collaborative project leads reported that strong and visible commitment from senior leadership was an important factor in their ability to achieve project milestones. A number of interviewees observed that project goals that were aligned with an organization's overall strategic plan, and that were championed by engaged senior leadership, made it more likely that the project staff were successful in their ability to carve out the time and get the attention of the participants they needed in order to move the project forward.

Robust Project Management

Many interviewees reported that having a dedicated project management lead was crucial to the success of grant activities. This individual's role included utilizing detailed project management tracking tools (something more robust than just a checklist), formulating realistic timelines that took into account multiple dependencies, and providing ongoing and intensive communication and education to collaborative partners and vendors. Almost all grantees observed that the time required to complete these tasks was often initially vastly underestimated. One collaborative commented, "When it comes to HIE implementation, you can't lead from behind. You have to push each and every day and lead that effort."

A number of collaboratives also noted the significance of facilitating face-to-face interactions and education for their community partners. For many groups, it was important for partners to hear the same information, all at the same time, in order to successfully come to a shared understanding. These face-to-face meetings also helped keep partners engaged and the project's momentum moving forward. Several grantees reported that project managers who were not local to the project, or who conducted all communication and engagement activities remotely by phone or by webinar, were not as successful in their roles.

The Promise of Data Analytics to Encourage Participation

A common strategy used by several of the grantees in order to successfully bring community partners to the table was the promise of future data analytics capabilities. Many of the community partners reported that they were far more interested in acquiring data analytics than in achieving HIE itself. Often, those organizations had previously invested significant time and resources in HIE systems that had never achieved functionality, and they were extremely hesitant to invest in another untested system. Several collaboratives used the promise of future data analytic capabilities to help drive the value proposition for what they could offer through the HIE in order to overcome providers' initial

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hesitance to participate. For example, one collaborative decided that their method for delivering claims data reports to their Integrated Health Partnership (IHP) provider members would only occur through Direct secure messaging. That requirement provided the catalyst for providers to invest the time and resources needed to get their Direct messaging capabilities off the ground, which might not have happened otherwise.

Setting Achievable Goals to Build Momentum

Several collaboratives mentioned the importance of achieving small, but meaningful, first steps in order to build trust among the community partners and momentum for the project. For example, some collaboratives noted the success of adopting a “crawl, walk, run” mentality focused on implementing Direct messaging among their community partners as a first attainable step.

A number of collaboratives who did not start out by setting small, achievable first steps, reported slower overall progress on their project milestones. A few grantees remarked that their original project proposals had included ambitious goals, such as establishing a query-based HIE system in order to facilitate care coordination across settings, however as implementation work began, these collaboratives found they had to narrow those goals down to more manageable objectives. Overall, these collaborative project leadership teams often struggled with whether they should take small, potentially achievable first steps (such as establishing Direct messaging capabilities among current partners), or whether they should continue to invest in infrastructure and governance models that might eventually allow them to achieve longer-term goals such as establishing data warehouses with a wider set of partners. The time and energy spent deliberating these questions slowed down the overall progress on project milestones for many of these grantees.

Open Communication with the State

A related implementation facilitator, mentioned by numerous grantees, was a perception of the state’s willingness to communicate openly and be flexible with project goals and objectives. Several grantees indicated that although they felt the state was not always able to provide the kind of support or advice the collaboratives desired (such as specific advice about how to proceed when CHIC was not recertified), the collaboratives did appreciate that the state was willing to have constructive conversations with grantees about how to adjust project goals and pursue alternative solutions in the face of unforeseen challenges. Ongoing communications and iterative dialogue about project goals between the state and collaborative project leads was cited by several grantees as key to building a sense of trust and a shared understanding of expectations. As one grantee explained, “The state has been understanding of our issues and the challenges that have come up, and they’ve agreed to flex with our revised proposal, continue the funding, and see what happens. It’s been the most iterative grant process I’ve ever been a part of.”

Several grantees also mentioned the value of the state’s role in facilitating communication among the various collaboratives, such as through the quarterly grantee conference calls. A number of interviewees also indicated that they would have liked to see the state do more of that type of convening, especially

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in-person. One collaborative suggested that the state should convene the Round 1 and Round 2 grantees and host a “what I wish I would have known” discussion session so that grantees could learn directly from each other.

Addressing Governance and Care Model Issues Before Technology

A number of the collaboratives stressed the importance of addressing governance issues and finalizing care coordination models before deciding on a technology or vendor solution. One collaborative commented that they felt the technology solution they ultimately would end up with was stronger because they had spent significant upfront time understanding their patient’s needs, defining their care coordination plan, and ensuring that all parts of the care team knew how they were going to be involved. Another grantee noted that “sharing data does not automatically equal coordinated care. Senior leadership had to be clear with the IT staff about what the care model and work flows needed to look like so that IT could build a system to support that.” One collaborative that had committed to a technology vendor before finalizing their governance and care models found that they had to make significant adjustments to their technology configurations along the way as their governance and policy procedures were modified.

Challenges

Lack of Familiarity with HIE Among Collaborative Partners

A common challenge identified by interviewees was an overall lack of understanding regarding what HIE actually entails and how HIE could be used in their care setting. Many grantees reported that because there was a wide variation in collaborative partners’ knowledge of HIE functions and terminology (such as the differences between push and query capabilities),²⁹ project leads often underestimated how much time and communication would be necessary to arrive at a common understanding of what HIE capabilities would be achieved through the project. It was not uncommon for both development and implementation collaboratives to report spending many months meeting with partners to discuss HIE capabilities and assessing their readiness to participate in HIE activities.

One stumbling block noted, especially by those grantees who were attempting to interface with an Epic EHR, was the difficulty they reported in convincing project partners of the value of true bi-directional communication. Several project participants mentioned that they already had access to an Epic module that allowed for view-only access to their patients’ data, but felt that was insufficient for the type of integrated care model they envisioned. One interviewee explained, “Our corporate organization felt we were already meeting HIE requirements, and kept asking us why don’t you just use EpicCare Link? We had to continually try to educate them that that viewing an Epic module was not achieving true interoperable health information exchange.”

²⁹ In a query-based exchange a user can “pull” information about a patient. As opposed to a Direct-based exchange where a user needs to “push” information about a patient to a known user/organization.

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Insufficient Internal Staff Resources to Manage Grant Activities

Another major challenge identified by interviewees was insufficient internal staff capacity, mostly due to the under-estimation of the time needed to achieve grant goals and milestones. Many aspects of the project management, especially grant management duties such as completing budget revisions necessary for the unrestricting process, revising project work plans, and tracking and submitting invoices were noted as burdensome for grantees. In addition, grantees mentioned their difficulty in dedicating enough staff time toward the ongoing communication and education activities that were needed to keep the project moving forward. It was not uncommon for project management staff of some collaboratives to report needing to communicate daily with their partners in order to ensure that the participants understood what was expected of them and that vendors were following through on their to-do lists. Instances of staff turnover in that project management role, or lag in bringing on a staff person into that role, created delays, which sometimes slowed momentum.

Complex Governance and Data Privacy Legal Issues

Establishing governance structures and addressing data privacy legal issues were other commonly identified challenges for grantees. Numerous interviewees stated that they had underestimated both the difficulty and the amount of time and resources it took to establish a governance structure that could accompany the technical solution to health information exchange. Collaboratives looking to exchange information across unaffiliated organizations had to incorporate feedback from multiple sets of attorneys and varying legal opinions, which made reaching an agreement among all parties challenging.

Many interviewees also commented on the challenges data privacy issues present when trying to exchange health information. Grantees noted that Minnesota's strict state data privacy laws (see Exhibit 3.1) make it difficult to actually implement true HIE, and many project teams spent a great deal of time trying to devise a feasible solution. One collaborative estimated that 80% of their project's workgroup time over the past year was focused solely on working through consent related issues. Another grantee mentioned that the key challenge in Minnesota's data privacy laws is the requirement of obtaining written consent before sharing information. This collaborative felt that getting consent to share data in writing is logistically challenging and causes delays in effective care coordination. Numerous grantees expressed desire to see the state develop a standard data use agreement that would work within the Minnesota rules that they could use to facilitate this process.

Varying Levels of Partner Readiness to Implement HIE Through EHRs

A common challenge, especially for the implementation grantees, was the varying levels of collaborative partners' readiness to implement the technical capabilities of HIE within their EHRs. Grant budgets and timelines were often based on establishing exchange with "ready" EHR systems (those that already had the capabilities for sending, receiving and querying Information). Prioritizing HIE work, both within an individual provider organization and with EHR vendors themselves, was challenging. Many of the partner organizations reported facing other competing health information technology (HIT) priorities, which are often planned out years in advance. Several collaboratives experienced delays trying to finalize

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commitments from partners because those provider organizations had their resources tied up in meeting other meaningful use requirements. For example, one collaborative mentioned that their mental health provider partners' EHR systems did not have their meaningful use exchange capabilities scheduled to be implemented until the 2nd or 3rd quarter of 2016, which did not align with the timelines of the grant. Moving HIE readiness work up on the HIT priority list resulted in additional, unanticipated costs for those providers.

Grantees also reported challenges with the wide variability in the quality of IT support available, especially in small and rural organizations. Those organizations that did not have in-house or onsite IT resources to help prepare EHR systems for HIE were dependent on their EHR vendors' skills and capabilities. One collaborative shared the example of a partner organization in the public health setting who was willing and excited to engage in HIE, but who could not participate due to the inability to complete the work necessary, such as building, testing and implementing interfaces to get their electronic systems ready for HIE.

Workflow Issues

Addressing workflow issues was a major obstacle for several grantees who were trying to implement HIE protocols. One participant commented, "Electronic messaging needs to be efficient, it needs to be embedded in the EHR; otherwise it disrupts workflow almost as bad as using paper records. In some cases, electronic fax is currently more efficient than Direct messaging."

In addition, when addressing workflow issues, collaboratives faced yet unresolved decisions about who would ultimately be responsible for coordinating care among partners. As one collaborative explained, "In planning for an environment where care is shared and coordinated among different organizations, it will be important for everyone to understand who has primary responsibility for a patient's care. If everyone gains access to data it will be vital to know who is empowered with making decisions about what to do with that data and to clearly define the role each different organization will play in delivering better outcomes and reduced total costs of care. Shared treatment plans do not automatically equal coordinated care."

Difficulty Identifying a Capable HIE Service Provider

CHIC's sudden withdrawal of its application to be recertified as a Health Information Organization (HIO) in Minnesota in the spring of 2015 presented a major challenge to grant project timelines and goals. Grantees also struggled to identify and understand the true functionalities that the remaining HIE service providers could offer. They reported that vendor's websites often did not provide detailed information about their service capabilities, and a number of grantees spent considerable time developing RFPs in order to assess HIE vendor functionalities and qualifications. Some grantees reported that they had difficulty getting HIE service providers to return calls or respond to them in a timely way. When grantees were able to schedule in-person or virtual vendor demonstrations, those presentations often revealed that the HIE service providers did not have capabilities to support the care management goals the collaboratives had envisioned. A few grantees did report that a vendor had offered to create a

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product from the ground up – but the price was too high and the timing would take too long for that to be a viable option for those grantees.

The lack of true understanding of the HIE marketplace capabilities made several projects challenging, and project goals, expectations, and timelines had to be modified during both the development and implementation processes. A number of project leads reported spending time managing partners' expectations regarding what would be possible during the grant project timeline. Some development grantees ultimately were not able to select a vendor as they had originally envisioned because of this lack of clarity around vendor capabilities. Numerous grantees expressed a desire for the state to collect, consolidate, and share information on HIE service provider capabilities and pricing.

Conflict Between Grant Program Goals and the Current State of Minnesota's HIE

Several of the interviewees expressed frustration with a conflict they observed between the overall goals of the e-Health grant program (to support the secure exchange of information across settings for the purpose of more effective care coordination) and their perceived limitations of Minnesota's current HIE structure (requiring connection through a HIO or HDI which only supports the exchange of standard electronic data). Several grantees indicated that in order to facilitate the robust care coordination they envisioned, they wanted to be able to exchange nonclinical data that did not fit into a standard Continuity of Care Document (CCD) structure. As one interviewee explained, "I think the state thought, 'we have all this data, we ought to be able to use it for care coordination.' But when you get into the realities of a community based care coordination process, it doesn't fit with our HIE structure."

Some grantees assumed that because the grant program would only cover HIE subscription costs associated with State-Certified HIE service providers, that those vendors would be capable of exchanging data in a format that would support the care coordination models the collaboratives had envisioned. However, that assumption ended up not being true for a number of the grantees, especially for those partnering with unaffiliated organizations that did not already have electronic health records (EHRs). As one interviewee noted, "We were naïve. We didn't know the right questions to ask to understand the state's HIE requirements and limitations. We assumed it would work, because they told us to use it."

Policy Considerations

A number of e-Health grantees (and Roadmap project participants) identified policy or legislative changes that they felt are needed in order to successfully achieve HIE that will support integrated care delivery.

Establishment of a Single Statewide HIE Entity

Grant participants overwhelmingly called for the state to re-examine its market-based approach to HIE, and to move toward a single statewide HIE entity. Grantees stated that they felt the prospect of payment reform has significantly altered the HIE environment, making the success of a statewide HIE more likely. One participant explained, "The environment is different now than when Minnesota first tried a statewide HIE entity in 2004 and with CHIC. Previously, the focus was on exchange for exchange's

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sake. Now the focus is on the need for exchange that will help providers be accountable for change and total cost of care.”

Participants remarked that the current market-based approach is complex, expensive, and that there’s no incentive for different vendors to work together. One participant noted, “The cost of HIE is way higher than we thought it would be two years ago. There’s no way small entities can afford even a basic HIE connection. These HIE vendors are all for-profit companies. If they’re expecting to make a profit they can’t make it off the little guys, especially in rural areas.” Another participant commented, “Why are we paying a lot more for all of these private for-profit companies when that money could be going back into care? When there’s multiples of that [HIE vendors] it exponentially increases the cost and technical connections that you need to put in initially. All the costs associated with writing participation agreements for everyone makes no sense. Maybe we should go for a model like some of the other states where HIE is like a non-profit utility that serves all. As a citizen I don’t want my money going to support all this waste.” Another participant agreed with the concern about the role of the market in a community-based approach, “Capitalism is great but we’ll never be able to standardize because everyone thinks they have the next great idea that will make their HIE better. Instead of sharing it, it’s viewed as intellectual property and we’ve got to hammer it home against the competitors.”

Participants also voiced concerns about the perceived lack of clear direction from the state on this issue. Some providers felt unsure whether the state was going to continue to support multiple regional HIEs or if it would eventually go to back to one statewide entity. Smaller community organizations, in particular, reported their hesitancy in “pulling the trigger” on selecting a HIE vendor because they didn’t want to make the wrong decision. A number of participants had previously invested significant time and resources to get connected for an exchange, only to see it fail. Some of these participants indicated that they didn’t want to commit to a new product unless they were confident that was the direction the state was going to go.

Development of an Infrastructure for Shared Data Services

In the absence of establishing a single statewide HIE entity, participants encouraged the state to explore developing statewide HIE shared services, such as consent management or an electronic record locator system. As one participant explained, “If the state is going to go with a market driven process, then you need an entity to connect all these things. The shared services are the backbone. If you’re going to move clinical data across the whole state, you have to have a common point.” Participants repeatedly expressed frustration at the duplication of efforts they all were experiencing in areas of developing governance, data sharing agreements, and consent management policies.

State Certification of Federally-Recognized HIE Service Providers

A third policy recommendation made was the desire to update Minnesota’s HIO oversight law to allow for state certification of federally-recognized HIE vendors. Currently, HIE vendors who meet national HIE standards still have to apply for Minnesota’s Certificate of Authority in order to provide HIE services in the state. A number of providers reported that they had previously chosen a certified EHR vendor that

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meets meaningful use requirements, but because it is located out of state, they could not utilize the embedded HIE functionality and still meet the legislative HIE requirements. Some providers reported hearing from their EHR vendor that it does not have enough business in Minnesota to make it worthwhile for it to go through the state's regulatory process to be certified as a MN HIE service provider.³⁰ This dilemma forces a provider to either scrap its EHR system in favor of one that works with a local HIE service vendor, or exchange information outside of the state's requirement. One participant explained, "I'm technically not meeting the state requirement even though I can share the data because the vendor isn't certified in the state."

Consider Stronger Economic Incentives/Mandates to Encourage More Data Sharing

A number of grantees commented on their desire to see stronger payment incentives, or even mandates, that would encourage organizations to share data outside their own organizational walls. While the prospect of payment reform appears to be accelerating conversations among providers about the need for data in order to know what is happening to their patients, the actual number of value-based payment arrangements is small. One suggestion was made to require that hospitals provide every IHP real time clinical data on the patients they serve as a condition of participation in Medicaid. An additional suggestion was made to look at HIE models from other states, such as the Blue Cross Blue Shield Physician Group Incentive Program Health Information Exchange Initiative in Michigan. This program provides financial incentives to physicians' organizations that participate in the statewide admit-discharge-transfer (ADT) notification service.

Sustainability Insights

Overall, many e-Health Collaborative grantees expressed concerns about the sustainability of the HIE work they had begun under both the development and implementation grants. Some of the most commonly identified sustainability considerations are below.

Costs of HIE Investments

Several grantees raised concerns about the high costs of HIE activities. Collaboratives reported receiving HIE vendor proposals ranging from \$150,000 up to \$525,000. Questions about who should be responsible for the ongoing costs associated with HIE connectivity are being asked by many of the collaboratives. Financial sustainability was an important consideration for many of the collaboratives as they initiated conversations and participated in demos with HIE vendors. One collaborative reported eliminating vendors who offered attractive services at the outset because of unaffordable costs over time. They stated, "We didn't want to fall in love with a system that wasn't going to be affordable." In addition to the ongoing HIE subscription costs, collaboratives reported struggles with identifying resources to cover the costs of EHR software updates necessary for HIE connectivity.

³⁰ A number of changes were made to the HIO oversight law in 2015 that were aimed at streamlining and simplifying the HIO/HIE certification process, including clarifying that large EHR vendors, such as Epic, do have to be certified.

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Aligned Economic Incentives

Collaboratives reported that having a sightline to shared savings payments was an important factor that facilitated success of their HIE activities. Several implementation grantees noted that their ongoing HIE work was either made directly possible by shared savings payments, or the promise of future shared savings. One collaborative commented that because they participated in an IHP that had already achieved savings, they were explicitly recommending that their provider partners use some of their shared savings payments to cover the ongoing HIE costs not covered by the grant. Another collaborative shared that “if our savings continue at the rate they have, it will be sufficient to fund the ongoing HIE operational costs. There’s a lot less reluctance about that then there was a year ago because we didn’t know if the money would be there. We feel differently now, but it is all tied to our ability to achieve savings.” Collaboratives that did not have a direct sightline to shared savings payments reported greater difficulty in identifying ways to pay for the ongoing operational costs of HIE connectivity, as well as greater difficulty in convincing partners to invest in HIE in the first place.

Concern About the State’s Ability to Achieve True Statewide Exchange

Because there is no formal requirement that the various collaboratives be able to exchange data with each other, some collaboratives wonder whether their work will result in the creation of 12 isolated exchanges across the state. As one interviewee noted, “They’re creating castles with moats and there are very few bridges.” Grantees worry that the potential cost and time commitments required to build the connections necessary to communicate with 12 different collaboratives will be prohibitive. One project participant did note, however, that through the grant process they had settled on an approach, developing an Application Programming Interface, API (a web-based app that enables an application to integrate with an EHR), rather than connecting to a single State-Certified HIE, that they felt was more feasible to scale and would be more financially sustainable in the future.

Lack of Funding for Care Coordination Work

Several collaboratives also reported facing challenges in identifying a viable and sustainable funding source for the care coordination work that is expected to be enabled by the HIE capabilities. Because e-Health grant funds only covered technical aspects of HIE development, collaboratives (especially those without a direct line of sight to shared savings payments) reported struggling to identify how to pay for the care coordination work they wanted to implement within their new models. Collaboratives worried about their ability to prove accomplishments of the grant funds since the state wouldn’t support “putting that new data into play.” One grantee commented, “We’re worried we’re going to have an elegant system and not have the people to use it.”

Some grantees noted that upfront investments for things like care coordination and providers’ fees were especially important for Medicaid providers that do not typically have those resources available. One interviewee observed, “...Other states are making upfront investments with care coordination fees and provider fees. Minnesota is unique in that no state resources have gone into this so far. When you talk with other states you always hear that they couldn’t have done this without sustained funding to cover operational investment.”

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4. ACCOUNTABLE CARE ORGANIZATIONS

Introduction

Accountable Care Organizations (ACOs), provider delivery systems that manage the health care needs of a defined population through performance and financial incentives, are one of the building blocks of the Minnesota Accountable Health Model. Drivers 2 and 5 of the Model both pertain to the advancement of ACOs in Minnesota, both in the Medicaid program and across other payers. Though implemented prior to the Minnesota Accountable Health Model, the Minnesota Department of Human Services' (DHS) Medicaid ACO demonstration—called the Integrated Health Partnerships (IHP) program³¹—has been a testing ground for many of the investments in Drivers 2 and 5.

Specifically targeting Medicaid ACOs participating in the IHP demonstration, the goal of Driver 2 activities and investments is to provide IHPs with better data analytic tools to systematically manage risk, lower health care costs, and improve the quality of care. The goal of Driver 5 is more expansive: to standardize the performance measurement, competencies, and payment methodologies of ACOs and ACO-like arrangements across payers in Minnesota.³²

Guided by the work of the state's Data and Infrastructure and the ACO Requirements and Performance Workgroups, as well as external stakeholders who serve on the Community Advisory and Multi-Payer Alignment Task Forces, DHS and Minnesota Department of Health (MDH) staff have translated Drivers 2 and 5 into the following key investments in 2014 and 2015:

- **Enhanced reporting to Medicaid IHPs.** DHS and its contractor (SAS Institute) made enhancements to standard IHP reports and developed and launched a common portal (the "DHS Partner Portal") for ease of access in the first quarter of 2015. User training was provided via webinar to all IHPs, and data user group meetings with IHP analytic staff have been held to discuss reports and enhancements to reports available through the portal.
- **Technical assistance to IHPs.** DHS developed and released a Request for Proposals (RFP) in early 2015 for a vendor to provide consultative services to DHS and technical assistance in the area of data analytics to new and existing IHPs. 3M Company (hereafter referred to as 3M) began an 18-month contract to carry out technical assistance activities beginning in June of 2015, with a total award amount not to exceed \$1.75 million.

³¹ Minnesota's IHP demonstration, implemented in 2013, was originally called the Health Care Delivery Systems (HCDS) demonstration.

³² See Minnesota Accountable Health Model Driver Diagram in Exhibit 1.1 of this report. Also available at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_182962

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- **Data analytic grants to IHPs.** DHS released an RFP for IHP data analytics grants in April of 2015. New and existing IHPs were eligible to apply for and receive grants to support their own investments in data analytics. Ten IHPs have been awarded data analytic grants between \$100,000 and \$500,000, with grant terms between August 2015 and January 2017.³³ Thus far, a total of \$3.78 million has been awarded to IHPs under this grant opportunity.
- **ACO Baseline Assessment.** As a first step toward alignment of ACO components across multiple payers, MDH—through a contract with IBM/KPMG—conducted a baseline survey of ACO and “ACO-like” arrangements in Minnesota. Through this survey as well as interviews and focus groups with representatives from provider organizations and health plans, IBM/KPMG gathered and synthesized information about the scope and characteristics of existing ACO arrangements in the state.

As the state’s contractor for Minnesota’s SIM evaluation, the State Health Access Data Assistance Center (SHADAC) conducted interviews in the fall of 2015³⁴ with a mix of executives, administrators, and clinicians (n=61) from 15 of the 16 IHPs. In addition, SHADAC spoke with state program staff at DHS and MDH associated with Drivers 2 and 5 of the Model. It is important to note that at the time of these interviews, IHP data analytic grant and technical assistance activities were just getting underway. So while we provide insights into these activities in this chapter, SHADAC plans to more thoroughly evaluate these activities in 2016, once IHPs have had an opportunity to make progress on their data analytic projects and to engage with DHS’ technical assistance contractor, 3M. This year, our interviews focused on the progress IHPs have made in the areas of clinical innovation, data analysis, physician engagement, and community partnership development. Finally, we do not discuss the state’s ACO baseline assessment in detail, as the findings from and limitations of this study have already been well-documented by IBM/KPMG and MDH as part of the SIM grant.³⁵

In this chapter, SHADAC summarizes our findings about Medicaid ACOs in Minnesota by synthesizing key activities, early outcomes, opportunities for continuous improvement, and program sustainability issues across IHPs.

³³ The Federally Qualified Health Center Urban Health Network (FUHN) is not included in this total. FUHN applied for a data analytics grant, but as of the writing of this report, FUHN’s contract has not yet been executed.

³⁴ Note that interviews with Round 1, 2, and 3 IHPs were either in-person or telephone discussions conducted during October and November of 2015 and addressed IHP innovation, quality measurement, physician performance management and engagement, data analytics and reporting, and sustainability insights.

³⁵ “Baseline Assessment of ACO Payment and Performance Methodologies in Minnesota for the State Innovation Model (SIM).” IBM/KPMG, prepared for the Health Economics Program, Minnesota Department of Health. May 2015. Web. Feb 2016

<http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Renderition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_197638>

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Background

In contrast to some areas of Minnesota’s Accountable Health Model, many of the investments discussed in this chapter are meant to accelerate a program that existed before the SIM award. In 2010, the Minnesota Legislature mandated DHS to develop a demonstration project to “test alternative and innovative health care delivery systems, including ACOs that provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement.”³⁶ The intent was to improve the quality of health care services and lower costs in publicly-funded health care programs in Minnesota as well as to align with new opportunities available to states under the newly-enacted Affordable Care Act (ACA).

In early 2011, planning for the “Health Care Delivery Systems (HCDS)” demonstration became an important component of a package of policy and budget initiatives challenging managed care and fee-for-service delivery systems to deliver more cost-effective care in the context of an historic \$6.2 billion state general fund budget deficit. Developed to operate alongside the long-standing participation of managed care organizations in Minnesota’s public programs, the HCDS demonstration was also designed to create new options for Medicaid providers to directly share in the gains and risks of developing clinical models that would improve quality for Minnesota health care program enrollees and to test payment models that would increase provider accountability for these improved outcomes.

Several mature, vertically integrated health care systems in the Minnesota market were not only interested in demonstrating their value to the state, but were already participating in Medicare Pioneer ACO/Shared Savings programs and well-poised to provide the infrastructure necessary to jumpstart the state’s initiative. The state aligned its own initiative with these existing initiatives in order to reduce the burden on participating providers and encourage greater participation. In January 2013, the state entered into contracts with five HCDS delivery systems in the Minneapolis/St. Paul metropolitan area, and one delivery system in northern Minnesota. These delivery systems contracted with DHS to participate in a shared savings/risk program based on a total cost of care (TCOC) calculation and other quality metrics, and provide comprehensive care to Medicaid and MinnesotaCare enrollees.

High-level requirements for participating HCDS providers included developing new care models and strategies to provide comprehensive and coordinated services, engaging and partnering with patients and families, and instituting formal partnerships with community organizations to encourage the integration of social services into clinical care. However, participating delivery systems had significant flexibility to design, develop, and refine their own clinical models and innovations. Importantly, the state’s goal for the demonstration was not to create one model, but to encourage the creation of many. To that end, the state provided flexibility for either small or large organizations to participate; “integrated” delivery systems take on upside and downside financial risk, while non-integrated delivery systems can participate as “virtual” partners with upside risk only.

³⁶ Minnesota Statutes §256B.0755.

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Integrated Health Partnerships

Since the inception of the program in 2013, DHS has renamed the HCDS demonstration the IHP demonstration. Ten more delivery systems joined the demonstration as IHPs in 2014 and 2015, for a total of 16. And, as of the end of 2015, IHPs have approximately 225,000 attributed lives.³⁷ Exhibit 4.1, below, provides lists the six IHP delivery systems that began participating in 2013 (hereafter referred to as Round 1 IHPs); three that began participating in 2014 (Round 2 IHPs); and seven that began participating in 2015 (Round 3 IHPs), along with the geographic areas in Minnesota they serve and whether they are integrated or virtual partners in the IHP demonstration. (The state announced a fourth round of IHP entrants on February 22, 2016, which include Allina Health, Gillette Children’s Specialty Healthcare, and Integrity Health Network.)

Exhibit 4.1. IHP Participants as of December 2015

IHP	Geographic Area	Virtual or Integrated
ROUND 1:		
Children’s Hospitals and Clinics of MN	Minneapolis/St. Paul	Integrated
CentraCare Health System	St. Cloud/Central Minnesota	Integrated
Essentia Health	North East and North West Minnesota	Integrated
Federally Qualified Health Center Urban Health Network (FUHN)	Minneapolis/St. Paul	Virtual
North Memorial Health Care	Minneapolis/St. Paul	Integrated
Northwest Metro Alliance	Minneapolis/St. Paul	Integrated
ROUND 2:		
Hennepin Healthcare System	Minneapolis/St. Paul	Integrated
Mayo Clinic	Rochester/South East Minnesota	Integrated
Southern Prairie Community Care	South West Minnesota	Virtual
ROUND 3:		
Bluestone Physician Services	Minneapolis/St. Paul	Virtual
Courage Kenny Rehabilitation Institute	Minneapolis/St. Paul	Virtual
Lake Region Healthcare	Fergus Falls/West Central Minnesota	Integrated
Lakewood Health Systems	Staples/North Central Minnesota	Integrated
Mankato Clinic	Mankato/South Central Minnesota	Virtual
Wilderness Health	Northeastern Minnesota	Virtual
Winona Health	Winona/South East Minnesota	Integrated

Source: SHADAC, *Database: Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative*, University of Minnesota, School of Public Health. Minneapolis, Minnesota. April 2015.

Notes: Database is based on state documentation, grant applications and agreements, organization websites, and consultation with the state and some grantees.

³⁷ Minnesota Health Care Financing Task Force, Presentation to Health Care Delivery Design & Sustainability Workgroup, Oct. 2015.

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Key Activities

In our interviews with IHPs, SHADAC identified specific examples of IHP program strategies, which include:

- Clinical strategies and/or integration of nontraditional services from other priority settings (e.g., behavioral health, long term services and supports, social services, public health);
- Data analytics and reporting;
- Physician engagement in value-based payment strategies; and
- Partnership development.

Of particular interest to SHADAC were activities that were happening within these delivery systems in large part because of the IHP program, and which ones were in existence prior to IHP that have been supported by the program. Within certain delivery systems, it was clear that the IHP program has propelled innovation and related investments. For others, the IHP program appears to be more of a contractual overlay that supports or builds on existing strategies (e.g., health care home initiatives, other ACO programs,³⁸ other federal grants) and momentum. We summarize these findings below.

Clinical Integration Strategies

IHP informants offered several examples of clinical integration strategies that were either described as accomplishments under the IHP program or aligned with IHP goals, including:

- **Team-based care models.** These models incorporate care coordinators, social workers, pharmacists, behavioral health workers, and health coaches. In describing the most important accomplishments under the IHP program, one IHP said, “It’s been the advancement of the team based care model. We’ve even been able to deploy this and test it on other [non-IHP] members. Care team members communicate with one another and develop shared care plans, and we are starting to engage physicians in these teams.”
- **Embedding care team members in primary care clinics.** As one IHP described, “We embed a social worker or psychologist (within the practice or down the hall) so when a patient presents [with behavioral health issues], we can do an active handoff. The idea is that the patient gets consistent care without stigma. We are building expertise within the primary care system, versus using specialists.” Another shared, “We have focused our resources where there is a population with frequent emergency room use. Psychologists and care coordinators have office space at four clinics now.”
- **Clinical navigation.** Some IHPs hired a “clinical navigator” with direct care management experience to interpret IHP data and manage care coordination for high-risk patients across clinics. As one IHP described, “We promoted one of our Registered Nurses (RNs) into a patient outcome specialty position. She gets all the data from health plans, state [IHP] data, care

³⁸ For example, the Medicare Shared Savings Program or Hennepin Health model.

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assessment results from care coordinators and providers, and [from that] she identifies a high-risk caseload. She then works collaboratively with care coordinators and providers to create action plans for these patients.” In describing a similar position, another IHP described, “We took an RN and said ‘let’s get her out of the clinic and put her above it all.’ She goes into charts, recognizing patients and what their issues are, and provides guidance to care coordinators.”

- **Super-utilizer programs.** These programs focus on providing intensive care management to patients with complex needs who often have high emergency room utilization and hospital readmission rates. As noted by one IHP, “We started looking at the inpatient side at who had been hospitalized more than three times and who had been in the emergency department more than three times. As those patients came in, a social worker and nurse went and talked to the patient and they would say, ‘Something is happening when you leave, would you let us work with you at home to change this situation?’ We found that individuals didn’t want to be in hospital. We had a lot of good receptivity from patients.”
- **Reorganization of care coordination function.** SHADAC learned of IHP reorganization of the care coordination function, with an emphasis on ambulatory settings. As one IHP described, “We are now saying, what is the skill level needed in different settings? Where do we need social workers, care managers, or support staff? The majority of care management resources were in the hospital, on the acute care side. But we are recognizing that you need to flip that. Care management needs to be for the whole system. That’s what we are doing differently today. Also, it is about people in these different [care coordination] roles understanding the scope of their responsibilities, from the Intensive Care Unit, to the Medical-Surgical unit, to the Skilled Nursing Facility, to home care. They have to think more broadly than before—it’s outside of their comfort zones.”

Data Analytics and Reporting

DHS provides participating IHPs with standard data packages derived from Medicaid claims data to help them better understand resource use and identify areas for targeted interventions. IHP providers receive:

- **Provider alert report.** Monthly report listing a subset of attributed recipients with either an emergency department visit or hospital admission in the prior month;
- **Care management report.** Monthly patient-level clinical profile for all attributed recipients including risk stratification, predictive values and likelihood of hospitalization, coordination of care and chronic condition flags, and other utilization indicators;
- **Utilization detail files.** Monthly files containing professional, facility and pharmacy claims attributed recipients for the most recent 12-month period (does not include paid amounts or chemical dependency treatment data);

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- **TCOC package.** Quarterly reports on TCOC performance, including population risk profiles and aggregate costs (inside and outside the IHP) by provider and category of service.

According to state staff, early on in the program, DHS' process for creating and delivering these standard reports to IHP providers tended to be manual and time intensive. During 2014 and 2015, DHS and its contractor (SAS Institute) made enhancements to previously available provider analytics and reporting resources. DHS hired new staff so that it could be more responsive to organization-specific inquiries about the data, and provided implementation support and training to new IHPs with regard to data analytics and reporting. Using SAS tools, DHS staff also created a common portal that IHPs can log into to view and download their specific claims-based reporting and files.

Our interviews highlighted that IHPs all have varying levels of data infrastructure, analytic resources, and capabilities, and thus use this standard data suite differently. IHP informants offered the following examples of how they currently use the data provided by the state:

- Using provider alerts and care management reports as is, that is, with little IHP manipulation;
- Combining care management report data with the IHPs own clinical records, and using this combined file as the “source of truth” for identifying high-risk pools and prioritizing care coordination interventions;
- Integrating claim and/or pharmacy utilization files into IHPs own data warehouse to incorporate data into existing reports or custom reports for the IHP program;
- Building high-level dashboards and reports for leadership that focus on or delineate results for the IHP program;
- Narrowing the state’s IHP care management reports down by indicators important to the IHP, using those to prioritize care coordination efforts; and
- Using claims and pharmacy detail as a basis for more formal research projects (e.g., how people with behavioral health and medical needs can navigate the health care system).

Certain delivery systems conceded that working with the state reports and analytic tools to identify clinical or cost improvements was still a “growth opportunity” for them. And, to some degree, all IHPs voiced their challenges interpreting and applying population health and risk information, and getting real-time feedback on their care management, quality improvement, and cost containment initiatives.

For the 10 IHPs³⁹ receiving provider analytics grants, work on data analytic projects to overcome some of these challenges was just beginning at the time of our interviews. Exhibit 4.2, below, provides an overview of the key investments planned by IHPs as part of their grants.

³⁹ The Federally Qualified Health Center Urban Health Network (FUHN) is not included in this total. FUHN applied for a data analytics grant, but as of the writing of this report, FUHN’s contract has not yet been executed.

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Exhibit 4.2. Overview of IHP Data Analytics Grants

Planned IHP Data Analytics Grantee Investments	Round 1: Children's	Round 1: Essentia	Round 1: North Memorial	Round 2: Hennepin	Round 2: Southern Prairie	Round 3: Courage Kenny	Round 3: Lakewood	Round 3: Mankato Clinic	Round 3: Wilderness Health	Round 3: Winona Health
Enhanced analytics to support care coordination efforts	✓	✓			✓		✓		✓	
Reporting tools to manage and track quality initiatives						✓				
Impact evaluations related to specific clinical interventions						✓				
Cost model for complex populations						✓				
Integration of claims-based data provided by state with IHP's clinical data, sometimes into an existing data warehouse or population health analytic system (e.g., Optum One)		✓	✓				✓	✓		✓
New indicators of risk (e.g., incorporating social determinants of health)				✓	✓					
Patient risk stratification through development of disease registries or population flags	✓			✓					✓	
IHP quality measurement/performance dashboard				✓					✓	
New population health management/care coordination processes and programs			✓							✓
Admit-Discharge-Transfer (ADT) and other provider alerts					✓				✓	
Financial reporting					✓					

Sources: IHP data analytic grant proposals, IHP data analytic grant contracts with DHS, IHP interviews conducted in the fall of 2015.

Note: FUHN was also awarded a data analytics grant, but as of the writing of this report, FUHN's contract has not yet been executed.

As of the writing of this report, 6 of the 10 IHP data analytics grantees had submitted a first quarter progress report to DHS. SHADAC's synthesis of these documents indicates that the IHPs are in the beginning phases of their projects, solidifying their project teams, refining project timelines and deliverables, acquiring data analytic tools, and working with vendors to begin data integration, analysis, and report development activities. Several grantees provided the positive feedback that DHS had been extremely helpful in sharing resources and responsive to IHP inquires. As mentioned above, SHADAC will more thoroughly evaluate grantee activities in 2016, once IHPs have had an opportunity to make more significant progress on their data analytic projects.

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In addition to asking the IHPs listed above about the work associated with their data analytic grants, we asked IHPs who did not apply for the grants why they had not applied. These IHPs cited a number of reasons for not pursuing this opportunity, including grant fatigue, lack of time, and a leadership issue within one IHP that caused the organization to miss out on the opportunity to submit a proposal.

Partnership Development

IHPs are required to develop new care models and strategies, provide comprehensive and coordinated services, and collaborate with community organizations toward service integration. But participating delivery systems have significant discretion in how to pursue these goals. As such, partnerships between IHPs and community organizations are evolving in a variety of ways, both formal and informal. Examples of community partnerships offered by IHPs during our interviews included:

- Development of a “disability competent” network of outside providers for patient referrals (IHP noted wanting to refer patients to providers who would treat their patients with respect);
- Referrals to outside long term services and supports needed by patients, such as meals on wheels, home care, and hospice;
- Referrals to food banks (e.g., Second Harvest Heartland) for attributed patients with food security concerns;
- Referral-based partnerships with community-based mental health recovery programs to help patients with behavioral health needs once discharged from the hospital;
- On-going discussion and informal collaboration with a school that educates many of one IHPs most complex cases;
- Partnerships with Emergency Medical Services (EMS) organizations to form community paramedic programs;
- Contractual arrangement with a behavioral health organization to provide “fill-in” services for patients so an IHP can keep a high census; and
- Partnership with a university to train health coaches—the IHP utilizes health coaches in its patient engagement strategies and students earn credits toward their degrees.

IHPs emphasized that new partnerships take time to develop, and that partnerships with social and community resources are evolving over time. Some partnerships were started because of the IHP demonstration, while others were in existence prior to the program. When discussing newer partnerships, several IHPs noted that their original plans for partnerships often change as organizations begin working together. As one IHP noted, “As you work together, you keep coming up with new ideas. Where we think we are going to go with one another [in partnership] is usually different from where we actually go.” Another perspective offered by a few IHPs was that IHP involvement in Health Information Exchanges (HIEs) projects were bringing community partners closer together.

Most of the partnerships discussed were informal, with no financial commitment or binding language between organizations. Certain IHPs discussed the possibility of bringing community partners into their attribution formulas and distributing shared savings to them in the future, but emphasized that were no

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“lines of sight” to specific plans yet. No IHPs discussed bringing community partners on to help bear downside risk.

Virtual models like Southern Prairie Community Care (SPCC) and Wilderness Health, both of which rely heavily on community partnerships with clinics, hospitals, mental health centers, and (in SPCC’s case) counties, take time and resources (for governance and infrastructure) to become operational and self-sustaining. One virtual IHP conceded that they had “...really underestimated the amount of ground work needed to start working on their care teams. So much cross-pollination and continuous leg work has to occur [across partner organizations and within the layers of each organization] before the work of integrated care teams can even begin.”

Physician Engagement

When asked how physicians were participating in the new clinical strategies and data analysis efforts associated with IHP programs, many IHPs highlighted the importance of physicians being “blind to payer/contracts” in delivering the best care they can for all patients:

- “The physicians are aware we have a number of value-based care contracts but not necessarily which patients are under which contract. They know many strategies are in place to get better care in this environment.”
- “We’ve tried to insulate the frontline from some of the lingo – IHP group, etc. The more contracts we get, the more segments they’d have to understand. They are passionate for solving for certain problems. It’s too complicated to explain – so let’s just do the work.”
- “Providers want to provide services and resources for all patients – segmentation is uncomfortable for providers.”

Still, according to IHPs, providers have been engaged in reform in many different ways. For example, one IHPs described that their physicians had participated in community-wide public health conversations sponsored by the provider delivery system to discuss strategies for pursuing the Triple Aim. Other IHPs described how physicians participated in internal committees, workgroups, and task forces. Still others noted that physicians were engaged in ongoing process improvement work, especially with respect to how to work with care coordination staff. Another important role for physicians in reform, according to several IHPs, was engaging them as physician champions to help “sell” clinical improvements and analytic investments to others within the organization.

Some IHPs discussed physician engagement and data sharing as the “next new frontier” in clinical innovation and improvement. Many IHPs referenced provider compensation systems that were beginning to focus on quality scorecards and cost (across all populations). As one IHP noted, “We’ve had significant examples where sharing the data has shifted practice. As result of sharing this data, physicians are much more willing to be at the table. It’s not difficult to find physicians to participate in projects to make improvements.”

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Others were of the mind that involving physicians may not be the best way to go about innovating—to them engaging care coordinators and staff and arming them with the right patient data was the key to success. Referencing shifting philosophies or cultures when it comes to physician involvement, one IHP noted the following: “We have changed how we think about when to bring in a provider [to assist with patients]. We think of providers as a tool we use to better health, but they are not going to be helping people maintain their care between visits. Our patients need education in the home, and they’re not getting that from an occasional clinic visit.”

Early Outcomes

Expansion of the IHP program, Including New ACO Models

Although the IHP program existed prior to SIM funding, its expansion from six (in Round 1, which predated SIM) to 16 IHPs (in Round 3)—and its growth to 225,000 attributed lives—is at least partially due to investments made as part of SIM. In August 2015, the state reported total savings of \$14.8 million in Medicaid costs in 2013, the first year of the program, and total savings of \$61.5 million in 2014 (both state share only).⁴⁰ Of the \$76.3 million reported in savings across 2013 and 2014, roughly \$28.7 million has or is expected to be returned to IHPs in the form of shared savings payments.⁴¹

Expansion has meant greater geographic and organizational diversity among IHPs. New entrants also include IHPs that are beginning to test the inclusion of services not traditionally included (e.g., behavioral health) for complex populations and other ACO innovations. Each of the IHPs under contract with the state have different geographic footprints, target populations, organizational structures, and size. That new and different types of delivery systems—especially those that treat populations with complex medical and social needs—are interested in becoming IHPs has been very encouraging to state officials.

One Round 3 provider group (Bluestone Physician Services), for example, focuses specifically on people with disabilities, with services delivered in residential care facilities, community-based clinics, and patients’ homes. Another (Wilderness Health) is a community-owned, rural health care cooperative providing a full spectrum of primary care services from birth through the end of life. This diversity has meant that the state has had to “meet providers where they are” in terms of ability to take on risk—in other words, reexamine certain providers’ eligibility for upside risk only when provider groups are not able or willing to take on downside risk. In these cases, Minnesota has added caps on upside savings. Another example of this flexibility is that one Round 2 entrant, Southern Prairie Community Care—a collaboration between 12 counties in southwestern Minnesota and a virtual IHP—has incorporated

⁴⁰ “Integrated Health Partnerships: Partnerships save \$76 million in Medicaid costs.” Minnesota Accountable Health Model (SIM Minnesota). Minnesota Department of Human Services. Aug. 2015. Web. Jan. 2016 <http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16_196131.pdf>

⁴¹ 2013 Final Performance Results and 2014 Interim Performance Results. IHP Demonstration Project. Minnesota Department of Human Services.

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additional behavioral health services within its TCOC, providing financial incentives for behavioral health and physical health integration within its ACO model.

State officials noted that there will always be a healthy tension between being open to different types of provider groups, offering flexibility in model design, and maintaining basic standards and accountability. It was clear from our interviews that IHPs value this flexibility. In fact, in some cases it was apparent that if the state had not offered different tracks for participation (e.g., integrated versus virtual, level of risk sharing), several IHPs may not have had the ability or interest to participate. On the other side of the coin, one IHP serving a complex population stated that: “The IHP program still isn’t perfect in terms of flexibility, appropriate risk adjustment, etc. But our participation is indicative of our desire to keep pushing [for a better model], and to be at the table.”

Learning and Planning for Populations Served Through Data Analytics

Through analysis of state IHP data, IHPs are learning more about the populations they serve and shaping clinical initiatives that will impact both Medicaid and non-Medicaid patients. In most advanced payment models—especially those that involve performance incentives, shared savings, or global budgets—provider financial gains are dependent on achieving a certain level of performance on a set of quality measures. As such, measuring cost, utilization, and quality goes hand in hand with reforming payment structures. States, like Minnesota, involved in reforming payments to providers, have made significant investments in the data infrastructure and data analytic resources necessary to track these metrics at the provider level. In addition, states are beginning to provide information on individual patients, offering providers data to target specific patients, such as those with chronic diseases.

As mentioned earlier in this chapter, IHPs receive monthly patient-level data on emergency department admissions, hospital admissions, readmission counts, and other care management flags for all patients assigned to an IHP. IHPs also receive quarterly reports on TCOC performance, including population risk profiles and aggregate costs by category of service, and monthly line level detail on claims and pharmacy utilization (not including paid amounts due to legal limitations) for the most recent 12-month period for attributed patients.

Our interviews with IHPs generally reinforced the notion that the delivery systems need and desire just this kind of data to begin responding effectively to changes in payment models. While some delivery systems conceded that they were just beginning to use the data, most delivery systems expressed that they were hungry for claims data, and excited to have access to a snapshot of what is happening for patients both inside and outside of their own systems.

For some, examining the IHP data provided by the state was the first time they had looked at their Medicaid populations comprehensively. As one IHP described: “It’s the first time we’ve ever sat around table and looked at patients with more than six emergency departments visits in the past year. One patient had 77 emergency department visits! We already have a quality dashboard with 60 metrics, but that [report] doesn’t hit it. It was an eye opener. We have a lot of opportunity to look at over-utilization in this process. For example, this gentlemen with 77 emergency department visits had a mental health

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disorder that led him to be physically ill, which put his electrolytes off. He also had a co-morbidity of drug abuse. We reached out to the county for a comprehensive case management review, and he has now been placed by court order into a facility to help him. He has been agreeable to treatment and doing well.”

Other comments by IHPs highlighting how analyzing state IHP data is changing how they think about the populations they serve and beginning to inform their clinical strategies include the following:

- “Well, we looked at the pharmacy spend being one-third of the total dollars spent. Up until then [before the IHP program], there was no incentive to monitor the cost, but now the Medicaid IHP program has a downside. We went to our leadership and said that this is something we could work on, but it would require us to hire someone, so we could make good changes that are cost effective. Most of the doctors supported this shift, so we created a pop-up [in the EMR] to show the cost of the medication and the best practices from the literature. As the physician is ordering it, the doctors can overwrite the pop-up. If we hadn’t had the IHP data [and contract], we wouldn’t have had nearly the amount of organizational support we have had to have a pharmacy stewardship program.”
- “In the past, we had a sense for our high risk kids. The IHP data has helped us broaden our thinking of who is a child at risk across the continuum of care. Not just at the clinic, or the hospital, or at a point in time. It has led us to think about the tools to identify these children, how we risk stratify the population, and what are appropriate resources to support children and families to eliminate or reduce these risks?”
- “The IHP data and program gave us a population that we can focus in on to test out our hypotheses. For example, we have had people interview IHP families who had children with high emergency department utilization. We would never have guessed that the challenges [we observed during these interviews] would have surfaced.”
- We look at patient level info on the IHP population. We had a lower benchmark against the rest of IHPs on our diabetes population. It was interesting because with the demographics of our population we assumed we had a lot of diabetics. Was this wrong or are some undiagnosed? How do we identify them? If we have folks not diagnosed that’s an issue. And we’d hope to get them in before they become insulin-dependent.”
- “When we did the first download of data we said, ‘where was this years ago!’ We didn’t know that 48% of our population is age 18 or younger, or that 73% of our population is related. So, what you are really talking about is families. Now we’re thinking about family interventions, we’re talking to the schools. We’re starting to put these pieces together. There have been some serious wow factors when we got the data...we had no idea.”

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- “The data are amazing. We found out about a higher than expected rate of depression. So we need to think about, okay, we know we have behavioral health gaps in the system, but how are we going to address that? Otherwise, you know it’s an issue but you don’t really know how much of an issue it is. It’s helping us say, okay, we need to put some resources into this. Who do we need to reach out to externally? What does it mean for our providers? What additional training will be required?”

New Investments in Population Health

Within certain delivery systems, the IHP program and associated savings potential has encouraged IHPs to make investments in clinical models and supporting data infrastructure with a population health orientation. As one IHP described, “IHP lit the match. We wouldn’t have proceeded so aggressively [with our clinical model] if not for the potential for shared savings. When you are dealing with Medicaid only, reimbursement for primary care is already so low. It would be a money losing proposition [to invest in a new clinical model]. Without the IHP, we were an individual, patient-focused model. Now we have the ability to move on population health.” Another stated that their delivery system’s “framework for population health and the model were all driven out of the IHP program, and would not have happened without the IHP. We would not be talking about this today had the IHP not brought out intellectual curiosity, and put some money on the line.” Another remarked that, “The whole shared savings discussion and the emphasis on value within Triple Aim created that burning platform that we needed to start thinking differently than we have in the past.”

Some delivery systems pointed to the scale of the demonstration as being especially important in allowing them to accelerate investments. As one IHP described, “The IHP program was helpful in getting to a critical mass of patients with aligned incentives. Participation in IHP quickly helped us to recognize that we could apply the same principles to Medicare Shared Savings Plan (MSSP) beneficiaries. Commercial arrangements have been much smaller and it has taken more time.” Others mentioned that it was helpful to have a tangible population on which to focus. One IHP stated, for example, “The IHP [demonstration] gave us a population that we can focus in on to test out our hypotheses.” Another noted: “For the first time, we had a reason [to innovate] that we could wrap our arms around. IHP made [the tasks] smaller – it is one specific population. It let us practice with the IHP population and extrapolate out to others as we learn.” Finally, in referencing its clinical navigator and program that was conceptually developed for the commercial population, one IHP shared that: “There wasn’t much risk there [within the commercial population]. With the IHP and critical mass, now we have something for her to focus on.”

For other delivery systems, the IHP program appears to be more of a contractual overlay that builds on existing clinical strategies and momentum. As one delivery system put it, “We are an excited partner, there have been a lot of learnings, and data are now available, but the IHP program is a contract, an overlay. Our [population health] programs were put into place by leadership long before the IHP contract.” Still, even in these organizations, there was evidence that the IHP program has played at least some role in shoring up organizational support for making investments in care delivery reform. One IHP

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described their program savings as a way to garner organizational support for funding community health workers over several years. Another stated that it was hard to get attention for population health investments within the organization until there was “value attached to it.”

Several new entrants to the program conceded that they were only in the early stages of planning related to the IHP program, but expressed their aspirations for how IHP could help support their delivery system reform efforts. For example, one Round 3 IHP said, “When we look at the Medicaid program...we are constrained by the fee-for-service system. It is a hamster wheel, unsatisfying for patients and clinicians. This [the IHP program]—hypothetically—will give us flexibility to break some of these patterns. We need to find different ways to intervene with patients. We’re getting what the system is designed for, not what’s needed.” In responding to the question of what made one IHP decide to pursue the opportunity, one IHP reported, “We know that health care is changing from the old FFS to more pay for value, value-based care. We saw that change. We thought the IHP opportunity would be a good opportunity to learn how to take that step, a good way to step from one canoe into another. IHP was a good way to help us move in that direction.”

Continuous Improvement Feedback

Valuable State IHP Data and Reporting, but Gaps and Barriers Remain

Most IHPs were very positive about the state IHP data and reporting they were receiving as participants in the program. Several even noted that the reports were better than any they were receiving from other payers. For example, one IHP noted, “They are the most beautiful reports I’ve ever seen in my life. For so long it has been hard to get any kind of data from health plans, so we were just blown away. We are probably not fully maximizing it [the data] yet, but we are starting to use it.” Another stated, “The reports from state are good. Some of the most actionable [data] we get.”

Still, when asked about the challenges they encounter, IHPs perceived several data gaps and barriers with respect to how to use the state data most effectively. One data issue that came up frequently was the fact that while IHPs receive data on every paid claim for their attributed population—both inside and outside their system—they do not receive the paid amounts associated with each of these claims. It is important to note that DHS is *unable* to supply this level of cost data on managed care enrollees under state law.⁴² DHS is also unable, under Federal law, to provide claims data for chemical and alcohol dependency treatment programs.⁴³

While IHPs generally expressed an appreciation of these limitations under state law, several advocated that the state develop better methods for assigning proxy unit costs to these claims for comparative purposes. Several IHPs also argued that without more detailed information on costs at the claims level, they had trouble comparing themselves to their peers and understanding where problems lie. One remarked, “The costs we get are at an aggregated level. When we think about having people getting services outside of the IHP, it may be that that provider does a better job and at a lower cost (so maybe

⁴² Pursuant to Minnesota Statutes, § 256B.69, subd. (9)(c)

⁴³ Pursuant to 42 USC. § 290dd-2 and 42 CFR § 2.1 to § 2.67

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we'd want to partner) but we don't have information to make those decisions. We know where utilization is going. But we can't tell what the costs are." Another said, "The biggest issue is the lack of detailed financial information. For other payers that we work with we are able to see every single paid claim [with paid amounts]. But for IHP, we don't get anything like that. We only receive high level totals."

While these comments reinforce a valid and significant data gap perceived by IHPs (i.e., the lack of line-level paid amounts on claims), they also highlight where more technical assistance and training may be required on the data analytics side. For example, as part of the TCOC package and care management reports, IHPs do receive aggregated paid costs at patient, provider, and service type levels. With the data provided by the state, there are several different ways an organization could use cost information—albeit aggregated cost information at patient, provider, or service type levels—to inform their clinical strategies.

Another commonly cited challenge by IHPs was knowing "where to start" with the data, given the plethora of data provided, and deciding who needs it.

- "The challenge is that it's so much information, what do we do with it/ how do we figure out the important pieces? One thing I see very beneficial is the ability for someone in IHP to pull out five key elements we should pay attention to. This is where you're different and should focus."
- "Figuring out what to do with it [the data]. The gap for us is having a tool to do the analytics for us. We have staff but we have a big boatload of data. What do we parse out from all that data? I think we need more analytic tools to help with that."
- "There is so much data coming at us. What is the right way to use data to identify patients/strategies to really have an impact? What is the right combo of data categories that will help us have an impact?"
- "Who needs what data – across the workflow? Population, finance level, clinical care....Now that we have access to data, who needs it and how can they access it?"

Still others discussed their questions about how to integrate retrospective claims data with internal clinical sources, and whether, in the end, this would actually be useful in terms of real-time clinical management:

- "Right now, reports are retrospective, so there is not an opportunity to course correct. What is meaningful information that could be part of decision support tied to an EMR that is linked to other sites, based on real-time data?"
- "The other issue is one of timing. The data we get from the state is old, so there is no way to make meaningful clinical changes for the patient at the right time."

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- “The claims detail file, from a research standpoint, is fantastic. I am able to look at that and do a lot of analysis that can show us where we’re having an impact and what might be a target, but there is nothing in the claims data that will allow us to impact a patient.”

Uncertainty as to How to Use the Technical Assistance Support Available from 3M

3M’s technical assistance contract includes providing both consultative services to DHS as well as direct technical assistance to IHPs. For DHS, 3M is to provide consultation related to “ongoing improvements in the provision of information to IHPs—including incorporation of risk adjusted comparative benchmarks for key utilization and cost metrics.” This consultation with DHS is intended to help DHS develop materials and recommendations that can be used across the demonstration to help IHPs address some of the same questions and concerns voiced above (e.g., determining where to start, prioritizing analytic activities, designing workflows).

At the time of our IHP interviews in the fall of 2015, 3M’s activities had just gotten underway. In fact, 3M’s direct technical assistance activities with IHPs engaged in data analytics had just kicked off, and IHPs had little to report on with regard to technical assistance requests or outcomes. Even so, we asked IHPs whether they were aware of the technical assistance available to them through the state’s contractor, 3M, and what plans they had for using it. At least to some extent, almost all IHPs were aware of the technical assistance available to them through 3M. However, several expressed uncertainty as to when and whether they would use the technical assistance. Some expressed that they had not figured out how to use 3M yet, some noted that they were not “at that point yet,” and still others expressed some level of confusion with what 3M could provide in the way of technical assistance. None of the IHPs, at the time of our interviews, could articulate what their technical assistance needs might be over the next year.

Based on SHADAC’s experience as a technical assistance provider to states, these issues of defining scope and identifying tangible needs are very common, especially when a flexible technical assistance agenda based on the varied needs and challenges of organizations is desired. Making sure each IHP has a single point of contact—one 3M technical lead—whom they can interact to discuss technical assistance opportunities or request one-on-one support will be important as the contract progresses. If IHPs do not appear to be participating as envisioned, it may be worth revisiting whether 3M’s scope is too rigid by checking in with IHPs to identify barriers to formulating actionable requests. Finally, with 3M, it might be worth grouping IHPs based on their likely need for support in specific areas to determine whether more efficient peer-learning opportunities may be developed to facilitate IHP interaction and sharing of information.

Sustainability Insights

Our interviews with IHPs shed light on the role the state could play in helping delivery systems sustain their momentum around value-based payments in the future, the overall financial sustainability of the IHP model as well as the ability of the IHP demonstration to influence the rest of the market (i.e., other payers).

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Lack of Clarity Between the IHP Program and the Managed Care Delivery System

A few delivery systems expressed concerns over their perceived lack of clarity in the state's future vision for the IHP program, especially the role IHP would play vis-à-vis the managed care delivery system. As one IHP said, "It does seem like the state is interested in growing the IHP model more significantly, but where the rubber meets road is with the role of the plans, and the possibility of direct contracting. It would be helpful for the state to have a clear vision in those difficult conversations, so that what comes out the other end is, what we need to give providers so that they can do their work."

Concerns that the Ability to Generate Shared Savings Diminishes Over Time

This process of re-calculating TCOC benchmarks (rebased at contract renewal) concerned many IHPs, who provided their perspectives that savings opportunities for IHPs would diminish over time. When an IHP begins, a baseline TCOC is calculated for the year prior to their start; a risk-adjusted, trended projection of TCOC is then calculated for the first three years of their participation. When an IHP renews its contract for years four through six of the demonstration, their TCOC benchmark becomes their year three TCOC. As one IHP put it, "Costs can't always go down. When have we hit an equilibrium, what is the end game? And, how do you structure payments so it doesn't blow up?"

Disconnect Between the Retrospective Attribution Model and Clinical Quality Improvement

Related to the differences across IHP and managed care models, several IHPs discussed the difficulties of managing patient turnover and care with the current, retrospective attribution model, their efforts in attempting to "capture" those in their system who were not accessing primary care for some reason, and their hope that the state would move toward a prospective attribution model. As one IHP noted, "In terms of challenges, one of the big things that has come up is that in just six months, we've had a third of the people fall off [the attribution list]...this seems to me to be so unstable." And, "33% churn, and we are still looking into why. We are dealing with a small population that needs many more wrap-around services. We know in six months' time we might not be able to impact them; these are big life challenges and they take a lot of time. These people need a longer-term approach." Another noted, "With a six-month turn around, you can't see differences. Our readmissions work is about 18 months."

Success Factors Unclear and, Therefore, Hard to Replicate

Finally, another sustainability concern voiced by several IHPs that had been successful in earning shared savings payments in 2013 and 2014 was that given all the factors influencing patient outcomes, quality of care, and costs, they were not yet able to identify exactly *why* they had been successful. As one IHP stated, "It goes back to the data discussion. While we've had success in shared savings, we can't always identify how we had that success. In terms of replicating, we have no idea. We have a plan as an organization to better understand claims data and the impact that has on our value-based purchasing contracts. We really didn't know at beginning. Hooray – we have earned shared savings—but do we know why?"

Slow Movement to ACO Models

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The overall market appears to be moving toward value-based purchasing, but not as quickly as certain delivery systems expected. A few IHPs disclosed that while the number of contracts utilizing value based payments appears to be on the rise, the share of revenue at risk from ACO-type arrangements was still quite low, and isn't always a "tangible motivator" for organizations. Interestingly, these anecdotal findings from IHP interviews also appear to support conclusions from the ACO baseline assessment. One of the key findings from the assessment, for example, was that "while Minnesota has a strong history of integrated care, and ACO models are beginning to take root, the accountable care market is not yet at full maturity." And, that "the percentage of revenue currently at risk in ACO or similar arrangements is low, with two-thirds of providers indicating that 10 percent or less of their organization's revenue is at risk."⁴⁴ While the shift from a fee-for-service system to one of value-based payments appears to be happening, many noted that it was happening more slowly than they had anticipated.

Several IHPs noted that the macro economics of the payment system in its current state do not support the dramatic changes that some individuals within these organizations would like to see sooner rather than later. IHP informants provided insightful comments about how delivery systems have to balance their investments in population health management with the financial realities of living in two worlds (fee-for-service and value-based payments). For example:

- "We have really tempered our enthusiasm. Not too much, too fast, and that really forced us to be specific on the kinds of things we're doing. We can't just go out and build a big infrastructure."
- "It goes to building competencies with population health. When we talk to the board [of the IHP], they want to know how far we can go with the risk-based contracts without going over the skis, so to speak. By having data and time to get smarter, we feel confident we can move down the road without having to jump off a cliff."
- "We're doing a lot on the clinic side looking at care model innovation and thinking about how we provide care in a way today that's different than before. It's really difficult to live somewhere between a fee-for-service and a shared savings model. Today, we're still more rooted in the fee-for-service system. As we try to implement some of these initiatives—care teams, care coordination models, community health workers (CHWs), pharmacists within medical settings, behaviorists—most of these initiatives lose money in a fee-for-service environment. We need to provide value and shared savings on one hand, but our budgets are driven from a fee-for-service perspective. It's hard to balance, and we don't want to get too far ahead of shared savings when the opportunities aren't there yet to absorb cost."

⁴⁴ "Factsheet: ACO Baseline Assessment." Minnesota Accountable Health Model (SIM Minnesota). Minnesota Department of Health. Web. Feb. 2016.

<http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16_197637.pdf>

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Finally, to stabilize their investments while living in these “two worlds”, several IHPs argued for prospective payments to maintain their care coordination improvements and data analytic infrastructure (as opposed to receiving all of their gain sharing retrospectively).

- “With SIM in general and IHP, the state is assuming the building blocks are more evolved than they actually are. The entire thing is still operating on the margins. The reality of how aligned the incentives are—all of this is still built on a fee-for-services chassis. Four years ago, 4% of our revenue was something other than fee-for-service, today it is at 3%. All alignment is still after the fact. So after the fact, with some payment three years down the line, this is not a logical business model - some payout three years down the line? We need to point out to the state where aspirations and reality are far apart.”
- “This work requires significant investment on an organization’s part to do things differently, but doing things differently impacts short term revenue (e.g., emergency department revenue will decline). Can we have payment models reward us to do that work so we don’t cannibalize ourselves? We are trying to work to manage care, but we need to find a way to survive through it—we do it because we know it’s the right thing to do. We need a counterbalance to the investments we make and the revenue taken out of our system.”
- “We need to figure out a way to be compensated at the right time for doing the right thing.”

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5. TEAM-BASED INTEGRATED/COORDINATED CARE

Introduction

Driver 3 of the Minnesota Accountable Health Model aims to facilitate the expansion of coordinated, integrated, team-based care and service delivery across providers and care settings. This driver focuses on equipping providers, especially rural and small independent providers, with some of the tools and resources necessary to achieve these aims. The activities funded under this driver support health care system transformation through investments in infrastructure, the development of implementation supports and quality improvement activities, support for practices that want to seek certification or re-certification as Health Care Homes (HCHs) or Behavioral Health Homes (BHHs), and support for integrating providers from emerging professions, including community paramedics, dental therapists, and community health workers.

The rationale for these practice transformation activities is that a number of Minnesotans, particularly those with multiple medical or behavioral health issues, face challenges in getting the care they need. In addition, patients with complex conditions often face challenges beyond the need to obtain medical care, such as a lack of access to healthy food, inadequate physical safety, and the need for supportive services that cross settings of care. Many of these patients can get lost within the complexities of separate, often disjointed, care delivery systems resulting in poorer outcomes and higher costs.

The Department of Health (MDH) and the Department of Human Services (DHS) are supporting a range of providers and teams in primary care, social services, or behavioral health to allow them to participate in transformation activities that help remove barriers to the integration of care. State investments in transforming health care practice in Minnesota, toward the goal of expanding the number of patients served by team-based, integrated, coordinated care include four grant programs (Practice Transformation, Emerging Professions, Emerging Professions Toolkits, and Practice Facilitation). These grant programs are briefly described below. In addition, the state has expanded its Health Care Home Learning Day events and it has established a learning collaborative, facilitated the exchange of information across the collaborative, provided technical assistance, and developed a quality improvement framework. More detailed information on each of these grant programs is available in the Team-based Care Investments Appendix G to this report.

- Emerging Professions Integration Grant Program.** This grant program focuses on expanding the number of patients served by team-based integrated/coordinated care by supporting the adoption of emerging provider types. The Minnesota Accountable Health Model has identified three emerging professions to test for integration into the health care workforce: community health workers; community paramedics; and dental or advanced dental therapists. The desired outcome is that each will integrate into a team environment and change overall team capacity

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as well as patient outcomes. A total of 14 one-year awards of approximately \$30,000 each were issued across three rounds of funding from July 2014 to August 2016.

- **Emerging Professions Toolkit Program.** The goal of this program is to develop tools and resources to aid in the integration of the three emerging professions – community health workers, community paramedics, and dental or advanced dental therapists – into the workforce. The toolkits are intended to inform potential employers how to hire emerging profession practitioners, how to successfully integrate them into care coordination models, and what potential benefits arise from hiring an emerging professional - benefits to the organization, care delivery team, and patients and clients served by the emerging profession practitioner. Three contracts totaling approximately \$297,480 were issued in summer 2015, with final deliverables expected in fall 2016.
- **Learning Communities Grant Program.** The purpose of the general Learning Communities is to develop learning teams who have common goals or interests in implementing transformation in a focused, structured environment, and to share knowledge of best practices. Grantees recruit the participants in these learning teams and engage them to share experiences focused on specific transformation topics with their peers. The state has awarded four general Learning Communities grants to date, three in Round 1 and one in Round 2. These are 9-month grants of approximately \$50,000.
- **Practice Facilitation Grant Program.** The goal of these projects is to support a range of providers and teams in primary care, behavioral health, social services, long term and post-acute care, or Accountable Care Organizations (ACO) or similar models to allow team members to participate in transformation activities that help remove barriers to care integration. Grantees are qualified through experience to do practice facilitation. Two contracts totaling \$966,601 were awarded; the period of these contracts is estimated to be 20 months.
- **Practice Transformation Grant Program.** Practice Transformation grants support activities to integrate primary care, behavioral health, and social services, and have been made available to primary care providers, behavioral health providers, and other providers. Funds could support: 1) the redesign of clinical systems work; 2) the development of new data collection, management, or analysis tools; 3) implementation of new work flows; 4) preparation of HCH; 5) BHH planning; and other activities. This program includes three rounds of grants. Round 1 funded 10 six-month grants of approximately \$20,000 each (February 2015 – July 2015); Round 2 funded 12 nine-month grants averaging \$23,500 each (September 2015 – June 2016); and Round 3 awarded 24 six-month grants of approximately \$10,000 each. Overall, this grant program distributed 46 awards totaling \$716,082.

The evaluation design relies upon grantee interviews at or near the end of the grant periods. Due to these timing constraints, this report presents findings from first round Practice Transformation Grants and only describes key activities of the Emerging Professions and Learning Communities investments. In

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Round 1 of the Practice Transformation grant program, ten grants were awarded in January 2015. SHADAC researchers conducted in-person and/or telephone interviews with key project personnel in each of these ten grantee sites. The interviews were scheduled as close as possible to the grant end dates. Eight interviews were completed in August 2015 and two were conducted in December 2015. Topics covered during interviews included grant activities, accomplishments, learnings, relationships to other SIM or related work, and sustainability.

Background

One of the principal goals under Driver 3 of the Minnesota Accountable Health Model is to expand patient-centered, coordinated care, building on the infrastructure and momentum of the existing HCH initiative. Minnesota has made strides toward expanding HCHs. At the end of 2014, a total of 359 clinics were certified HCHs and at the end of 2015 that number had risen to 361 certified HCHs, with an additional 21 border state clinics also certified. The MDH HCH initiative was part of Minnesota's 2008 state health reform legislation aimed at improving the health of the population, the patient experience of care, and the affordability of health care – the Triple Aim. It represents an approach to primary care in which providers, families, and patients work in partnership to improve health outcomes and quality of life, and where coordination of care is a central component. HCH represents a patient-centered, team-based approach to primary care in which providers, families, and patients work in partnership to improve health outcomes and quality of life, and where coordination of care is a central component. Care coordination is reimbursed at a PMPM rate based on a complexity tiering structure and adherence to standards. Payments are made for enrollees in Minnesota's public health care programs, state employees, and enrollees of state-regulated private health plan products.

HCH certification is voluntary, but providers and clinics wishing to be certified (and regularly re-certified) by the state must meet a rigorous set of standards related to access and communication, population-based registries, care coordination, care planning, and quality improvement. HCHs are designed to support partnering with patients and families to provide coordinated care and services. Certified practices and providers are then eligible to receive monthly per-person payments for care coordination activities, which are tiered based on the complexity of the patients' chronic health conditions.⁴⁵ Providers and clinics that have elected to become certified HCHs are also required to participate in the statewide learning collaboratives that provide opportunities for HCHs and state agencies to exchange information and enhance understanding related to quality improvement and best practices.

DHS is developing the BHH model as an important component of the broader behavioral health/primary care integration effort in Minnesota. BHHs target complex, high-acuity Medicaid enrollees because people with serious mental illness experience barriers to health care access, high co-occurrence of chronic health conditions, and early mortality. The integration of primary care and behavioral health

⁴⁵ For Medicaid, payments range from approximately \$10 per member per month (PMPM) for Tier 1 to \$61 PMPM for Tier 4.

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services can follow several models including: co-location of services; contracted relationships between primary care and behavioral health providers; or in preferred/established referral patterns. BHHs will operate under a “whole person” philosophy meaning that in a BHH, people will have their comprehensive physical and behavioral health needs addressed in a coordinated matter. And, where appropriate, BHH providers will coordinate non-clinical services so the person will have their health care coordinated with social and community supports. The Practice Transformation Grant program supports interested grantees in planning and preparing to become BHHs. Participation in BHH services will be voluntary.

Emerging Professions Integration Grant Program

The Emerging Professions Integration Grant Program funds grantees to hire staff with unique medical training with the potential to increase access to care for underserved populations. The three professions included in this grant are dental therapists (DT)/advance dental therapists (ADT), community health workers (CHW), and community paramedics (CP). The activities described in this section were identified through SHADAC’s review of grantees’ proposals, quarterly reports and final reports.

Key Activities

Dental Therapy Grants

The state awarded four agencies the Dental Therapist Grants, providing initial funding for clinics to hire a DT and focus on providing dental care to children, families and individuals who are racial/ethnic minorities, speak English as a second language, and receive Medical Assistance. A DT performs basic dental treatment and preventive services with the supervision of a dentist or another qualified licensed provider. Clinics with a DT expect to increase access to quality dental care for underserved populations. While each agency is implementing activities specific to the needs in their community, common activities include:

- Hire, supervise, and retain DTs;
- Provide preventive and routine dental services using DTs;
- Train DTs on dental equipment and tools;
- Develop collaborations with external partners to increase high quality referrals; and
- Increase awareness of the DT’s role inside and outside the clinic.

Community Health Worker Grants

The state awarded seven agencies across Minnesota with a Community Health Worker Grant. These agencies work with diverse and underserved populations including adults with chronic medical conditions, individuals living with a mental illness, jail-involved populations, refugees, and Medicaid beneficiaries. This grant provides agencies and CHWs with resources to:

- Coordinate care and follow-up with clients to determine if services are appropriate;
- Encourage attendance at medical appointments and medication compliance;

This program is part of a \$45 million State Innovation Model (SIM) cooperative agreement, awarded to the Minnesota Departments of Health and Human Services in 2013 by The Center for Medicare and Medicaid Innovation (CMMI) to help implement the Minnesota Accountable Health Model.

- Provide culturally appropriate education on oral health and healthy lifestyles (diet, weight control, exercise);
- Create a CHW teaching curriculum;
- Collaborate with community organizations; and
- Educate partners on the CHW's role.

Community Paramedic Grants

The state awarded four organizations the Community Paramedic Grant. Many of the grantees are large clinics or hospital systems that provide services to Medicare/Medicaid beneficiaries, communities of color, and individuals living with mental illnesses, chemical health issues and chronic health conditions. This grant provides the resources for the agencies and CPs to:

- Provide in-home consultation and care to individuals who frequently visit the ED;
- Follow-up with clients who were recently discharged from the hospital;
- Lead community education classes;
- Develop educational materials on hiring, training, and retaining a CP; and
- Inform internal and external providers of the CP's role.

Emerging Professions Toolkit Program

The three Emerging Professions Toolkit Program grantees are assembling resources to help potential employers in hiring emerging professions practitioners and successfully integrating them into care coordination models. The toolkits are also intended to outline the potential benefits of hiring an emerging professional. Each of the three grantees focuses on one emerging profession. Grantee activities include reviewing the literature, conducting an environmental scan, and collecting data and information from focus groups and interviews to inform the development of the toolkits. These contracts began in mid-2015; toolkits are expected in fall 2016.

Learning Communities Grants

The General Learning Communities Grants funded organizations with expertise in developing and managing learning teams with common goals or interests, who come together to share knowledge of best practices and are actively engaged in implementing transformation with the goal of advancing patient-centered, coordinated, and accountable care. In the first round, three General Learning Communities Grants were funded and each was designed to focus on a separate transformation topic.

Each of the grantees is unique and focuses on a range of geographic regions across widely divergent target populations and topic areas. More detail on each of the three Round 1 grantees is available in Appendix G. Despite the pronounced differences among the grantees, they all shared some common activities, namely recruiting for various teams and team members early in the process. In addition, they reported facing the common challenges of completing a project within the compressed timeline allowed by this grant, as well as in recruiting and retaining participating organizations or groups.

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Practice Facilitation Grants

Two Practice Facilitation Grants were awarded to provide support to a range of providers and teams in primary care, behavioral health, social services, long term and post-acute care. The two grantees are Institute for Clinical Systems Improvement (ICSI) and the National Council for Behavioral Health (NCBH). The initial activities of these two include recruiting, screening, selecting, and finalizing agreements with participants in the practice facilitation provided by the grantees. Both agencies are also providing assessments; identifying the needs of participating organizations; working with organizations to address their priority needs and building upon their strengths; initiating in-person meetings with their organizations; coaching both in person and on-line; providing bi-monthly webinars; and potentially conducting affinity groups. In addition, the grantees are working with their respective participant organizations to complete the Continuum of Accountability Assessment, and to compile and analyze the data from these assessments.

ICSI/Stratis Health is providing practice facilitation services to seven primary care/specialty provider organizations and one social service agency which have the following priority needs: chronic care management, health IT, HCH certification, integration of behavioral health or alternative models of care, quality improvement, and total cost of care (TCOC). The National Council for Behavioral Health is providing services to 10 community mental health centers, 3 federally qualified community health centers, and 2 social service organizations. Priority needs that have been identified by the organizations they are working with include: accelerating behavioral health and primary care integration; data use related to analytics and interoperability; identifying and assessing service costs; and whole health programs.

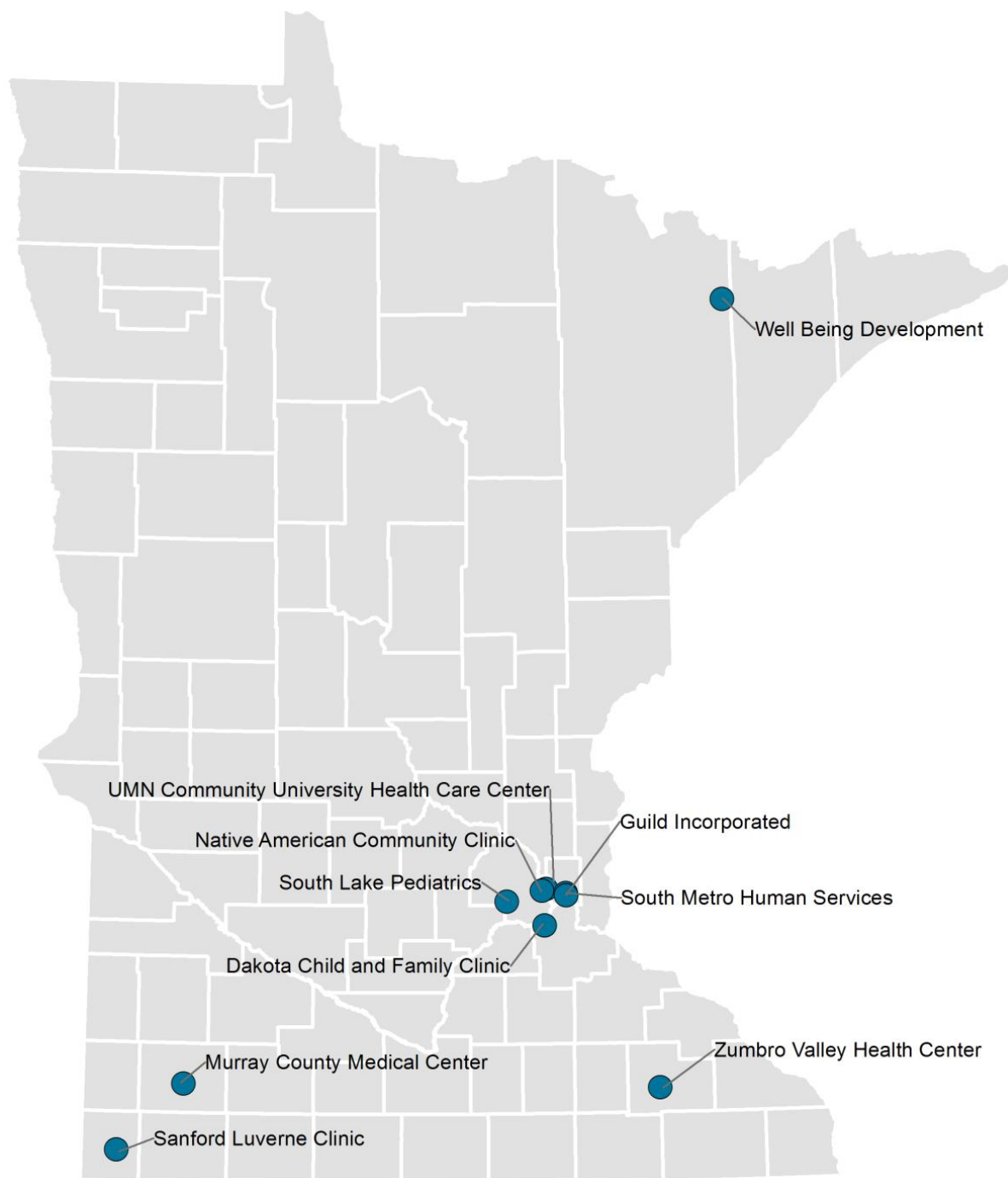
Practice Transformation Grant Program, Round One

The goal of the Practice Transformation grants is to support primary care, social services, and behavioral health provider teams to participate in transformation activities aimed at fostering integration of care. Practice Transformation grant funds supported the broad goals of the Minnesota Accountable Health Model in the areas of providing coordinated care across settings for complex patients, populations, and models of accountable care.

The first round of grants under the Practice Transformation Grant Program totaled \$194,768 and funded four primary care, four behavioral health/social service, and two combined primary care and behavioral health organizations during the first half of 2015. Geographically, four of the grantees are in Greater Minnesota and six are in the metropolitan area (see Exhibit 5.1).

This program is part of a \$45 million State Innovation Model (SIM) cooperative agreement, awarded to the Minnesota Departments of Health and Human Services in 2013 by The Center for Medicare and Medicaid Innovation (CMMI) to help implement the Minnesota Accountable Health Model.

Exhibit 5.1. Practice Transformation Grantees, Round 1



Source: SHADAC, *Database: Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative*, University of Minnesota, School of Public Health. Minneapolis, Minnesota. Dec. 2015.

Notes: Database is based on state documentation, grant applications and agreements, select progress reports, organization websites, and consultation with the state.

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Key Activities

Activities funded by the first round of Practice Transformation Grants supported models that integrate primary care, behavioral health, social services, training, and coordination of care. The main activities completed across the 10 grantees are discussed in this section.

HCH Certification or Recertification Preparation

The first round of Practice Transformation grants allowed providers and clinics to prepare for HCH certification or re-certification process. Grant-funded activities included: engaging the services of consultants to conduct gap analyses; generating quality improvement plans for clinics and providers engaged in the HCH certification or re-certification process; updating care plans to meet HCH requirements; and establishing or refining care coordination processes, refining team roles and functions, and enhancing care coordination support.

Care Coordination

Care coordination includes providing support for the sharing of information across providers, patients, types of service, locations, and time frames to ensure that patients' needs are met and that their preferences are incorporated into the efficient delivery of high-quality care. Activities undertaken included: supporting staff time dedicated to care coordination activities; engaging consultants to identify needs and develop work plans; and providing training to support and enhance care coordination effectiveness.

Primary Care and Behavioral Health Integration

Grantee activities related to integrating primary care and behavioral health services included: looking for practitioner or clinic partners to share physical space (e.g., a primary organization agreeing to move in to the same space as a behavioral health organization); identifying interested parties and negotiating for contractual relationships between primary care and behavioral health providers; identifying patients in need of referrals; working to get information from behavioral health visits incorporated into primary care EHR; bringing primary care and behavioral health personnel together in regular staff meetings (for grantees with primary and behavioral health services already co-located); and providing training for care coordination staff on both the primary care and behavioral health areas to strengthen skills in care coordination and patient hand-offs.

BHH Planning

These grants were also used for planning for BHHs, of which the implementation was delayed. As of this writing, the state certification process of BHHs has begun, with a target launch of July 1, 2016. To date, grantees have engaged in planning activities related to BHH that include: pulling together the individuals to form BHH teams within their organizations; setting short- and long-term goals to be ready for BHH implementation; and participating in the First Implementers Group convened by DHS.

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Patient Registries and Data Analytics

Many grantees created or enhanced existing patient registries, implemented panel management logs to help attain outreach goals, and developed new data collection processes and analytic tools intended to streamline care coordination activities and improve the quality, access, and efficiency of delivering care. Several grantees created condition-specific action plans, integrated care plans, and other templates, which are at various stages of being incorporated into and made accessible through the EHR. Other activities initiated under these grants included standardizing workflows and processes for EHR documentation and using new tools to support providers' ability to access and pull information from the EHR to better facilitate cohesive care coordination.

Outcomes

The Round 1 Practice Transformation grants were for six months, although several were extended for limited amounts of time. As of this reporting, all first round Practice Transformation grants are complete. Grantees reported a number of accomplishments attributable, at least in part, to the activities funded by these grants.

Successful Health Care Home Certification or Re-Certification for Grantees Seeking It

Zumbro Valley Health Center became the first community mental health organization in the state to receive HCH certification. Several other grantees were already certified Health Care Homes at the start of this grant program and maintained certification. Seven first round grantees were certified HCHs as of early 2016.

Enhanced Coordination of Care

Reported outcomes related to enhanced care coordination models included:

- Improved communication between providers, care coordinators, and health educators;
- Revised staffing and position duties to facilitate work at the top of the license (e.g., RNs);
- Bringing formerly siloed co-workers together via changes to internal meetings;
- More patient referrals to health coaches, dietitians, and other specialized services;
- Increased number of patient concerns addressed in a visit; and
- Improved discharge planning and post-hospitalization care for patients.

Several grantees reported that training – some delivered through HCH Learning Days – was effective in building skills in engaging patients and families via health coaching, motivational interviewing (a method of patient interaction aimed at strengthening the patient's motivation towards a goal by exploring his or her own reasons for change), and patient-centered action goal setting.

Fostered Integration of Primary Care and Behavioral Health

Many grantee activities were related to increasing integration between behavioral health and primary care. Grant-funded activities contributed to a number of accomplishments in this area, including bringing formerly "siloed" co-workers together through modified staff meetings to include both primary

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care and behavioral health personnel (for providers with co-located primary care and behavioral health). One grantee said, “The care coordinators and – on the behavioral health side, they call them integrated care managers – they meet together. In the beginning, they had separate meetings. Now they meet together. So that’s huge...regularly talking about and reminding themselves to say, ‘Any time we’re looking at the patient, we’re looking at the whole patient.’” In addition, several grantees developed new electronic care plans with input from both primary care and behavioral health; training was provided regarding these new tools.

One primary care grantee implemented the use of a depression screener with all patients and monitored changes to the rate of depression diagnosis. Another grantee developed a system for monitoring referrals to behavioral health services and following up to ensure that behavioral health treatment notes are received and included in the EHR.

One behavioral health organization engaged a nurse practitioner and a registered nurse to provide primary services on-site; another entered into an agreement with a primary care provider group to co-locate with a social service organization, and is pursuing the same with a dental provider and a pharmacy. A third grantee created a behavioral health network with representatives from primary care and mental health organizations to foster stronger collaboration, cooperation, and referrals.

Readiness for BHHs

In advance of the BHH requirements being issued, Round 1 Practice Transformation Grant program recipients made progress in planning and establishing readiness for BHH implementation. The results of planning efforts to date include: BHH teams have been established within the grantee organizations interested in seeking BHH certification; BHH teams have guided the planning process in these organizations; and action plans have been developed. Planning processes have included consideration of how BHHs might affect other operations and service lines; preparing for possible re-organization of other services; and initiating internal discussions about how and whether to provide different types of care coordination/case management for different types of services.

Expanded Patient Registries and Enhanced Analytic Capacity

Many grantees created or enhanced existing patient registries, implemented panel management logs to help attain outreach goals, and developed new data collection processes and analytic tools intended to streamline care coordination activities and improve the quality, access, and efficiency of delivering care. Several grantees created condition-specific action plans, integrated care plans, and other templates which are at various stages of being incorporated into and made accessible through the EHR. Other activities initiated under these grants included standardizing workflows and processes for EHR documentation and using new tools to support providers’ ability to access and pull information from the EHR to better facilitate cohesive care coordination.

Facilitators

Factors viewed by Round 1 Practice Transformation grantees as enabling their work included the following.

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Ability to Dedicate Staff Time to Practice Transformation Activities

Almost all interviewees communicated the importance of the grant in affording provider and staff time to focus on practice transformation planning and implementation work. As one grantee said, “Anytime you get a grant like this...it helps stimulate you to think about the new things you can do.” Several grantees also valued the structure that comes with a grant (timeline, deliverables, regular meetings with funder) to keep things moving.

Committed Leadership Aligned with Existing Momentum

Committed and flexible leadership within the provider organizations was described by multiple interviewees as an important facilitator. These grantees underscored leadership support of key principles of care coordination and integration and that the grant activities aligned well with the organization’s mission as well as previous or other current practice transformation efforts. One interviewee also noted that their status as an independent clinic allowed their organization to be more nimble and responsive to changing transformation priorities.

Access to External Expertise

Several grantees identified an external facilitator and consultant as key to their work. One grantee stated that they had an existing relationship with the consultant they leveraged through the grant, and that history was also helpful because there was little work required to get the consultant up to speed on their internal processes and challenges. Two other grantees utilized the expertise of a consultant with whom they had not worked in the past.

In all cases, grantees expressed that it was constructive and productive to have someone with technical expertise come in, take a step back with the organization, and help grantees think through integration workflow changes and technology enhancements. One consultant was also helpful in addressing resistance among staff to changes in workflow/culture.

Communication Among Multiple Stakeholders for Transformation

The importance of engaging all stakeholders (providers, other care team members, staff, IT personnel, etc.) in designing and implementing practice transformation activities was emphasized by a number of grantees. Grantees used existing provider and staff meetings, initiated new staff teams focused on integration or other practice transformation activities, facilitated staff presentations and other approaches for staff to share what they and their different departments do, and staff trainings to engage different individuals in the activities and/or to inform them of status.

One grantee said, “We approached patient care as everyone in the building has a role. Everyone needs to be on the same page as to their role. Having everyone on the same page can really help facilitate the work.” Another grantee mentioned the importance of having care coordinators work in the same physical space as physicians to facilitate collaboration.

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Challenges

A number of grantees drew attention to challenges associated with implementation of the Practice Transformation grant.

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Limitations of Existing EHR Systems

Reported challenges with EHR systems included:

- A lack of familiarity among organization staff with the EHR system to maximize its utility;
- The lack of capacity of some EHR systems to incorporate a desired reform. For example, one grantee created a registry in Excel separate from the EHR because registries in the EHR are not designed for either behavioral health or population health management;
- The significant amount of time and funds it can take to implement a reform into an EHR system. One grantee commented, “The diabetic flow sheet has information we wish we could include, like immunizations, but we have to manually enter it in order for it to be utilized. Providers like to have all that information in the flow sheet. Their EMR is a different system. It’s a big cost issue.”
- Limitations in the EHR system to pull data from different parts of a patient’s chart for workflows/integrated care plans and the challenges with keeping these data up to date;
- Their EHR system being different from the systems used by other providers around them; and
- The complexity of capturing different health assessment and other data required by different payers within their EHR.

Although a few grantees reported some EHR system strengths and interviewees consistently cited advantages from the technical/workflow enhancements made possible through the grants, many indicated that significant challenges related to interoperability and data remain. For example, several conveyed challenges with getting information back from specialists and other referrals, and others mentioned that their workflows continue to rely on manual data entry and/or mechanisms external to the EHR such as Excel. Making state technical expertise/assistance related to IT available to grantees was a recommendation by one grantee. As one grantee stated, “Our care coordinators are not IT people; we don’t hire them for that.”

Staff Turnover and Limited Workforce Availability

Staff turnover was noted by several interviewees as a barrier in the implementation of their grant and/or their practice transformation efforts in general. Staff time is required to design and execute practice transformation activities as well as to orient and train other staff on new processes.

Turnover in staff can cause delays and other difficulties in the implementation of the activities. Staff turnover is especially challenging if the person who is leaving the organization is critical to new processes (such as a care coordinator or care coordination lead). Onboarding new staff involves training time for both existing and new staff as well as a learning curve for new staff, particularly if processes pertain to complex patients.

Standardization of processes, standardization of templates, and training manuals were three approaches described by grantees to assist in transitioning new staff. A related barrier is the ability to find, hire, and afford new staff with the necessary qualifications. Two grantees identified workforce challenges in rural

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areas. Another mentioned limited IT expertise among their current staff and the lack of financial resources to hire an IT person.

Resistance to Organizational Change

Several grantees experienced reluctance among providers and staff while implementing their practice transformation activities – “...that tendency for people to want to continue what they’re doing in the way they’ve been doing it and not wanting to change.” For example, grantees struggled with getting clinical staff to think about and use data and getting physical health providers to understand the importance of behavioral health care (and vice versa).

Leveraging strong rapport with staff/providers, holding meetings to share information about the status of practice transformation activities, and training staff on new processes were examples provided by grantees to ease concerns and improve understanding of the changes.

Restrictions in the Allowable Uses of Grant Funding

A couple of grantees complimented the grant program for not requiring the hiring of new staff. Being able to support existing staff in these efforts (as opposed to searching for, hiring, and onboarding new staff) was considered helpful for these grantees. Nonetheless, a few grantees pointed to limitations with the grant funding, highlighting that grant funds were not allowed to be used for the purchase of internet access, hardware, software, or incentives for patient participation in practice transformation activities. These grantees commented that some providers do not have the financial means readily available to support these types of purchases.

Continuous Improvement Feedback

The grantees interviewed offered some useful insights for the state.

Appreciation for State Support and Flexibility

Many grantees communicated an appreciation for the opportunity to interact and check in with state staff via monthly phone calls, some referring to one state staff person in particular as a “partner in the work.” One grantee expressed appreciation for the state’s willingness to be flexible with project goals and objectives and to have constructive conversations about how to adjust project goals and pursue alternative solutions due to unforeseen changes.

Learning Opportunities Important

Trainings and learning opportunities provided by the state were noted by a couple grantees as helpful in facilitating progress on their grant activities. One interviewee pointed out that these types of trainings or learning opportunities are most useful when they result in a tangible, practical skill or tool that can be brought back to day-to-day-patient care (e.g., motivational interviewing). A grantee noted that IT assistance would have been helpful. One grantee recommended group phone calls so that grantees can be introduced to and share experiences and insights with other grantees.

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Small Grants Enable Important Incremental Change

Several grantees echoed the sentiment that it does not require a large grant to make a big impact. For some of the individuals, the effectiveness of these small, first-round Practice Transformation grants was due to allowing funds to hire specialized consultants to work with grantees on issues specific to each grantee (e.g., data privacy, information sharing). In addition, several grantees appreciated the value of being able to carve out distinct, recognized, staff time dedicated to practice transformation. As one grantee pointed out, “Anytime you have a targeted effort for something, you carve out the time for it. We ended up saying ‘This is our practice transformation time. Or this is our practice transformation meeting’.” Finally, one grantee mentioned the importance of the grant in energizing existing efforts and keeping efforts on track, saying “I really believe that if we hadn’t gotten the transformation grant, we would still be kind of stagnant. We would not have changed anything we have.”

Sustainability Insights

SHADAC researchers asked each of the Round 1 Practice Transformation grantees about the sustainability of the work funded under the Minnesota Accountable Health Model and summarized finding below.

Some Activities are Self-Sustaining, Incorporated into Daily Work

Where grant funding was used to develop new or refine existing processes, the work was completed and staff members were trained during the grant period; so, going forward, the changes will remain incorporated into the regular work and the activities will be sustained as part of regular daily work. For example, role clarification and position description revisions, will not go away at the end of the grant period. One grantee summed it up this way, “The work we did with this grant, the work we accomplished, is now part of the work we do.”

Some grantees also noted that for some grant-funded activities (e.g., workflow redesign, new tools or practices to support enhanced care coordination), the recognized value is sufficient to warrant continued funding within an individual organization. As one grantee said, “We won’t go without it [care coordination]. It’s not going to happen. We’ll keep scrapping to keep our heads above water.”

Leveraging HCH Infrastructure

The Practice Transformation grant program was built on the infrastructure and momentum of the existing HCH Initiative to further expand patient-centered, coordinated care across the state. By design, allowable activities under this grant program included preparation for HCH certification, recertification, or planning activities for BHH. The ongoing HCH infrastructure, tools, and maintenance of certification and the impending BHH will serve as sources of sustainability for the practice transformation gains resulting from this grant program. In addition, the payment mechanism for HCHs will continue to support some care coordination activities.

Pursuing Additional Grant Funding

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Many of the grantees expressed a strong can-do attitude about their organizations' histories of successfully identifying and seeking opportunities for grant funding to support their work. Of the ten grantees in this round of grants, three applied for and received Round 2 funding, and three organizations submitted successful applications for all three rounds of Practice Transformation grants.

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6. ACCOUNTABLE COMMUNITIES FOR HEALTH (ACH)

Introduction

The goal of Driver 4 of the Minnesota Accountable Health Model is that “provider organizations partner with communities and engage consumers to identify health and cost goals and take on accountability for population health.”⁴⁶ The key effort under this Driver has been the implementation of a two-year competitive grant program (January 2015 – December 2016) to establish 15 Accountable Communities for Health (ACHs) across the state. A related activity under this Driver was the award of a competitive ACH Learning Collaborative Grant to provide technical assistance and peer learning opportunities to the ACHs during their grant period. Each ACH has received approximately \$370,000 for the program period. The National Rural Health Resource Center (the Center) was awarded approximately \$200,000 as the ACH Learning Collaborative or technical support provider between February 2015 and December 2016. Both grant programs are being overseen by the Minnesota Department of Health (MDH).

In this chapter, we first introduce the 15 awarded ACHs and briefly describe the work of the Center in 2015. Using information obtained from interviews with each of the ACHs and a review of ACH documentation, the balance of this chapter focuses on the work and approaches being implemented by the ACHs and key findings to date.

Awarded ACHs

ACHs are collaboratives including providers and other organizations to identify and implement 1) care coordination and 2) population-based prevention strategies to address the health care needs of a community population. The ACH grant program includes several core requirements for ACHs, including the establishment of an ACH leadership team, a community-based care coordination system or team, a population-based health prevention component, a plan for sustaining the work of the ACH beyond the grant period, an approach for measuring progress toward goals, and participation in the ACH Learning Collaborative and evaluation activities. Each ACH has focused its implementation efforts on a target population, such as people living within a particular geographic area (e.g., community or county), high health care resource utilizers (e.g., individuals who have multiple emergency department visits per year), individuals with a specific health condition or disability, or an underserved or marginalized group. Each ACH involves multiple organizations within a community, ranging from five to over 20 organizations. ACHs are required to include at least one organization participating in or planning to participate in an accountable care organization (ACO) payment model. In addition, each ACH was encouraged to include providers and other organizations that reflect the goals of Minnesota’s Model, including the priority settings identified under the Model: local public health, long-term care services

⁴⁶ Source: State of Minnesota. *Resources*. Web. Dec. 2015.

<http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LATESTRELEASED&dDocName=SIM_Docs_Reps_Pres>

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and supports, behavioral health, and social services. Each ACH must also include people who live in the community and organizations that represent the target population.

The map and table below (Exhibits 6.1 and 6.2) identify the 15 awarded ACHs in the state. Three of the ACHs—Ely, Hennepin County Medical Center, and Mayo—received sole source grants as an extension of a prior grant program administered by MDH’s Health Care Home (HCH) program called the Community Care Team (CCT) Pilot. (Two of these CCTs changed their activities and/or their target populations when they began their ACH work.) Between 2011 and 2012, the CCT grant program provided resources to health care providers to improve existing partnerships of local hospitals, primary care clinics, public health, behavioral health, social services and other community services. In order to improve collaboration, the CCTs formed leadership structures to engage partners, form a decision-making process, and enhance communication. Each CCT targeted a distinct population and sought to integrate services, coordinate care, develop cost-effective practices, promote patient centered care, and tackle health disparities.

ACH Learning Collaborative

The goal of the ACH Learning Collaborative is to provide technical support to and facilitate peer learning among the 15 ACHs to increase knowledge and capabilities related to patient-centered, coordinated, and accountable care. The state required that the National Rural Health Resource Center address two topics in its learning activities (leadership team development and sustainability planning) but otherwise, the Center’s work has been informed by a web-based technical assistance needs assessment survey administered to the ACHs by the Center in the summer of 2015.

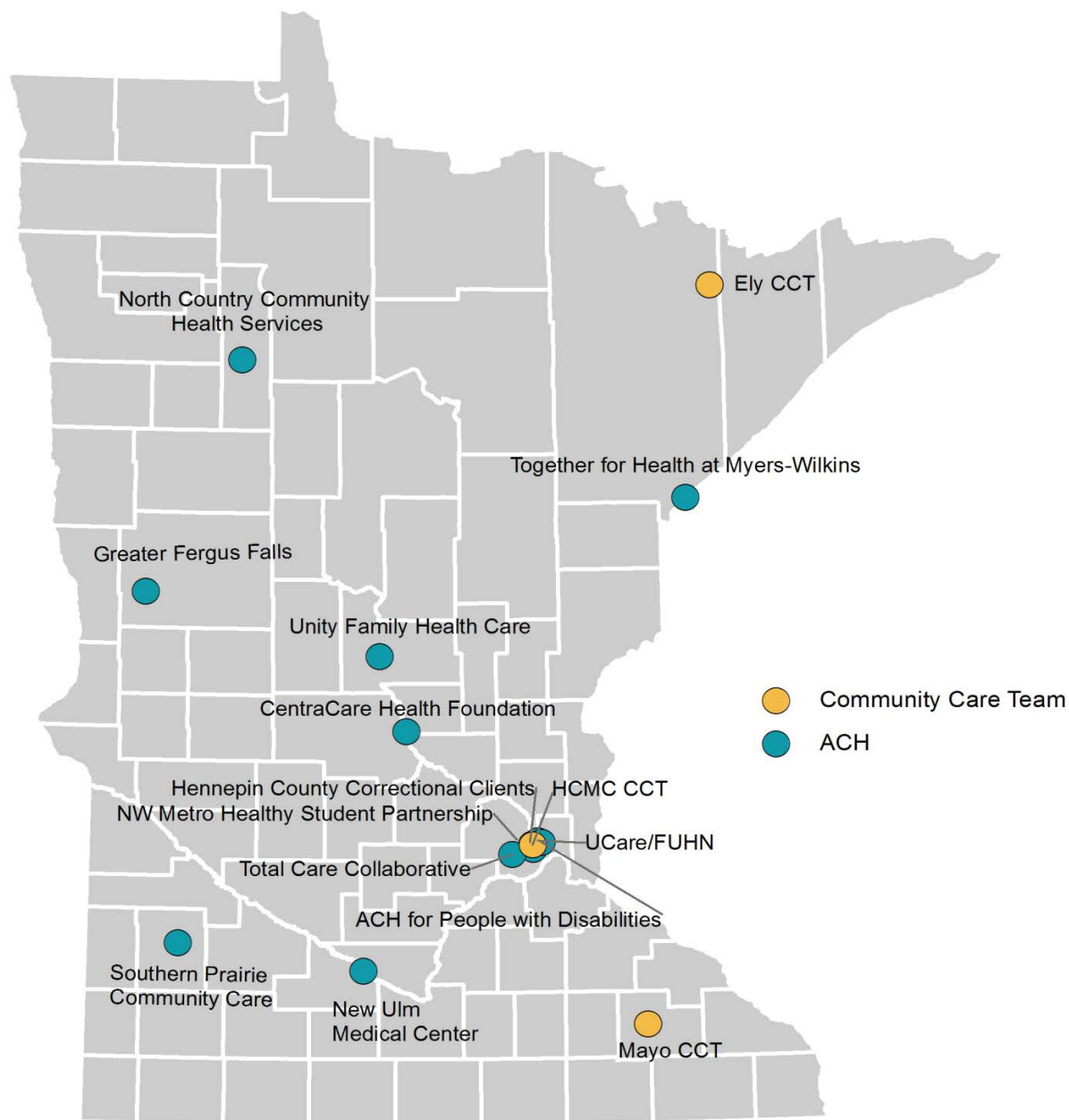
During 2015, the Center held a number of learning sessions for ACHs. These included:

- Two in-person ACH workshops, one in May 2015 focused on leadership team development and sustainability practice and the other in October on e-Health and data analytics;
- Two webinars, one in July 2015 summarizing the results of the ACH technical assistance needs assessment survey and the other in August 2015 on care coordination; and
- Two cohort calls in September and December 2015 to facilitate peer-to-peer sharing on care coordination and tools and e-Health and data analytics.

ACH grantees are required to participate in Learning Collaborative events. In addition to these group learning events, the Center has received requests from and has provided one-on-one support to most of the ACHs. According to reporting by the Center, these requests have pertained to community integration and partnership, e-Health, data analytics, care coordination, behavioral health integration, and culturally appropriate care. This assistance has been provided by Center staff, state staff, or contracted experts via email and telephone throughout the year.

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Exhibit 6.1. Minnesota Accountable Communities for Health (ACH) Grantees



Source: SHADAC, *Database: Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative*, University of Minnesota, School of Public Health. Minneapolis, Minnesota. Dec. 2015.

Notes: Database is based on state documentation, grant applications and agreements, select progress reports, organization websites, and consultation with the state. Plotted organizations may overlap because they are in close proximity.

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Exhibit 6.2. Minnesota Accountable Communities for Health (ACH) Grantees

ACH Name	Lead Agency	Description
ACH for People with Disabilities	Lutheran Social Service	Explore models of health care delivery and improve disability-competency of medical providers with a holistic LifePlan approach for people with intellectual and developmental disabilities who live in the Metro area and are supported by Altair ACO member organizations.
CentraCare Health Foundation	CentraCare Health Foundation	Reduce the incidence of unmanaged diabetes in Latino and East African patient populations in Stearns County .
Ely CCT	Essentia Health Ely Clinic	Provide coordinated health and social services for people living in poverty or with behavioral health challenges in Ely and surrounding communities .
Greater Fergus Falls ACH	Partnership4 Health CHB	Coordinate health and social services for people on MN Healthcare Plans and uninsured low-income residents in Becker, Clay, Otter Tail counties .
Hennepin County Correctional Clients	Hennepin Health	Improve enrollment in health programs, reduce homelessness, increase employment, and reduce recidivism among correctional facility clients in the Metro area .
HCMC CCT	Hennepin County Medical Center	Provide mental health -focused care using community interventions that combine social connectedness and healthful lifestyle, improved care transitions, and other support in Brooklyn Park .
Mayo CCT	Mayo Clinic	Link chronically ill adults in Rochester area with community services using a wraparound process to support patient self-management.
New Ulm Medical Center	New Ulm Medical Center	Decrease emergency department visits and inpatient admissions, and improve health outcomes in New Ulm's Medical Assistance population .
North Country Community Health Services	North Country Community Health Services	Improve region's capacity to support at-risk youth in crisis who live in Clearwater, Hubbard, Beltrami, and Lake of the Woods counties and White Earth Tribe .
Northwest Metro Healthy Student Partnership	Allina	Provide Anoka-Hennepin School District high school students with expanded mental health screening, supportive services, and health education.
Southern Prairie Community Care	Southern Prairie Community Care	Develop a community-wide initiative to delay and ultimately prevent Type 2 diabetes in those at risk who live in 12-county area in southwestern Minnesota .
Together for Health at Myers-Wilkins	Generations Health Care Initiatives	Meet health and wellness needs of students and family members of Myers-Wilkins Elementary School and the surrounding neighborhoods in Duluth .
Total Care Collaborative	Vail Place	Increase person-centered care for people with serious mental illness living with chemical dependency issues and co-occurring chronic diseases who live in North Minneapolis, Robbinsdale, Brooklyn Center, and Brooklyn Park .
UCare/FUHN ACH Initiative	UCare	Document and strengthen processes of care for MN Healthcare Plans members at FUHN clinics in the Metro area .
Unity Family Health Care	St. Gabriel's Health	Mitigate need, overuse and access to prescription narcotics and illegal drugs among seniors and other individuals in Morrison County .

Source: State of Minnesota. Accountable Communities for Health Grant Projects. Web. Dec. 2015. <http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=sim_achg>
 p#>Note: Bold text indicates target population.

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The remainder of this chapter presents summary information about ACHs' leadership and governance, care coordination approaches, implementation experiences, as well as continuous improvement and sustainability insights to date. The findings included in this chapter were identified through SHADAC's review of grant program materials and grantee submitted reports as well as interviews with individuals engaged in each of the 15 ACHs (a total of 102 individuals). Interviews with ACHs were conducted between October and December 2015.

Most interviews with ACHs were in-person at the location of the lead or other partner organization; discussions with three ACHs were conducted via telephone. Two separate interviews were conducted with most of the ACHs. One interview was focused on the leadership structure, partners, and governance of the ACH. This interview typically included representative(s) of the lead agency and members of the ACH leadership team. The other interview focused on the ACH's care coordination approach, processes, and tools and included individuals most familiar with the ACH's care coordination effort (e.g., project managers, community health workers [CHWs], etc.). During both interviews, SHADAC researchers asked participants about accomplishments, facilitators of that progress, barriers or obstacles experienced, lessons learned to date, and assistance/support needed. Three areas were not a focus of the 2015 interviews: ACH's population-based health prevention component, individual ACH measurement/monitoring plans, and sustainability planning. These areas are being considered for prioritization in the state evaluation for 2016.

Accountable Communities for Health

Key Activities

Structure and Governance

As described above, each ACH was required to establish a leadership team and a community-based care coordination system or team. The state envisioned the leadership teams to represent a broad range of providers and organizations in the community, people who live in the community, and members of the target population and charged the teams with identifying the health priorities and strategies to be implemented within the community. The care coordination systems or teams were intended to build on existing resources to provide assistance for individuals living in the community, such as transitions management, referral coordination, and community service coordination. The names of these teams or groups vary across the ACHs.

During the first year of the grant, all 15 ACHs formed a leadership group as well as identified or put in place a community care or care coordination team/staff. In many cases, a project director, manager, coordinator, or other individual(s) serve on both the leadership and care coordination teams to facilitate communication between the two groups. Five ACHs have an additional operations-focused leadership group interconnecting an executive/advisory leadership team and the care coordination team. Six of the ACHs have pulled in existing councils or leadership structures to serve as the basis for their executive/advisory or leadership teams.

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In addition to the core leadership and care coordination teams, many ACHs have other bodies incorporated into their structure. Nine ACHs report to, consult, or otherwise interface with other groups that have an advisory role in the work, such as a community task force or board. In addition, ten ACHs include other subgroups or workgroups within their structure. Some include a group focused specifically on community or population health initiatives; an evaluation subgroup has also been established under several ACHs. Other subgroups or workgroups may address health information exchange or data analytics, represent a particular provider group, or focus on sustainability beyond the ACH grant.

Our interviews in 2015 included questions about formal agreements in place, decision-making approaches, and communication plans for ACH leadership teams and other executive groups. While this information was not mentioned during or clear from a subset of the ACH interviews, seven ACHs reported having some formal document outlining ACH leadership partner responsibilities, roles, and in some cases decision making expectations. For five of these ACHs, a charter had been written during the first year of the grant. An additional ACH had created an interagency governance agreement for the leadership team, and another had outlined this information in an addendum to their work plan. The approaches ACHs are using for decision making included informal, consensus, and “modified-consensus.” In some cases, a decision making approach was not specified. All ACHs reported regular meeting schedules for their leadership groups. Several reported that following ramp up, meetings remained regularly scheduled but had become less frequent over time (e.g., from monthly to quarterly). Many ACHs indicated that email, telephone, and “spin-off” meetings also are used for communication in between formal meetings.

Partners and Roles

Lead Agencies

Although all ACHs involve multiple providers, organizations, and individuals, the grant mechanism requires a fiscal agent and lead agency. For seven of the ACHs, the fiscal agent for the grant is (or is affiliated with) a health care provider such as health center, clinic, or hospital. Other fiscal agents include a social service agency, a behavioral health provider, a managed care program, a health plan, an organization representing a multiple county health collaborative, county public health agencies (2), and a private foundation.

Collaboratives determined their respective lead agency based on a number of factors. The MDH CCT grant program was awarded to health care providers, and the three ACHs that were prior CCT grantees continued with the same lead under the ACH grant program. In addition, a strong connection between ACH goals and HCH activities or medical care coordination in general factored into medical systems or clinics serving as the fiscal agent for several other ACH grants. For other ACHs, the fiscal agent was determined based on the agency’s resources and capacity to apply for funding. For a third of the ACHs, the lead agency was determined in response to an agreement that the agency was the best suited to be lead agency or due to no other agencies “jumping on it.”

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One of the goals for our 2015 ACH interviews was to understand the organizations involved in each of the ACHs and their respective roles in the collaborative. Across the ACHs, many fiscal agents have similar functions, including project management/coordination, financial monitoring, state reporting, communication, facilitation of/participation in ACH leadership team, and oversight of implementation. This overarching role as the hub or “anchor” or “backbone” organization was highlighted by nearly all fiscal agents. Some roles, however, were noted only by a particular subgroup of fiscal agents. For example, county health and county public health leads called attention to their role in health promotion and population health. Most lead agencies that are health care providers noted being the source of referrals/patients targeted by the ACH as well as involved in care/service coordination and facilitation. Two fiscal agents emphasized their role in providing data and data analytics.

It is important to note that almost half of the ACHs include another organization that, in collaboration with the fiscal agent, participates heavily in overall ACH leadership and management.

Partnering Organizations and Community Members

The types of partners involved in an ACH vary and include health systems, health clinics, hospitals, local public health organizations, behavioral health providers, health plans, human service and social service agencies, schools and/or school districts, housing resources, disability service providers, long-term care providers, correctional facilities, faith-based organizations, legal services, city governments, and individuals who live in the community and who represent the targeted population.

Many of the ACHs build on existing collaboratives and partnerships among providers and organizations. Not only do the three CCT grantees leverage existing formal collaboratives, but so do eight other ACHs. In addition, three other ACHs reported that the key ACH organizations have a prior history of working together. Even so, the majority of ACHs identified new partnering organizations, and for two of the ACHs, most if not all of the partners represent new relationships. Nearly all ACHs considered engagement of new partners or the strengthening of existing partnerships one of their most important accomplishments for the first year of their grant.

ACO Partner

By the end of their first grant year, ACHs were required to have at least one active provider or organization partner engaged in an ACO or a similar accountable care model based on performance on cost, quality, and experience. This partner may be involved in a Medicaid Integrated Health Partnership (IHP), safety net ACO (e.g., Hennepin Health), Medicare ACO (Shared Savings or Pioneer), commercial ACO, or other ACO or ACO-like arrangement. ACO partners include an IHP fiscal agent (e.g., Northwest Metro Alliance or Southern Prairie Community Care), a specific clinic/provider participating in an IHP or other ACO arrangement (e.g., Essentia- Ely Clinic or New Ulm Medical Center), or a health plan or managed care plan (e.g., South Country Health Alliance or Hennepin Health).

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By late 2015, all ACHs had an ACO partner in place, and most currently have only one ACO partner. However, five ACHs—ACH for People with Disabilities, HCMC CCT, Hennepin County Correctional Clients, New Ulm Medical Center, and Together for Health at Myers-Wilkins—have more than one partner engaged in an accountable care model. In total, 13 ACHs include a provider/organization participating in an IHP; four ACHs have a partner engaged in a Medicare ACO; one ACH is partnering with Hennepin Health; and five ACHs include a partner involved in another ACO or ACO-like arrangement.

The role of the ACO partner(s) on the grant and within the ACH governance varies across the ACHs. For about half (7) of the ACHs, an organization participating in an ACO is the fiscal agent. In 14 ACHs, an ACO representative or provider participant is serving on the ACH leadership team. In 13, at least one staff member from an ACO or provider participant is serving on the community care or care coordination team or system. For 10 ACHs, a staff person of the ACO partner plays a significant part in overall project management for the ACH. Some ACO partners have also provided data, data analytics, and connections with providers and have been a source of patients/referrals for the ACHs. In only one ACH, the ACO partner participates on neither the leadership team nor coordination team.

Each ACH was asked about the overlap between its ACH target population and the patient populations attributed to their ACO partners. The majority of ACHs (11) reported that their target population likely includes ACO patients but is broader and includes non-ACO attributed individuals as well. In fact, only one ACH, led by an ACO partner, reported specifically targeting their ACO population. As one respondent described it, “We don’t necessarily target [attributed] patients...the work of [our ACH] is bigger than that.” If individuals attributed to an ACO are touched, “it’s not by design.” Three ACHs with IHP partners called attention to an inability to pull data to identify IHP patients specifically: “We are struggling to connect with those patients and identify who may be good candidates for this work.” Overall, our interviews indicate that while providers participating in ACO arrangements are significantly engaged in most ACHs to date, the link between ACO attributed populations and ACH services is not well known and may be minimal in some cases.

Local Public Health

In an effort to encourage better integration of health care systems and public health in the state, MDH’s request for ACH proposals conveyed a desire for local public health participation in ACHs. At the same time, the RFP acknowledged that public health organizations may have difficulty participating due to time and resource constraints.

As of the end of 2015, nine of the ACHs had a local public health partner involved, two did not, and the engagement of public health in four ACHs was either forthcoming or unclear. As mentioned above, for two of the ACHs, a public health organization is the lead ACH organization. Specifically, Otter Tail County Public Health is the lead grant organization for Greater Fergus Falls ACH, and North Country Community Health Services is the lead grant organization for the North Country ACH.

Interviews with ACHs revealed that the involvement and role of public health in ACHs are less clear or light in some cases. For example, three ACHs commented that they “don’t see them that much,” the

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relationship was “ambiguous from the beginning,” or there “could be a stronger connection” when it comes to public health participation.

That said, local public health organizations have a noticeable role in several ACHs. Under six ACHs, at least one local public health organization is a member of the ACH leadership team. Local public health organizations also participate in the community care or care coordination teams associated with about half (7) of the ACHs, and in a third of the ACHs, a local public health organization is participating in both the leadership and care coordination teams. Across ACHs with a public health partner, public health organizations have brought a health promotion focus, hired key coordination staff, conducted population health activities, contributed data and evaluation expertise, and supported community engagement and relationship building.

Members of the Community and/or Target Population

Under the ACH program, communities around the state have identified community-specific population health needs and are developing and implementing community engagement, care/service coordination, and prevention-based population health efforts to address these needs. A key component of the state’s original vision for this program was the inclusion of community members (including those for whom ACH efforts are targeted) in the development and implementation of the work of the ACHs. One of the recommendations from the Community Advisory Task Force ACH Subgroup was that community members have not just an advisory role but also a role in decision making. To this end, the RFP for the grant program specified that the leadership team of the ACHs should include community members and members of the target population.

All ACHs have either implemented new opportunities for community and/or target population member participation or leveraged existing mechanisms for community representation and input among partnering organizations. As of the end of the first year, eight ACHs had at least one community or target population member included on their leadership team. One ACH’s leadership team includes up to 15 members, and another includes eight community consultants who are paid on an hourly basis as subcontractors for their participation. Four ACHs have community or target members involved in a community care team, advisory group, or subgroup of the ACH. Two other collaboratives reported that they are still seeking to identify a member on their leadership team.

ACHs have also encouraged and facilitated community participation through other means. These include focus groups, surveys, interviews, or other activities which have been carried out by seven ACHs to solicit input and feedback from community and target population members. Five ACHs also called attention to existing approaches to and structures for community engagement among participating organizations, such as a community, patient, or consumer councils or patient representation on clinic boards.

Finally, hiring has been another approach for engaging individuals within the community. Two ACHs in particular emphasized the importance of hiring CHWs and other staff who are members of the community or share characteristics with the target population.

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Community-Based Care Coordination

In its RFP for the ACH Grant Program, MDH calls for an ACH “community based care coordination system or team” that:

“...provides direct service coordination for persons in the community...develops transitions management for high need patients and families from health care delivery systems and coordinates referrals with a broad range of community providers and partners to address social determinants of health to ensure patient centered coordinated care with enhanced communication is in place.”⁴⁷

The goal of care coordination within the ACHs is to address the challenges that individuals, especially those with complex conditions, face in getting the care they need—challenges that are often rooted in the social determinants of health and therefore extend beyond the medical realm. Community-based care coordination integrates medical and other services to reduce care fragmentation and avoid the risk of duplicative care coordination efforts.

The RFP for the ACH grant program required that applicants develop a community care coordination model/system that includes community providers/partners. Applicants were required to demonstrate the leveraging of existing resources in the community, outline staffing and administrative structures for the ACH, and provide a detailed implementation plan addressing proposed communication methods, data-sharing, transitions planning, and systems for referrals with a broad range of providers and partners. The RFP did not prescribe any particular framework or model for care coordination, providing flexibility to communities to identify and implement an approach based on the needs and means of their community.

By the end of 2015, 14 ACHs had initiated their care coordination efforts, and one was finalizing the development of its coordination approach and planning to pilot its approach soon. The following section on care coordination activities includes an overview of models and approaches across ACHs, a description of care coordination personnel, and a summary of elements of care coordination reported by the ACHs. Our narrative includes both ACH care coordination that had already been initiated by the end of the first grant year and care coordination that was planned.

Care Coordination Models/Approaches

Locus of Care Coordination

ACH care coordination efforts are anchored or oriented in three different contexts: Just over half (9) are or will be conducting care coordination from the starting point of a medical facility or organization (clinic, hospital, health plan); four situate care coordination within a community organization (e.g., social

⁴⁷ See page 16 of the Request for Proposals for the ACH Grant Program.

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Renderion=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_189328

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service agency, school, group living community); and two use a combination of medical and community-based starting points.

When care coordination is anchored in a medical context, it is generally the case that any non-medical components of this coordination involve the identification of community resources for individuals who need assistance with social determinants of health. Individuals are then, for the most part, being connected outward to community organizations and social service agencies that can help directly with these issues. When ACHs anchor care coordination within a community organization, social determinants of health are addressed within the non-medical community, either by the anchor organization itself or by connecting the individual to other non-medical resources, which are often brought to the individual at the anchor care coordination organization. Individuals who have medical needs are then connected outward to medical organizations (clinics or hospitals) for medical services. The two ACHs that have care coordination being initiated at both medical and community-based organizations involve a “no wrong door” approach to care coordination, such that individuals are connected to both medical and non-medical services through a web of connections in the community. In these cases, care coordination for some individuals originates from the medical realm and moves outward to the non-medical community, and care coordination for others starts from the non-medical realm and moves outward for any medical or additional community resources needed.

Intensity of Care Coordination

Because the ACHs have had significant latitude within which to develop their approach to community based care coordination, and furthermore the ACHs are working with a broad range of target populations across a variety of settings, no single care coordination model accurately captures the care coordination approaches ACHs have developed and implemented to date. With this in mind, the care coordination activities of the ACHs can be broadly conceptualized within a framework that scales care coordination activities along a continuum of intensity that increases in tandem with patient needs. Lower-intensity coordination includes activities such as assessments and referrals. With greater patient need and increasing care coordination intensity, coordination activities expand to include elements such as the development of an individualized care plan, patient and family education and patient engagement, the involvement of a collaborative care team, and ongoing monitoring and follow-up.⁴⁸

The care coordination efforts of about half of the ACHs fall at multiple points along this continuum. As one of these ACHs explained, “Some people need info[r]mation and resources. Some need referral and/or a handoff. Some people need to remove barriers. Some people need the full wraparound...” Other ACHs, on the other hand, tend to concentrate their work at certain points along the care coordination continuum: One ACH works primarily at the low-intensity end of the care coordination continuum, while four ACHs, each of which target particularly high-need individuals such as those with developmental disabilities and mental illness, focus on high-intensity coordination work. For three of the

⁴⁸ McDonald, KM, Sundaram, V, Bravata, DM, Lewis, R, Lin, N, Kraft, S., et al. “Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Coordination).” Rockville, MD: *Agency for Healthcare Research and Quality* (2007).

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ACHs, the general intensity of care coordination was not yet clear at the time of interview and was not further clarified in their 2015 Annual Reports.

Care Coordination Personnel

Nearly all (14) of the ACHs have hired or will be hiring dedicated care coordination personnel as part of the ACH or have assigned existing personnel to the ACH initiative. Grant-funded care coordination personnel include CHWs (five ACHs), licensed social workers (LSW, three ACHs), registered nurses (three ACHs), public health nurses (two ACHs), and a health coach (one ACH), along with personnel who do not have specific certifications but are carrying out a care coordination function (five ACHs). Depending in part on the certification and the environment in which the staff member works, the ACHs refer to their community care coordinators using a variety of titles beyond “care coordinator.” Such titles include: care facilitator, family resource facilitator, family health coordinator, family advocate, service coordinator, nurse navigator, case manager, and integration coordinator. A few ACHs commented on the complexity of and confusion around the language used to discuss the care coordinator role.

Elements of Care Coordination

While the ACHs do not adhere to a single community-based care coordination model or approach, below we summarize core elements of the ACH care coordination efforts. These elements were identified by a review of the literature on care coordination and were the focus of our ACH care coordination interviews.

Identification of Patients/Clients for Coordination

The ACHs identify potential clients for care coordination in a number of different ways. In almost half of the ACHs, individuals are referred for care coordination by a medical provider or a community provider. In one case, individuals are identified as candidates for care coordination via a health needs survey. Another ACH uses a payer list of plan enrollees, and two ACHs use disease screenings, while another uses disease registries drawn from electronic health record (EHR) data. In one case, individuals are identified for care coordination based on their residency status in a community facility. Two ACHs employ a “no wrong door” approach wherein individuals can connect with the ACH care coordination effort through any available referral pathway. Three ACHs use multiple mechanisms to identify clients for ACH care coordination.

Patient/Client Awareness of Care Coordination

Whether and how individuals are made aware of the ACH’s care coordination effort varies among the grantees. About a third of ACHs promote their care coordination services in the community through activities such as hosting and tabling at events, distributing brochures, and attending community meetings to increase awareness. However, at least two-thirds of ACHs—including some that are conducting community-level outreach—do not explain or identify their coordination services to individual clients or patients as any sort of formal effort or program. One such ACH noted, “We haven’t used the term, ‘You’re entering care coordination’...enrolling into a program...and then [being] discharged...we’ve gone away believing that that would confuse the patients.” In these cases, clients or patients know that someone is helping them to access services and resources, but they likely do not

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know that this is occurring as part of a particular care coordination initiative. “I’m here to help you.’ We’ve gone that route instead.” The extent to which individuals are made aware that they are entering “care coordination” as such is generally limited to the process of obtaining consent for coordination services. In two cases, physician hand-off is an added introduction into care coordination for a patient.

There are a few cases in which individuals are actively engaged in the receipt of a particular set of ACH services, whether or not they know that these services are “care coordination.” Under these scenarios, the ACH care coordination process—or its eligibility criteria—are more formalized and/or the intensity of the care coordination services tends to be greater. One of these ACHs offers a structured 12-week program that incorporates specific goal-setting activities and scheduled care team meetings with the individual. Another ACH may require that clients change payers and providers specifically in order to receive coordinated care through the medical provider involved in the collaborative. The other ACH requires that patients sign a formal care plan to which any ACH care coordination they receive is connected.

The care coordination approaches of some ACHs are also consciously integrated into an individual’s regular medical care, which helps secure patient buy-in to the coordination process. In one ACH, case managers meet with patients during the hospital discharge process; in four ACHs, individuals may attend formal care team meetings; and in five ACHs, an individual may meet with multiple members of his/her care team simultaneously outside of the context of a formal care team meeting (e.g., during a patient appointment).

Provider Awareness of Care Coordination

More than half of ACHs (8) mentioned conducting outreach, whether formally or informally, to providers to raise awareness of care coordination efforts—an awareness that is particularly critical in nearly half of ACHs where individuals are referred for care coordination by a medical provider or a community provider. In six cases, provider outreach has been conducted via presentations at staff and provider meetings, but one ACH instead made personal communications with providers. For one ACH, the exact mechanism of provider outreach was unclear.

Individual Needs Assessments and Care Plans

All of the ACH care coordination systems incorporate an assessment (whether formal or informal) of individuals’ needs and barriers related to social determinants of health in order to identify potential interventions. Generally, these assessments are related to one or more medical conditions that have already been identified or diagnosed (often via formal diagnostic assessments), and social determinants of health are examined as they relate to the condition(s). For example, one ACH targets individuals who have diabetes that is not well-managed. CHWs meet with these patients to help them identify barriers and concerns related to managing their diabetes (e.g., lack of access to healthy food). Another ACH works with patients receiving chronic opioid therapy who are at high-risk for medication overuse/abuse. In this case, a nurse navigator and licensed social worker (LSW) meet with patients to identify barriers to behavioral change (e.g., anxiety, financial pressures, housing needs). Most ACHs (12) assess needs via conversation (telephone or in-person) with the individual patient or client and/or a family

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member/guardian. Two ACHs also conduct home visits as part of the needs assessment process. One ACH assesses client needs via a comprehensive health survey.

Some of the ACHs also collaborate with individuals to establish care plans that incorporate the individuals' goals. Six ACHs noted that they establish formal care plans for individuals, although one of these creates care plans only for individuals with complex needs. Four ACHs did not report establishing formal care plans but did note that they establish client goals as part of a needs assessment conversation. One ACH that currently focuses on "goal planning" was also working on a crosswalk of existing care plans across partner organizations with the aim of ultimately creating a shared "community care plan." Finally, one ACH was working toward the implementation of a "collaborative" (i.e., not cross-walked) care plan to be shared among partners in 2016.

Authorization to Share Personal Health Information

ACHs must obtain a release of information (ROI) in order to share protected patient or client information for the purpose of care coordination that extends beyond the medical continuity of care framework. Eleven of the ACHs have or are establishing ROIs for care coordination so they can share information with other providers (e.g., social service agencies). In most cases, ROIs apply only to the organization responsible for leading the ACH care coordination effort. However, even if a particular ACH organization has a signed copy of its own ROI on file, an organization to which the ACH has referred an individual will not be able to *exchange* information about the individual without its own signed ROI on file. The need to obtain another signed ROI can delay and/or prevent effective coordination. To address this issue, two ACHs created a comprehensive ROI that encompasses most or all organizations involved in the ACH that may need to share information. Two other ACHs take a different approach, keeping the ROI forms for multiple organizations on hand for individuals to sign as needed to facilitate information sharing. Another ACH uses an online referral tool that incorporates the ROIs of each referral organization so that the ROIs can be filled out and filed at the point of referral. Even with these ROI systems in place, additional consent is sometimes needed, depending on the organizations to which clients are referred.

Communication Protocols among Providers and Organizations

Staff involved in ACH coordination communicate via telephone and in-person conversations and at regular or ad hoc in-person meetings with medical providers and other members of the care coordination system. In four of the ACHs, team members can also communicate with one another via secure email. Two ACHs also rely on secure online communication portals to exchange medically relevant information. Regardless of the communication mechanism, team members de-identify patient or client scenarios if there are any restrictions on information sharing (i.e., ROI not yet obtained). Because of information-sharing restrictions, ACHs rely primarily on phone calls to make referrals to outside organizations for services that extend beyond the scope of continuity of care—i.e., social services, community resources, etc. There are a few exceptions to this, with one ACH also using an electronic referral tool to communicate with a set group of community providers and another using secure email under an agreement with a set group of community partners.

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Referral Tracking and Follow-Up

Two-thirds (10) of ACHs systematically track medical and/or non-medical referrals for the purposes of follow-up and evaluation. Whether and how referrals are being tracked at five of the ACHs was not clear from interview data or their 2015 Annual Reports. Among the ACHs with care coordination anchored in a medical provider context, three track medical referrals within a patient’s electronic medical record (EMR), and two of these also track non-medical referrals within the EMR, with the third tracking non-medical referrals separately via spreadsheet. Four medical ACHs track only non-medical referrals, three using spreadsheets to do so and one using an interactive referral tool (two of these do not make medical referrals and two do not track medical referrals as part of ACH care coordination).

Of the ACHs involving referrals from both medical and non-medical settings, one ACH tracks both medical and non-medical referrals in the EHR but also maintains spreadsheets to track some casual non-medical referrals. Another ACH described a “continuum of charting,” depending on the intensity of care coordination provided, with charting/tracking becoming more complex as client needs increase, such that the tracking/charting mechanism scales up from de-identified spreadsheet rows, to fully identified Excel sheets, to database files. Finally, one of the ACHs with a “no wrong door” model uses Synergy—a student data management system—to track referrals.

The primary means for non-medical referral follow-up among ACHs is to contact the patient or client directly and determine the outcome. This approach is the least complicated from a data privacy perspective, since only one signed ROI—i.e., that of the referring organization—is necessary. Any exchange of patient or client information with a third party (i.e., the organization to which an individual has been referred) depends upon that organization having its own signed ROI on file. However, in the event that a patient or client cannot be reached for follow-up, ACHs will follow-up with the referred organization to the extent possible within privacy guidelines.

Team-Based Care/Care Teams

According to the commonly-cited definition from Naylor, Coburn, and Kurtzman (2010)⁴⁹:

“Team-based health care is the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers...to accomplish shared goals within and across settings to achieve coordinated, high-quality care.”

ACH coordinated care teams, then, exist when there is collaboration by at least two providers involved in the coordination of an individual’s care. In the case of ACHs, these providers often extend beyond the physicians, nurses, etc., included on a traditional medical care team to include social service providers and community resource providers, with the composition of care teams varying depending on the target population and the setting in which care coordination takes place. For example, ACH care coordination

⁴⁹ Naylor, MD, Coburn, KD, & Kurtzman, ET. “Interprofessional team-based primary care for chronically ill adults: state of the science.” Unpublished white paper presented at ABIM Foundation meeting to advance team-based care for the chronically ill in ambulatory settings. Philadelphia, PA, March 24-25, 2010.

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systems that are situated in clinics and hospitals (9 ACHs) are more likely to include medical professionals on their care teams: medical care coordinators, nurses, physicians, pharmacists, etc. On the other hand, ACH care coordination systems that are situated in schools (3) may include school counselors, school nurses, social workers, school therapists, and teachers on their care teams. Even within a single ACH, care team membership may vary from one patient or client to another, depending on the individual's needs and preferences.

Using the care team definition identified above, all of the ACHs incorporate care teams into their coordination efforts, although care teams are not established for every single individual or scenario (for example, if a simple referral is the only need), and care teams may be more or less formal/structured both within and across ACHs. In the majority of ACHs (13), members of the care team consult one another individually as needed and meet with clients or patients on an individual basis. In eight ACHs, care teams gather for formal group meetings to discuss particular cases; in four of these cases, the formal meetings may include the patient or client as well. In five ACHs, a client/patient may meet with multiple members of his/her care team simultaneously outside of the context of a formal care team meeting (e.g., during a patient appointment). The care team approach of the ACH that has not yet implemented its care coordination efforts is as yet unclear.

Health Information Technology

As indicated above, a number of ACHs have incorporated or are working to incorporate some form of electronic HIE into their care coordination approaches. Four ACHs are working directly in the EHR to coordinate care, and two are establishing a Nightingale Notes application to interface with the EHR for care coordination purposes. One ACH is unique in documenting care coordination not only through the EHR but also through an online communication portal through which analytic data can be shared. As noted earlier, one other ACH uses an interactive referral tool to communicate with a community of providers about individual patients, and this ACH is currently working on creating a link between the referral tool and the EHR. Also noted earlier, one of the ACHs uses an electronic student data management system to coordinate care. Finally, another ACH coordinates care using secure direct email messaging using continuity of care standards with a set of community providers each of whom has a contract with an HIE intermediary to send and accept secure information from any of the other participating providers. Three ACHs without an electronic HIE in place commented on the potential benefits of a shared data space/portal. One pursued the idea but determined that it was not logistically feasible, and the two others are still pursuing it. By the end of 2015, five ACHs were not exchanging individual-level information electronically, and the one that had not yet begun care coordination did not address whether electronic HIE would be incorporated into its care coordination approach.

Early Outcomes

As described above, our interviews with ACHs in late 2015 focused particularly on the design and implementation of their leadership structures and governance as well as their care coordination approaches. The 15 ACHs have each established a leadership structure and governance approach and are now actively overseeing grant activities. Ten ACHs had initiated their care coordination efforts at the

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time of our interviews. Of the other five, one had implemented a portion of its care coordination while planning additional care coordination activities, and four were finalizing the development of their coordination approaches and planning to initiate or pilot this work soon. This section summarizes the key preliminary outcomes and achievements ACHs identified in the areas of leadership, governance, and care coordination for the first year.

Forming New Partnerships and Strengthening Existing Ones

Nearly all ACHs consider engagement of new partners or the strengthening of existing partnerships one of their most important accomplishments for the first year of their grant. ACHs made connections to new agencies and resources and were able to become more familiar with organizations with whom they were already connected. ACHs talked about getting people “to the table” for the ACH work. The development of relationships, said one ACH, “is very valuable and will continue on because we’ve been able to see it working first-hand.”

Several ACHs observed positive outcomes associated with the engagement of community members and the strengthening of these relationships as well. For example, one indicated how the ACH effort is “bringing us together with the ...community. It’s healing some wounds, perceived or otherwise, on both sides.” Another stated that leadership team membership has made community members feel valued, respected, and listened to, resulting in high trust between providers, other organizations, and community members.

Increase in Provider/Organization Awareness of Patient and Population Needs

About half of the ACH grantees communicated an increase in their awareness and understanding of the experiences and health and social needs of their community members and patients. Both engaging community members and partnering with other providers and community organizations that serve community members have contributed to this learning. When asked about their accomplishments during the first year, one ACH stated: “The awareness of the problem. We would never have discovered the level of [the problem] we have, with what’s happening in the community...You hear about it at the state level, but until the physicians realize what’s going on, you won’t have that community health improvement. It’s really a community health problem...People can’t fathom the depth of the problem.”

One ACH care coordination team member summarized the value of this understanding: “As you go through the steps of encountering things, you mature in your ability to assess the situation and respond appropriately to it... We’ve moved from reactive to proactive.” A comment from another ACH provides another example: “One of the things that is happening that is important...we have found...with some of our target population is that their health literacy and their understanding is not as high as you might think. They don’t understand diabetes, what creates it, how it destroys their health, and how to prevent it...We [increase their understanding of diabetes] in a few different ways...we use every opportunity to educate them about their risk. Education is key.”

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Improvement in Provider/Organization Knowledge and Leveraging of Resources

The majority of ACH grantees articulated that their partnerships with other providers and organizations has increased their knowledge (“learning together”) about existing resources, other areas of expertise (e.g., health care, behavioral health, housing, corrections), how other providers or organizations operate, a broader system of care, and/or how various providers and organizations may fit together to address the health and social needs of community members and patients. As one ACH stated, “...we [i.e., the partnering organizations] were the target population in the first year...focused on how do we communicate with each other, what do we need from each other.” Other ACHs emphasized the importance of “you guys inside our walls, us working outside our walls” and that “understanding each other’s roles has been a really big lesson.” A positive effect of this progress has been that it has “broken down siloes” and has revealed ways in which organizations can “complement one another rather than compete.”

Interviewees repeatedly made the case for how the knowledge of organizations and existing resources is essential for progressing toward Minnesota’s aim of team-based integrated and coordinated care. One ACH stated that they are “more proactive and deliberate in care coordination. Even though resources were available, we are being proactive in connecting [individuals] with them.” Another ACH reported that they have developed “more informed processes around something as basic as making a referral,” and more than one ACH mentioned simply having a name and contact information for a specific individual at another provider or organization as a concrete example of the value of organization collaborations. Most ACH interviewees made the connection between the knowledge gained from getting to know and working with other organizations and improvements in the care they provide, remarking that it has helped providers relate to patients/clients, assess an individual’s situation and strategically develop a plan of care and action, tap the right resources and connect to them, and not duplicate efforts. As one ACH noted, these improvements not only benefit the populations targeted by the ACH care coordination efforts but other patients/clients served by participating organizations. Also, as providers and participating organizations develop expertise in connecting with community resources, this experience can be passed along to patients/clients, teaching them “the process of accessing resources” and “empowering” them for the future.

Facilitators

ACHs were asked about the factors that have facilitated the implementation of their collaboratives and the progress they have made in the first year. While some facilitators were unique to individual ACHs, several were common among multiple ACHs. This section summarizes these key themes.

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Building on Existing Partnerships, Infrastructure, and Resources

A number of ACHs noted that they benefited from organizational partnerships, infrastructure, and resources that were in place before the start of the ACH and upon which they have been able to build and expand. Existing partnerships aided further collaboration because core relationships had already been established among ACH partners. For example, to launch its care coordination and population prevention efforts, Together for Health at Myers-Wilkins was able to leverage a longstanding collaborative—the Myers Wilkins Community School Collaborative. The relationships that were already in place through this collaborative of neighbors, school administrators, teachers, and community organizations facilitated the ACH’s effort to engage community partners.

Engaged Community and/or a Bridge Person to Community

Several ACHs reported the active involvement of community members and members of the target population as a factor that has enabled the ACH work to advance. As one ACH participant explained, “I have been impressed by how well community consultants and everyone on the Leadership Team have been able to take that deep dive into what causes health disparities...I think the depth of understanding that came from our community consultants and our community, to have it articulated, to say, okay this is where we need to put our energy.” The involvement of community members and/or people who know and are trusted by the target population has also been important. When asked about the factors that have facilitated their ACH progress, one interviewee commented the following about the ACH’s project manager: “Having someone like [her] and her connections to all these community-based organizations, someone with knowledge and insights into what all these places do. The project manager learning curve was short because it was not hard to get people to the table.”

Need/Desire for Services in Community

Individuals involved in a number of ACHs commented on the community’s commitment to address the particular health concern identified and the need and/or desire for ACH services within their communities as a facilitator of their work. “It’s an obvious need,” observed one ACH. In fact, some ACHs reported that there is more demand for ACH resources and services than was anticipated. For example, the two ACHs that are engaging multiple schools have received inquiries about their ACH efforts by additional schools within their respective districts. As described above, some informants indicated that organizations and individuals have more awareness of community needs due to the work of the ACH, and this increased awareness has helped to advance the work of the ACH.

Point Person(s) at the Center of the Work

Many ACHs called attention to the significance of having a central care coordinator or project manager in carrying out the ACH work. This person makes connections in the community, coordinates between health care providers and community-based resources, plans meetings, keeps the group on schedule, helps to problem solve, etc. One person, speaking about their ACH project manager, observed, “If [she] were gone, [the ACH] would fold.” One ACH staff person noted the challenges around staff capacity in their partnering organizations: “My job is to make the collaboration work, but most people don’t have

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someone to make it work...it's really hard." Several grantees called attention to the importance of the ACH grant funds in supporting the project manager role.

Committed and Flexible Leadership Within Participating Organizations

Multiple ACHs commented on the organizational support in place for the ACH work and the importance of such support in advancing the ACH. This support and flexibility "was key" in the face of constraints, noted one ACH. Another ACH partner observed, "for [us], [the ACH] is in line with our mission: working with a vulnerable population, trying to do more outside our hospital walls in partnership...we need to be partners in the community." "Physician champions" were also highlighted by several ACHs, in some cases playing a particularly salient role in securing provider buy-in for the ACH work. As one ACH partner noted, "physician to physician advocacy matters more than hearing it from someone else."

Shared Staff Across Organizations

Some collaboratives include a project management or care coordination staff member who is employed or supported by more than one partnering organization. For example, one of the community care coordinators involved in one ACH is a LSW who is employed part-time by the lead organization and part-time by the County. The ACH has benefited from her in-depth knowledge of county and community resources and systems, which she is able to share with the other ACH care coordinator and the broader ACH team so that they can more efficiently build and expand their own directory of resources for patients.

Challenges

ACHs reported the following common barriers and challenges in the implementation of their collaboratives during the first year.

Delays Due to Federal Contracting Requirements

Federal contracting requirements related to the process of unrestricting funds delayed the start of ACH implementation.

Difficulty Engaging ACH Organization Partners

Several ACHs conveyed difficulty getting partner organizations to join the leadership team, attend meetings, contribute their insights, and communicate their concerns. This issue sometimes stemmed from the large number of community partners with whom an ACH was engaging, and it sometimes stemmed from the amount of time required to develop new relationships. In other cases, ACHs reported that there was simply a limited number of available community partners. Some ACHs were able to engage partners but observed that the engagement was not necessarily meaningful. As one ACH described: "They're engaged but not in a central way. It took a little while to get [them] on board and coming to meetings regularly. They seem invested now, but we live in a world where people's schedules are busy."

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Difficulty Engaging Community Partners and/or the Target Population

Several ACHs reported difficulty engaging members of the community and/or members of the target population and sustaining engagement once/if it was initiated. This barrier can stem from a number of issues including language and/or cultural differences, lack of trust between community members and providers, lack of interest among the target population, time conflicts among the target population, lack of transportation, and the inability for the ACH to provide participation incentives. One theme was the challenge of getting individuals facing multiple stressors and challenges (social or income, for example) to engage in a long-term or time-consuming program, taking into consideration transportation barriers and child care needs: “We initially struggled with incentivizing clients to come to the...meeting and being engaged with the ACH...Space for holding the...meetings is [also] an issue...We need to be on a bus line, accessible, and we haven’t found this yet.” Following the start of the ACH grant awards, CMMI modified its funding restrictions related to the support of community participation, and some ACHs observed that this modification has helped. For some organizations participating in ACHs, working with the target population was “a new space” (e.g., working with teens for the first time), and organizations have needed to develop knowledge about and capacity in working with a new group.

Several ACHs noted that building rapport with clients may be inhibited if the provider or care coordinator and patient/client do not share language, customs, beliefs, and values. Several of the ACHs noted that it is essential for providers and other staff to provide culturally competent and respectful care and/or to hire staff, at all levels in the collaboration, who are members of the community or target population. On the other hand, even in cases where care coordination staff share membership of a social group, culture was noted as a challenge: “You’re their family. They expect me to go beyond my duty.... [They say:] ‘Fight for us. You should fight for us.’”

Navigating Different Organizational Structures and Siloed Service Arenas

All of the ACHs are comprised of diverse partnering organizations, including health care providers, mental health providers, local public health, and community organizations. Several individuals reported the challenge of becoming familiar with the ways in which different organizations operate as well as the larger service arenas and sectors in which they exist. As described earlier, many ACHs also considered this increase in understanding a significant accomplishment of their work.

Service Gaps and Workforce Issues

Several ACHs expressed concerns about gaps in the availability of certain services, especially in rural areas. Specifically, individuals cited a lack of adequate chemical dependency services, psychiatric care, and dental care. The need for more Medicaid dental providers was explicitly noted.

Other workforce challenges pertain to the hiring and retention of staff. Several ACHs reported challenges with finding skilled staff, finding skilled staff who were members of the target population (or who shared target population characteristics), lengthy and bureaucratic hiring processes, and turnover in staff and administration. In some cases, these challenges delayed the start of ACH efforts.

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Navigating New Care Coordination Roles

A number of ACHs called attention to some of the sensitivities integrating new care coordination roles into their partnering organizations. In the medical setting, “the nomenclature has become kind of a challenge. We had a CHW who was certified...And then [we have] RN-based care coordination.... And so we looked for a non-RN role, and at the same time it was almost a political thing, to not call them care coordinators, because those were RNs. So we landed with ‘care facilitator.’ But...they really serve the same function, just different target populations and sometimes different referral systems.” For individuals within the new role, such as a CHW role, there is a learning curve associated with getting to know the role and organization in a position that has not previously existed within the organization. “With different levels of nurses, everyone knows what is supposed to happen.” But this is not necessarily the case with CHWs and other staff involved in care coordination.

This is also true for nurse care coordinators being incorporated into non-medical environments. For one coordinator, a challenge was...“learning to navigate the public elementary school system. I’m a public health nurse. I worked for a tribal organization in a clinic doing home visits. I’m more familiar with the medical setting. There’s a completely new culture.” In both medical and non-medical settings, people spoke of the need to get to know people and how the organization works: “The little things. Barriers with territory, and not overstepping, and proving that I am here to support and not take over.”

Data Privacy and Difficulties Sharing Data

Challenges with sharing data between and among ACH partners (e.g., information about specific patients/clients for care coordination and integration) were cited by many ACHs. Some of the ACHs have sought out legal guidance on navigating the Health Insurance Portability and Accountability Act (HIPAA), the Family Educational Rights and Privacy Act (FERPA), and MN data privacy laws. Creating a shared and HIPAA-compliant electronic data sharing system appears to be one of the most widely cited barriers and caused the most frustration among ACH collaborations. The challenges and complexities of data sharing and infrastructure are also unique and variable depending on the ACH partners. Regulatory constraints and baseline data infrastructure vary considerably for schools, correctional facilities, county agencies, behavioral health providers, etc. As one ACH stated: “I think we will be working on [data sharing] for the next 30 years or so.”

Insufficient Resources for the Non-Clinical Needs of Patients/Clients

This challenge refers to the social or logistical needs of ACH clients. Some ACHs noted that they had insufficient resources for social service referrals for their clients. For example, in one case, clients who needed housing, and were referred for housing services, faced waitlists. In another case, clients face transportation barriers in obtaining ACH-arranged medical care and social services. Another ACH highlighted that what individuals need many times is financial assistance, which is outside the scope of ACH funding.

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Continuous Improvement Feedback

During interviews with the ACHs, SHADAC researchers inquired about the technical assistance ACHs have received, other desired support from the state, and any other feedback to the state. This section summarizes key themes in this feedback.

Responsive State ACH Coordinators

By design, the ACH grant program affords grantees flexibility in program design and implementation to meet desired goals. State staff ACH coordinators/implementation specialists overseeing the grant program hold monthly calls with individual grantees to monitor progress. A few ACHs referred to these interactions as helpful opportunities for reporting, framing needs, and problem solving. These ACHs conveyed appreciation of state staff responsiveness and the perspective they have brought to issues raised.

Technical Assistance and Peer-to-Peer Learning

When asked about their use of technical assistance resources, most ACHs spoke to participation in Learning Community events, Learning Days workshops, and, in a couple of cases, making specific requests of the Center. A number of ACHs indicated that the opportunity to interact with, learn about, and problem solve with other ACHs has been very helpful. With regard to group learning topics, some ACHs indicated that these learning events were too basic whereas others conveyed they were not basic enough. Several ACHs put a request in for more one-on-one technical assistance to address their unique needs. ACHs identified several learning topics of interest including data analytics, measurement, and evaluation; sustainability; reimbursement/billing; interprofessional team environments; data integration and sharing approaches; data privacy and state laws; maintaining momentum within communities; and using data to tell a story and make the case for potential funders.

Opportunities to Share Resources

Operationally, ACHs have completed similar implementation tasks including formalizing governance and care coordination models, reaching target populations, and initiating care coordination activities. Across ACHs, these tasks have involved common steps such as developing partnership agreements to formalize relationships among partnering organizations, seeking legal counsel for data privacy and sharing, developing assessment tools, and developing care workflows and care plans. A few of the ACHs called on the state to provide additional guidance, tools, or templates for like activities across ACHs to reduce unnecessary duplication and to share promising practices. While only mentioned once during interviews, ACHs have access to a SharePoint site maintained by the State, which, in part, serves as a repository of resources. Ongoing monitoring and updating of this site could support 2016 activities, evaluation, and sustainability.

Sustainability Insights

Many ACHs commented on the significance of the state's ACH grant program in affording impetus, resources, time, and staffing to either the formation or continuation of collaboratives and the work being accomplished by ACHs. This sentiment was best summarized by one ACH informant: "I think the

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grant is pretty key. Having the ability to be creative and innovative in this way that doesn't affect our operational budget yet. It's really difficult to have a proof of concept; difficult to invest in something that we're not sure is going to work."

Although ACH sustainability planning was not a focus of our 2015 interviews, issues and thoughts related to sustaining the work of the ACH beyond the SIM grant emerged during the discussions. First, early implementer ACHs, the CCTs, offered insights related to their ability to exist and continue between grant programs. In addition, ACHs referenced the potential for new opportunities to expand on ACH work and were considering strategies for financial sustainability of ACH activities beyond the grant program.

Lessons from Early Implementer ACHs

A couple of the CCTs noted that there was a three year gap between CCT funding and ACH funding under SIM. While it is clear that time spent on maintaining and developing at least one of the teams was reduced in between the grants, the teams did not disappear. "There was no stopping and restarting as an ACH." This sustainability was attributed in part to the relationship development and capacity building that had been accomplished under the CCT: "The CCT would have been sustained even without the [SIM] money because of the relationships." "In the beginning it was getting us to understand what we all do, how we could collaborate. Since that time we've been able to build on our relationships and experiences. I have more comfort in referring to other [ACH] members now." Another sustainability factor communicated by one of the CCTs has been support from the health care provider in which the CCT is anchored: "The support we receive from the clinic in between grants is essential." At least one newly formed ACH also mentioned the potential for support from its health care lead.

Reimbursement for Care Coordination

A number of grantees expressed concerns about the sustainability of ACH care coordination positions and efforts beyond the grant period given current funding options and reimbursement levels. Several grantees reported that health care coordination reimbursement opportunities are limited and, even if participating organizations are eligible for reimbursement from a payer, they are insufficient. For example, concerns were voiced about the current HCH reimbursement levels. In addition, there may be restrictions that vary by payer related to the provider type that can deliver the service to be eligible for payment, and a couple of ACHs explained that it is a burden to bill only certain payers for care coordination. Some grantees found it unethical to only offer these services to those patients with care coordination coverage. "As an organization, it is much harder to only bill certain patients." "Or the option was to just target certain populations..." "...And that didn't feel right, either." "So it was a service we provide gratis."

As described above, a number of ACHs called attention to how essential a central care coordination point person and/or project manager is for implementing and maintaining collaborative efforts while providers and organizations juggle service provision and other core activities. This person makes connections in the community, coordinates between health care providers and community-based

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resources, and oversees collaborative administration. Several grantees noted the significance of the ACH grant funds in supporting this position. Therefore, a key consideration in the sustainability of ACH efforts pertains to the funding options available for this role. “The care team needs a coordinator....That is never going to be reimbursable...Facilitating conversations is important.... And how do we work between agencies that are really large and complex...that times time.”

Positioning for New Opportunities and Funding

Five ACHs highlighted that their work as an ACH has helped to position their collaboratives for additional alliances and funding opportunities. As one ACH stated, “We have a good process in place for when other grants come up. We’ll have shown we can do it: being successful with a really vulnerable population, experience that vets us.” In fact, another ACH indicated that they were recently awarded a Spreading Community Accelerators through Learning and Evaluation (SCALE) grant, another ACH mentioned supplemental funding as well, and another mentioned that they were applying for other grants. In addition, one ACH highlighted that the grant allows them “to become ready for that value-based reimbursement that already is at our doorstep. I think as we have closer communications and partnerships with long-term care, mental health and we can do that care coordination across those entities, there’s going to be significant saving within the health care system. This grant has helped us build that foundation so that we can be ready for a different type of reimbursement world.”

ACHs acknowledged the necessity of good data and outcomes to make the business case for reimbursement of ACH work to internal leadership or to demonstrate to payers and external funders the value of their programs. Several ACHs noted challenges in quantifying short- and intermediate-term outcomes of their efforts.

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7. DISCUSSION

In October 2013, the Minnesota Department of Human Services (DHS) and the Minnesota Department of Health (MDH) received a three-year State Innovation Model (SIM) award from the Centers for Medicare and Medicaid Services (CMS) to implement and test the Minnesota Accountable Health Model, a multi-payer health care payment and service delivery reform effort in the state. This report summarizes the implementation of and the early results of this Model as of December 2015.

The state's goals for the Minnesota Accountable Health Model are that, 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 Accountable Care Organizations (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 of better care for individuals, better health for populations and lower per capita health care costs; and
- Communities, providers, and payers have begun to implement new collaborative approaches to setting and achieving clinical and population health improvement goals.⁵⁰

These four aims have been supported by five primary drivers, under which most SIM activities have been organized in Minnesota. These drivers are 1) the expansion of e-Health; 2) improved data analytics across the state's Medicaid ACOs (i.e., Integrated Health Partnerships, or IHPs); 3) practice transformation to achieve team-based, integrated and coordinated care; 4) implementation of accountable communities for health (ACHs); and 5) alignment of ACO components across payers related to performance measurement, competencies, and payment methods. The key mechanisms the state has used to execute its Model include grants and contracts, technical assistance, and other resources for providers and other organizations in the state.

In this discussion, we summarize the major findings of our evaluation to date across the SIM initiative in Minnesota. This chapter also provides continuous feedback and input for improvement of SIM in its final year and summarizes additional insights and key issues for the state as it continues its strategic planning for sustaining the Minnesota Accountable Health Model beyond the SIM award.

Findings

The goals of the state evaluation of the Minnesota Accountable Health Model are to document the activities carried out under the Model, document variation in models and innovation, identify

⁵⁰ State of Minnesota. *Resources*. Web. Dec. 2015.

<http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_Docs_Reps_Pres>

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opportunities for continuous improvement, assess how Model outcomes contribute to the state's aims, and identify lessons learned for sustaining the Model. Key evaluation data sources in 2015 included a database of organizations participating in SIM activities; semi-structured qualitative interviews with over 200 individuals engaged in the reform efforts including state leaders and staff, grantees, and contractors; and systematic review of state, grant, and contract materials.

Overall, grantees conveyed their organizations' enthusiasm and support for health information exchange (HIE), practice transformation, and collaborative approaches to population health, and they emphasized the importance of the SIM initiative in providing the impetus, resources, and time to develop and implement improvements within their organizations and communities. Our results through 2015 indicate progress toward the aims of the Minnesota Accountable Health Model, particularly with regard to patient-centered and coordinated care across settings, provider participation in Medicaid ACO models, and community collaboratives focused on clinical and population health. Nonetheless, important deficiencies persist.

Progress

Expansion of the Integrated Health Partnership (IHP) Model

Since 2013, the IHP program has expanded and includes new ACO models. Although the IHP program existed prior to SIM funding, its expansion from six to 16 IHPs in 2015 is at least partially due to investments made under the SIM initiative. Expansion of the Minnesota Model has meant greater geographic and organizational diversity among IHPs. New entrants also include IHPs that are beginning to test the inclusion of services not traditionally included (e.g., behavioral health) for complex populations and other ACO innovations. The IHPs under contract with the state differ in terms of geographic footprints, target populations, organizational structures, and size.

It has been encouraging to state officials that new and different types of delivery systems—especially those that treat populations with complex medical and social needs—are interested in becoming IHPs. One Round 3 IHP provider group, for example, focuses specifically on people with disabilities, with services delivered in residential care facilities, community-based clinics, and patients' homes. Another IHP is a community-owned, rural health care cooperative providing a full spectrum of primary care services from birth through the end of life. In February 2016, the state announced a new round of three IHPs, including a large system of primary and specialty health care services; an independent, non-profit children's hospital serving children with complex conditions; and a multi-specialty independent practice association located in mostly rural areas. The state now estimates a total of 340,000 attributed lives under the IHP program.

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Community Engagement and Development of Partnerships Among Providers/Organizations

A key component (and accomplishment) of the SIM initiative has been the engagement of and the strengthening of relationships among a diverse set of stakeholders. The SIM governance structure brought together two state agencies (DHS and MDH) to work collaboratively; the state has engaged a broad range of providers and community organizations in the direction (e.g., Task Forces) and implementation (e.g., grantees) of the Minnesota Model; and the Model has required, facilitated, and accelerated relationship building and partnerships that span care settings and sectors. It is not by accident that the SIM initiative in Minnesota has reached hundreds of organizations.

The state identified four priority settings under the SIM work, including behavioral health, long-term care/post-acute services and supports, local public health, and social services, and the state made deliberate efforts to recruit participants from these settings. For example, the entire e-Health Roadmap project focused specifically on the e-Health needs of these four priority settings. Many of the other grant programs under the SIM initiative have invited not only health care providers, including IHPs and Health Care Homes (HCHs), but organizations within these priority settings, particularly behavioral health providers. Further, the e-Health Collaborative grant program required that an applicant work with at least one or more of these priority providers, and the ACH grant program encouraged participation of these priority settings, ACOs, and other organizations. Both the e-Health Collaboratives and ACHs highlighted the formation of and the deepening of organization partnerships across settings as major achievements during the year.

State Executive Committee and Leadership Team members view the SIM initiative as a catalyst for engagement and a broader conversation about health and health reform in the state. The effect was not only to expand its relationships and partnerships with providers and community organizations across the state but also to raise awareness and knowledge of accountable care principles. “Providers are at the table in ways I have not seen even in all of our ACO discussions.” According to one Executive Committee member, “People not used to talking about health care reform and delivery are coming together to talk.... The conversation has gone from ‘I am not responsible for that’ to ‘I am talking about that.’”

Improvement in Provider/Organization Knowledge and Leveraging of Resources

Multiple interviewees from the e-Health Collaboratives, Practice Transformation, and ACH grant programs articulated that an artifact of new and deepened partnerships with other providers and organizations is increased knowledge – about existing resources, other areas of expertise (e.g., health care, behavioral health, housing, corrections), how other providers or organizations operate, a broader system of care, and how various providers and organizations may fit together to address the health and social needs of community members and patients. One participant in the e-Health Collaboratives program commented that SIM’s overall focus on the social determinants of health has helped community-based organizations gain a better understanding of what is happening in the health care market place, and how to be a viable player in health care settings. Likewise, an ACH participant noted that health leaders are learning about “health not just health care. We are working with health leaders

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who are just starting to figure out what this means: what is health outside their organizations?” This transfer of knowledge not only pertains to partnerships between different organizations or clinics but also partnerships within a provider or organization (e.g., when primary and behavioral health care are co-located).

Our interviews to date emphasized how this knowledge is crucial for progressing toward Minnesota’s aim of team-based integrated and coordinated care. Several ACH interviewees reported that this information has helped providers relate to patients/clients, assess an individual’s situation and strategically develop a plan of care and action, tap the right resources and link to them, and not duplicate efforts. One ACH explained that they are “more proactive and deliberate in care coordination. Even though resources were available, we are being proactive in connecting [individuals] to them.”

Increase in Provider/Organization Awareness of Patient and Population Needs

Another major theme of progress from our discussions with grantees is that SIM investments have helped to heighten their awareness and understanding of the experiences and health and social needs of their community members and patients, which are essential for patient-centered care. This learning has been facilitated in part by the exposure and knowledge that comes from engaging and partnering with other providers and community organizations that serve community members. An increase in awareness has also come from a number of other steps taken by Minnesota Model participants including developing and implementing new tools for assessing individual needs (e.g., Practice Transformation grantees, ACHs), engaging community members and patients in collaborative care models (e.g., ACHs), incorporating community care coordination staff into care models (e.g., Practice Transformation grantees, ACHs), improvements in electronic health record (EHR) capacity and output (e.g., Practice Transformation grantees), and receiving and analyzing data reflecting patient-level clinical profiles and health care and prescription use patterns within and outside of their own systems (e.g., IHPs).

Accelerated Discussion of HIE Across Providers and Sectors

Numerous e-Health Collaborative interviewees commented that the SIM funding gave them an impetus and legitimacy to bring collaborative members together and have conversations about using HIE to coordinate care in their communities that would have not been possible otherwise. A state Leadership Team member also noted the important role funding has played in shaping community HIE discussions, commenting: “The SIM process exposed problems with the [market-based] path we [the state] previously went down on HIE. It exposed gaps.” Grantees also reported that the grant gave them a focused, structured way to articulate the components of information that should be the priorities for HIE among the various partners, and an opportunity to learn about what they were capable of doing in HIE. Practice Transformation and ACH grantees also described the role of the grant work in advancing dialogue between providers and organizations about data sharing.

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Operational Improvements for Providers and Staff

Some grantees reported initial reluctance among providers and staff in the implementation of grantee activities (whether it be incorporating new data tools, new care coordination staff, a team-based model, or other new processes into an organization's operations or workflow) but noted that their interest and participation improved over time. Leveraging rapport with providers, training staff on new procedures, and demonstrating the value of these changes for reducing the workload and improving the workflow of others were all important for not only securing buy-in but in some cases creating more demand for the changes. When asked about the sustainability of SIM efforts, grantees called attention to the fact that some areas of organization-level transformation implemented under SIM have been institutionalized as part of the everyday operations of providers and organizations.

Gaps and Challenges

In the midst of the progress described above, several key gaps and challenges persist under the Minnesota Accountable Health Model, and in some ways have been illuminated by activities under the Model.

Slower than Expected Uptake of Value-Based Purchasing

The goal of Driver 5 under the Minnesota Accountable Health Model is to standardize ACO performance measurement, competencies, and payment methodologies across payers. As a first step toward this alignment, MDH conducted an ACO baseline assessment, a survey and qualitative interviews of provider organizations and health plans to assess the scope and characteristics of existing ACOs in the state, including Medicaid ACOs (i.e., IHPs), Medicare ACOs (Shared Savings or Pioneer), safety net ACOs, and commercial ACO arrangements.

Based on the results of this assessment and with the expansion of the IHP program, the overall market appears to be moving toward value-based purchasing. A few IHPs disclosed, however, that while the number of contracts utilizing value-based payments appears to be on the rise, the share of revenue at risk from ACO-type arrangements was still quite low, and this low amount at risk is not always a “tangible motivator” for organizations. These findings from IHP interviews also appear to support conclusions from the ACO baseline assessment survey and interviews. One of the key findings from the assessment was that “while Minnesota has a strong history of integrated care, and ACO models are beginning to take root, the accountable care market is not yet at full maturity.” Further, “the percentage of revenue currently at risk in ACOs or similar arrangements is low, with two-thirds of providers indicating that 10 percent or less of their organization's revenue is at risk.”⁵¹ While the shift from a fee-for-service system to one of value-based payments appears to be happening, several IHPs noted that it was happening more slowly than they had anticipated.

⁵¹ *Factsheet: ACO Baseline Assessment*. Minnesota Accountable Health Model (SIM Minnesota). Minnesota Department of Health. Web. Feb. 2016.

<http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16_197637.pdf>

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Given the slower than expected uptake of value-based purchasing across payers, and the fact that important questions persist about the payers and providers involved in ACOs and ACO-like models and the nature of these arrangements, state efforts under SIM to develop quality measures, core competencies, and aligned payment methodologies for ACOs have been on a slower timeline than originally planned.

Integration of Non-Medical Providers into ACO Arrangements Still a Vision

IHPs are required to develop new care models and strategies, provide comprehensive and coordinated services, and collaborate with community organizations toward service integration. Some IHPs bring partnerships with them, and others have developed partnerships as a result of the IHP program. IHPs have significant discretion in how to pursue collaboration, and partnerships between IHPs and community organizations are evolving in a variety of ways.

During our interviews with IHPs, most described partnerships with community organizations that are informal, with no financial commitment or binding language between organizations. Two virtual IHPs, Southern Prairie Community Care (SPCC) and Wilderness Health, rely heavily on community partnerships with clinics, hospitals, mental health centers, and (in SPCC's case) counties. Some IHPs discussed the possibility of bringing community partners into their attribution formulas and distributing shared savings to them in the future, but emphasized that there were no "lines of sight" to specific plans yet. No IHPs discussed bringing community partners on to help bear downside risk.

Our interviews with ACHs also inquired about the relationship between providers participating in ACOs and other ACH partners. One goal of the ACH grant program was "to test how health outcomes and costs are improved when ACOs adopt ACHs that support integration of health care with non-medical services."⁵² Overall, our interviews indicate that the majority of the ACO partners in an ACH are engaged in the collaboratives, but an explicit link between ACO attributed populations and ACH services is not happening or known to date. The majority of ACHs reported that their target population likely includes ACO patients but is broader and includes non-ACO attributed individuals as well. In fact, only one ACH reported specifically targeting their ACO population. A few ACHs described an inability to identify IHP patients who may be good candidates for ACH services. These ACHs called attention to barriers including a current lack of data that connects the two groups (ACO attributed and ACH targeted populations), internal data barriers, and challenges associated with the IHP program including the retrospective attribution of IHP patients and the incapacity to do panel work on the data the state provides to IHPs given the lag in these data.

⁵² See page 9 of the Request for Proposals for the ACH Grant Program.

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Renderion=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_189328

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Significant Difficulties in Advancing e-Health

The overall goal of the e-Health Collaborative grant program was to support secure HIE. While progress has been made in advancing discussion of HIE (see above), of the six Round 1 e-Health implementation grantees, only two have exchanged data across settings as a result of the grant activities to date. SHADAC's wide-ranging interviews across all aspects of the State's SIM work suggest that the impact of Minnesota's strict data privacy requirements (see Exhibit 3.1 – Minnesota Health Records Act) is ubiquitous, in many cases slowing progress and the advancement of the Minnesota Accountable Health Model. Organizations that want to share health-related information with partners outside of their own affiliation face both real and perceived legal barriers to do so. Many SIM grantees, including participants in the e-Health Collaboratives, IHPs, ACHs, and Practice Transformation grants noted the logistical difficulty they have had implementing new care coordination models, sharing information with new partners, or implementing new e-health infrastructure capabilities, due to the Minnesota Health Records Act requirement to obtain patient consent each time patient information is released for any reason. Pursuant to data privacy restrictions in the State's managed care financial reporting laws, IHPs also perceive significant gaps in the payment data included in the detailed Medicaid claims information they receive each month from DHS, gaps that they believe impede their ability to fully utilize cost information to inform their clinical strategies.

Some SIM grantees are beginning to demonstrate progress in overcoming privacy-related legal barriers; however, those advances come as a result of significant investments (both in terms of time and financial resources) in legal services research, and the development of new legal policies and procedures. A number of organizations have used grant funds to develop their own patient consent forms, which allows them to customize the forms based on the unique needs of their organization or collaborative. However, the result of having each grant program, or health care organization, create their own patient consent or privacy forms is that there is no standardization of policies or procedures across organizations, settings, or geographic locations. This customization only adds to the complexity of organizations trying to partner with one another in order to share information, and limits the ability to achieve true state-wide health information exchange.

Numerous SIM participants also commented on the unique challenges providers face when trying to share behavioral-health related information, as Minnesota's Health Record Act is also more stringent than federal law when it comes to sharing psychotherapy notes. This example is typical of the focus of data sharing efforts in many SIM supported projects, which thus far has been on sharing physical health information (such as information contained in a summary of care document, such as a Continuity of Care Document) with behavioral health providers, rather than sharing behavioral health information with other types of health care providers. A number of other organizations voiced concern that data privacy concerns were being raised as barrier to information sharing, when in fact, the real barrier was an organization's desire to maintain control of their own data. This trend to guard patients' data within organizational walls is happening nationally as well, as a recent Robert Wood Johnson Foundation report explained: "The infusion of billions of dollars in subsidies have significantly increased the adoption of electronic medical records, a needed prerequisite to electronic health care information exchange.

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However, it can be argued the primary benefit of EHR adoption has been to convert analog clinical data into digital data within the same health professional organization. While these data are being used to create internal feedback loops on the quality of patient care, the corporate islands remain intact.”⁵³ One ACH participant offered the responsibility and burden of protecting the additional information as another reason organizations may be reluctant to share data even with improvement in EHR and HIE capacity.

Many SIM participants in both the e-Health Roadmap and Collaborative grants also cited Minnesota’s market-based HIE structure as a significant obstacle to their work. Grantees reported that Minnesota’s HIE landscape, currently made up of three Health Information Organizations (HIOs) and 13 Health Data Intermediaries (HDI), is complex, expensive, and volatile. Numerous grantees highlighted the difficulties they faced, and the substantial amount of time they invested, in trying to identify and select a HIE service provider. This challenge was exacerbated when one of the HIOs that many of the collaboratives originally planned to use withdrew their application to be recertified in 2015. Several grantees also expressed concern that the state-certified HIO and HDI vendors do not currently have the capability to exchange non-standard data (such as non-clinical data), thus limiting their ability to effectively share data across care settings for the purposes of care coordination.

Longer Time Window Needed for Reform Implementation and Outcome Monitoring

The SIM award to the state is a three and a half year cooperative agreement, with individual grant programs ranging from six months to two years. At both the state and grantee level, participants highlighted the amount of time needed to ramp up and implement their programs. Members of the Executive Committee and Leadership Team acknowledged an intense period of start up to staff, train, and develop cross-agency infrastructure to support the implementation of the Minnesota Accountable Health Model and to meet federal and state contractual obligations and reporting requirements. The original planning phase of the state’s SIM cooperative agreement extended into the implementation phase to meet these demands. Across the board, grantees, including both individual organizations and multi-organization collaboratives, also reported work under SIM taking longer to gear up than expected. Reasons included the time required to unrestrict funds with Center for Medicare and Medicaid Innovation (CMMI) and successfully hire grant staff as well as the foundational work necessary for community engagement and partnership development. Several grantees have applied for and received no-cost extensions from the state to complete their work.

Even without these delays, both a challenge and concern for grantees has been the amount of time available to implement reform activities and to assess and achieve desired outcomes. A six-month time frame or even a two-year period is not conducive to measuring and meeting long-term goals related to clinical and population health improvement. Early and/or intermediate process and outcome monitoring

⁵³ *Health Information Technology in the United States, 2015: Transition to a Post-HITECH World*, Robert Wood Johnson Foundation, Sept. 2015.

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is likely the most feasible for many grants. Some grantees are concerned that the lack of long-term data will inhibit their ability to make the business case or to prepare successful grant applications to support their work following SIM funding.

Some Stakeholders Not at Table

Many organizations participating in SIM have leadership committed to the work, and the work aligns with organizational priorities. As part of evaluation interviews with the state Executive Committee and Leadership Team members as well as a focus groups with members of the e-Health Roadmap Project Oversight Team, Steering Team, and Workgroups from each of the four priority settings, stakeholders were asked about entities or individuals who have been absent from the SIM initiative in Minnesota. While several Minnesota Accountable Health Model stakeholders have a seat on the two Task Forces, these discussions suggest that some stakeholder groups are not actively engaged in the SIM initiative. These groups include a subset of payer representatives, some provider groups, consumers, employers, and some state government offices. Some of the large health care systems are at the table, including the Minnesota Hospital Association, but medical, specialty, and nurse associations are not currently participating on either Task Force. With the exception of the State Employee Group Insurance Program and the University of Minnesota, participation in SIM by major employers is limited. While community members and consumers have been engaged in a number of ACHs, the general public and consumers have not otherwise been involved, and there is question about the right point in time and the right way to engage them. Evaluation conversations also surfaced an interest in exposing SIM to more divisions and units within each of the lead state agencies – DHS and MDH –in the future.

Continuous Improvement Feedback to State

One goal of the state evaluation is to identify opportunities for continuous improvement in the Minnesota Accountable Health Model activities and programs. Based on discussions with participants across Model investments and findings from the evaluation to date, the following key feedback is offered:

- **Flexibility in program implementation.** Participating organizations have valued the flexibility afforded by the state in terms of program design and implementation to achieve desired goals. Regular and open communication between state staff and grantees was viewed as a successful strategy for problem solving and keeping the state apprised of implementation adjustments and progress toward goals.
- **SIM-wide resource sharing.** Grantees have simultaneously navigated e-Health, care integration, and care coordination challenges within and across grant programs. Some of these efforts may be unnecessarily duplicative and therefore inefficient. For example, e-Health Collaboratives could have benefited from an inventory of vendor capabilities and pricing. There may be overlap in ACHs in terms of tool development to facilitate care coordination. Legal and data privacy concerns have been navigated by multiple grantees with the help of consultants and

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others. There are opportunities for synergy across grant programs and Model drivers yet efforts to bring grantees require time and resources for all involved. We recommend continuing to facilitate and encourage use of grant program repositories such as the ACH SharePoint site for sharing information and both formal and informal grantee-to-grantee sharing at the Learning Days event and other General and ACH Learning Community programming.

- **Direction from state on HIE.** Grantees are seeking greater clarity as to whether or not the state is going to continue to support a market-based HIE approach; with many of the grantees encouraging the state to reconsider establishing a single statewide HIE entity. Participants are also anxious to see the results of the Privacy, Security, and Consent Management (PSCM) work under SIM as soon as possible, as these issues have been identified as major obstacles to HIE implementation across various SIM driver components. State staff report that they have been communicating with grantees about the status of the PSCM work on a number of occasions. For example, state staff shared an update on the status of the PSCM work with ACH grantees on an ACH cohort conference call in December 2015, and at an e-Health Roadmap Steering Committee meeting in January 2016. We also heard a call for the state to begin work now on developing uniform data standards for non-clinical data that would make the sharing of data across settings possible once the technology is place. Organizations are anxious to know what those standards will be before they invest resources in any new HIE capabilities, for fear of choosing the wrong system that will not allow them to “talk to” other partners.
- **Dissemination of SIM information, such as use cases, stories, and evaluation findings.** The use cases developed under the e-Health Roadmaps, the stories collected and produced by the Storytelling Engagement Project, and evaluation findings have the potential to be important sources of information about the SIM experience in Minnesota. During our interviews, grantees expressed interest in receiving evaluation findings. Dissemination of this material may also be used to support the momentum achieved under the SIM initiative and spark new stakeholder involvement, including under-tapped groups such as payers and consumers. There may be opportunities to combine evaluation findings with the stories compiled as part of this dissemination.

Insights for Sustaining the Model in the Future

In November 2015, DHS and MDH leadership consulted the Community Advisory and Multi-Payer Alignment Task Forces advising the state on the SIM award to confirm the continued relevancy of the four aims originally established for the Minnesota Accountable Health Model. During this meeting, state leadership and both Task Forces agreed that the aims remain appropriate and important and agreed with three priority areas drafted by the state for sustaining the Model. These include:

1. Continued efforts with health information exchange and data analytics;
2. Value-based purchasing and the alignment of incentives with desired outcomes; and
3. Community connections, partnerships, and authentic engagement.

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These priorities also align with many of the health care purchasing and delivery system strategy-related recommendations recently made by the Minnesota Health Care Financing Task Force in January 2016.⁵⁴ This task force was established by the 2015 State Legislature and Governor to advise on strategies to increase access to health care and improve quality of care, including financing, coverage, purchasing, and delivery.⁵⁵ Recommendations from this task force that are pertinent to the SIM initiative are summarized in Exhibit 7.1. These recommendations include enhancements to data sharing; enhancements that support integrated care delivery including value-based purchasing; and enhancements to pilots, demonstrations, and existing programs related to community engagement, patient attribution, care coordination payment, and non-medical services.

Grantee experiences and insights, as summarized throughout this report, reinforce both the state's SIM sustainability priority areas and many of the Health Care Financing Task Force recommendations outlined in the exhibit. Regarding the state's first priority sustainability area: EHR, HIE, and data analytic capacity are critical for practice transformation and collaborative approaches to population health, but as described in this report, grantees experienced several challenges related to the state's HIE structure, identifying a capable HIE service provider, state data privacy laws, and the financial sustainability of EHR and HIE costs. The Health Care Financing Task Force's recommendations take up many of these challenges. The forthcoming work of the PSCM grant may further clarify some of the data privacy concerns identified by grantees and elucidate a way forward for those who want to pursue greater information sharing. However, without additional legislative changes to the Minnesota Health Records Act and the response to other HIE challenges, the risk remains that any workarounds developed may be too costly and time consuming for smaller organizations to implement, thus limiting further advancement of the Minnesota Accountable Health Model.

⁵⁴ *Health Care Financing Task Force Report – At A Glance Summary of Recommendations*. Manatt Health, Jan. 2016.

⁵⁵ About Page. "About the Health Care Task Force." Minnesota Health Care Financing Task Force. Web. Feb. 2016. <<http://mn.gov/dhs/hcftf/about/>>

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Exhibit 7.1. Select Recommendations from the Minnesota Health Care Financing Task Force

Enhancements to Data Sharing

- Updates and clarifications to the Minnesota Health Records Act to conform with HIPAA and ensure that consent preferences are more easily operationalized at the provider level
- Ongoing education and technical assistance to health and health care providers and patients about state and federal laws governing exchange of clinical health information
- Conduct a broad analysis of HIE in Minnesota, including an assessment of the current market-based approach
- Expansion of HIT capabilities (e.g., EHRs) in a broad range of care settings
- Funding mechanism for core HIE transactions and establishment of statewide HIE “shared services” central vendor

Enhancements that Support Integrated Care Delivery

- Evaluation of value-based purchasing, accountable care, and care coordination programs related to the Triple Aim
- Alignment of multi-payer approaches to measurement, payment, attribution, and definitions
- Conduct a study of long-term payment options (e.g., value-based purchasing) for health care delivery, including a comparative cost/benefit analysis

Enhancements to Pilots, Demonstrations, and Existing Programs

Incorporation of the following enhancements into existing pilots, demonstrations, and programs such as IHP and HCH:

- Enhancement of community partnerships via: a) incentives for a broad range of community organizations within care coordination models and b) funding for community care collaboratives focused on social determinants of health and population health improvement
- Incentives for patients’ participation in collaborative leadership and advisory teams
- For measurement, include risk adjustment reflective of medical and social complexity and reward providers for both performance and improvement
- Incorporation of utilization measures assessing impact of care coordination into performance measurement models
- Provision of prospective, flexible payment for care coordination, non-medical services, and infrastructure development (for participants not attributed to an ACO)
- Provision of a prospective “pre-payment” of a portion of anticipated total cost of care (TCOC) savings (for participants attributed to an ACO)
- Consistency of payment approach for care coordination and alternative payment models across payers
- Establishment of care coordination payments sufficient for patients with complex needs
- Strengthening of patient attribution and provider selection processes
- Identification of methods to monitor non-medical services
- Inclusion of non-medical factors in complexity tiers used for the HCH and similar programs

Source: *Health Care Financing Task Force Report – At A Glance Summary of Recommendations*. Manatt Health, Jan. 2016.

Both the ACO baseline assessment conducted under the SIM initiative and our interviews with IHPs indicate that while value-based payments models are on the rise, the share of revenue at risk from ACO-type arrangements is low and ACO maturity in the state is overall relatively low in terms of patient engagement, population health management, clinical decision support, performance and utilization management, and other areas. While the IHP program has successfully expanded under the SIM initiative, some IHPs have concerns about the potential for diminishing shared savings over time and therefore the financial viability of the program.

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The Health Care Financing Task Force recommends the study of long-term payment options including value-based purchasing as well as the testing of a number of changes and improvements called out by IHP grantees related to the attribution methodology, payment and measurement determinations, and timing of compensation. In particular, IHPs discussed the problems associated with a retrospective attribution model and their ability to manage patient care in the short term, their concerns about diminishing potential for savings given how cost benchmarks under the current payment methodology are adjusted over time, their difficulty in determining exactly what is working and what is not working, and their desire to be “compensated at the right time for doing the right thing” (e.g., prospective compensation for care management and other infrastructure). In 2016, SHADAC’s evaluation will produce findings from analysis of Minnesota’s All-Payer Claims Database and the Statewide Quality Reporting and Measurement System on IHP program costs, treatment patterns, and quality measures.

Both the third sustainability priority area under SIM and the Health Care Financing Task Force recommendations point to a dedication to continued community engagement and partnership development. As summarized earlier in this chapter, participants in all grant programs communicated and illustrated the importance of community engagement and partnerships for practice transformation and improvements in care quality, but also how much time and resources were needed to reach out to potential partners, navigate new areas of expertise and organizational cultures and operations, develop and implement infrastructure necessary for collaboration, and execute partnerships. SIM participants called attention to the crucial role of a central point person for implementing and maintaining collaborative efforts while providers and organizations juggle service provision and other core activities. This person is recognized as the hub of the transformation activities and plays a significant part in making connections in the community, coordinating between health care providers and community-based resources, and overseeing the administration of transformation activities and communication. In some cases, this person is the administrative project manager for the grant; in other cases, this person may be a member of the care coordination team and is directly involved in the coordination of services for specific individuals; and in other cases, this person may play both roles. A number of grantees across the SIM initiative noted the significance of the grant funds in supporting community engagement and partnership development. Therefore, a key consideration in the sustainability of efforts pertains to the funding options available for positions to carry out these functions. “The care team needs a coordinator....That is never going to be reimbursable...Facilitating conversations is important.... And how do we work between agencies that are really large and complex...that times time.”

One focus articulated by SIM grantees and the Health Care Financing Task Force but not explicitly identified in the state’s current sustainability priorities under the SIM initiative pertains to payment models and approaches for care coordination. A number of grantees expressed concerns about the sustainability of SIM-funded care coordination positions and efforts beyond the grant period given current funding options and reimbursement levels for care coordination. Several grantees reported that health care coordination reimbursement opportunities are limited and, even if participating organizations are eligible for reimbursement from a payer, they are insufficient. For example, concerns were voiced about the current HCH reimbursement levels and the rates for the pending Behavioral

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Health Home (BHH) program. In addition, there may be restrictions that vary by payer related to the provider type that can deliver the service to be eligible for payment, and a couple of grantees explained that it is a burden to bill only certain payers for care coordination. Some grantees considered it unethical to only offer these services to those patients with care coordination coverage. In order to stabilize their investments, several IHPs also argued for prospective payments to maintain their care coordination improvements and data analysis functions linked to redesigning care delivery.

Conclusion

The state of Minnesota has embarked on an ambitious effort to expand value-based arrangements and patient-centered, community-based service delivery and coordinated care through the implementation of the Minnesota Accountable Health Model. One key goal of state's reform efforts is to develop new relationships across the medical care delivery system and local providers of health and social services to better meet the holistic needs of patients and communities and improve population health. The SIM grant funding has provided needed funds and infrastructure required for change but continued efforts will be required to sustain innovations over time.

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APPENDIX A

State Staff Training Sessions

Training Topic	Type of Training
SIM 101 overview	In-person
SIM overview Workgroup 1	In-person
SIM overview Workgroup 2	In-person
SIM overview Workgroup 3	In-person
SIM overview Workgroup 4	In-person
Community engagement	In-person
Minnesota's local public health system	Webinar
Statewide Health Improvement Program (SHIP) activities in Minnesota	Webinar
Community Transformation Grant (CTG) activities in Minnesota	Webinar
Health Care Home program/MAPCP demonstration	Webinar
New workforce models/new health care professions in Minnesota	Webinar
Community Care Teams	Webinar
Integrated Health Partnership (IHP) demonstration	Webinar
Behavioral Health Home planning/implementation efforts	Webinar
Preferred Integrated Network (PIN) for adults and children with severe mental illness	Webinar
Minnesota's Duals Demonstration: Medicare/Medicaid integrated managed care models	Webinar
The Reform 2020 waiver request	Webinar

Source: Minnesota Accountable Health Model Operational Plan.

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APPENDIX B

Task Force Meetings

Meeting Date	Topics
August 2013 (Joint)	SIM Vision and Goals, Operational Plan Overview, Health Information Technology (HIT)/Data Analytics RFI
October 2013 (Community Advisory)	Straw Proposal, Overview of ACOs/Delivery/Triple Aim, HIT/Data Analytics RFI, Feedback on Visions and Goals
October 2013 (Multi-Payer Alignment)	Data Analytics RFI, Straw Proposal, Feedback on Visions and Goals, Proposed Key Milestones
November 2013 (Community Advisory)	Straw Proposal, Evaluation Framework, Community Engagement
November 2013 (Multi-Payer Alignment)	Straw Proposal, Evaluation Framework, Baseline Assessment of ACO Participation
Early 2014 Subgroup: ACH	Subgroup met three times in early 2014 to provide recommendations to the Task Forces regarding the criteria and implementation of Accountable Communities for Health
January 2014 (Community Advisory)	Evaluation Framework, Accountable Communities for Health
January 2014 (Multi-Payer Alignment)	Evaluation Framework, Environmental Scan, and Baseline Assessment of ACO Participation
March 2014 (Joint)	Data Analytics and Reporting to MN Health Care Programs ACOs and Health Care Homes, Accountable Communities for Health
May 2014 (Joint)	CMMI, Evaluation Tool Framework, Accountable Communities for Health, Data Analytics for IHPs
May 2014 (Community Advisory)	Accountable Communities for Health
May 2014 (Multi-Payer Alignment)	Accountable Communities for Health Subgroup, Data Analytics
July 2014 (Community Advisory)	Data Analytics Subgroup, Accountable Communities for Health, Community Engagement
July 2014 (Multi-Payer Alignment)	Data Analytics Subgroup, Community Engagement
September 2014 (Community Advisory)	Data Analytics Subgroup, IHP Data User Group, E-Health Community Collaborative grantees, Community Engagement
September 2014 (Multi-Payer Alignment)	Data Analytics Subgroup, IHP Data User Group, Community Engagement
November 2014 Subgroup: DAS	Subgroup met three times from November 2014 – February 2015 to identify high priority data analytic elements for alignment
November 2014 (Community Advisory)	Data Analytics Subgroup, e-Health Advisory Committee, Evaluation, Community Engagement

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Meeting Date	Topics
November 2014 (Multi-Payer Alignment)	Data Analytics Subgroup, E-Health Advisory Committee, Evaluation
March 2015 (Joint)	Data Analytics Subgroup: Phase One Review
March 2015 (Community Advisory)	Data Analytics Subgroup, Emerging Professions, Community Engagement
March 2015 (Multi-Payer Alignment)	Data Analytics Subgroup, Emerging Professions
May 2015 (Joint)	Data Analytics, Evaluation, ACH Early Implementers (CCTs)
September 2015 (Community Advisory)	E-Health Roadmap, Sustainability, Data Analytics Subgroup
September 2015 (Multi-Payer Alignment)	E-Health Roadmap, Data Analytics Subgroup, Sustainability
November 2015 (Community Advisory)	Evaluation, Data Analytics Phase One and Two, Sustainability
November 2015 (Multi-Payer Alignment)	Evaluation, Data Analytics Phase One and Two, Sustainability

Source: "Task Forces." *State of Minnesota*. 6 Nov. 2014. Web. Dec. 2015.

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APPENDIX C

Overview of Grant Applicants and Awards, by SIM Component and Grant Program

Grant Program	Total Number of Applicants	Number of Awards	Total Amount Awarded
E-HEALTH GRANTS			
E-Health Collaboratives: Round 1	17	12	\$3,846,070
E-Health Collaboratives: Round 2	8	4	\$1,017,326
Privacy, Security, and Consent Management for Electronic HIE Part A	5	1	\$200,000
Privacy, Security, and Consent Management for Electronic HIE Part B	2	1	\$299,137
TEAM-BASED CARE GRANTS			
Emerging Professions Round 1	7	5	\$150,000
Emerging Professions Round 2	16	4	\$120,000
Emerging Professions Round 3	8	5	\$148,061
Learning Communities Round 1	8	4	\$348,235
Learning Communities Round 2	2	1	\$49,860
Practice Transformation Round 1	18	10	\$194,768
Practice Transformation Round 2	13	12	\$281,521
Practice Transformation Round 3	24	24	\$239,793
Practice Facilitation	4	2	\$966,601
ACCOUNTABLE CARE ORGANIZATION GRANTS			
IHP Data Analytics Grants	11	11	\$4,063,472
ACCOUNTABLE COMMUNITIES FOR HEALTH GRANTS			
Accountable Communities for Health	23	15	\$5,543,160

Source: "Minnesota Accountable Health Model Request for Proposals." *State of Minnesota*. Dec. 2015. Web. April 2016.

Note: Three ACHs were sole source.

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APPENDIX D

Continuum of Accountability Assessment Tool

Additional Findings

SHADAC researchers presented preliminary findings from the Continuum of Accountability Assessment tool to the State and external stakeholders in November of 2015.⁵⁶ For the purpose of this annual report, SHADAC updated the analysis database with additional tools completed by organizations participating in the Minnesota Accountable Health Model. High level findings are presented in the body of the First Annual Evaluation Report. Targeted analyses are presented in this Appendix.

The first two sections of this Appendix respond to specific questions raised by Task Force members, including the number and type of organizations reporting Electronic Health Record (EHR) adoption on their completed assessment tools as well as the average scores for items related team-based, integrated/coordinated care for certified Health Care Homes compared to similar non-certified organizations. The timing of this annual report coincided with the end of one grant program, Practice Transformation Round 1. In the last section of this Appendix, SHADAC reports preliminary findings from its analysis of tool data submitted by these 10 grantees before and after grant funding.

EHR Adoption

Out of the 172 organizations that submitted completed Continuum of Accountability Assessment tools, 133 indicated that they have implemented an EHR system. As expected, many of the organizations are clinical in nature, but behavioral health organizations have also reported high levels of EHR adoption (see Exhibit D.1).

⁵⁶ Slides are available on the State of Minnesota's State Innovation Model website. Minnesota Accountable Health Model: Community Advisory Task Force. November 18, 2015.
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Renderition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_198159

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Exhibit D.1. EHR Implementation by Organization Type

Organization Type	Numbers with EHR Implementation
Hospitals and/or Network of Hospitals	8
Clinics and/or Network of Clinics	34
Healthcare Systems	30
Health Plan	1
Behavioral Health	22
Social Services	6
Local Public Health	8
Human and Other Public Health and Social Services	9
Long-Term Post-Acute and/or Home Care Services	12
Other	3

Source: SHADAC, Assessment Tool Database: Continuum of Accountability Assessment Tools Submitted by Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative, University of Minnesota, School of Public Health. Minneapolis, Minnesota. April 2016.

Notes: This universe of organizations are those who listed a EHR name on their tool and did not choose pre-level for status of EHR implementation (Question 19). The same organization could have submitted more than one completed tool due to participation in more than one grant program.

Care Coordination

In Minnesota, care coordination has been a key component in its Health Care Home program. Health Care Home certification is based on criteria in the following categories: access/communication, patient tracking and registry functions, care coordination, care plans, performance reporting, and quality improvement. As seen in Exhibit D.2, on average, organizations that have Health Care Home certification scored higher on the questions regarding Delivery and Community Integration and Partnership. As explained in the report body, we use average scores (2-5) to look at movement along the continuum (Level A-D), with a higher score representing more progress in that area.

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Exhibit D.2. Delivery and Community Integration and Partnership

Question	HCH Average Score	% Pre-Level	Non-HCH Average Score	% Pre-Level
Population Management	4.20	0.0%	3.56	0.0%
Care Coordination	2.97	0.0%	2.90	10.2%
Team-Based Work	3.60	0.0%	3.47	10.2%
Referral Processes	4.05	0.0%	3.61	0.0%
Transitions Planning	3.48	2.0%	3.48	4.1%
Transitions Communication	3.68	4.0%	3.56	6.1%
Quality Improvement	3.79	0.0%	3.71	2.0%
Training	3.38	6.0%	3.19	10.2%
Community Resources	4.07	0.0%	3.76	0.0%
Culturally Appropriate Care Delivery	3.76	0.0%	3.43	2.0%
Emerging Workforce Roles	3.88	22.0%	3.48	28.6%
Patient and Family Centered Care	4.00	2.0%	3.56	10.2%
Patient Input for Organizational Improvement Activities	3.93	0.0%	3.56	2.0%
Self-Management Support	3.34	0.0%	3.12	2.0%

Source: SHADAC, *Assessment Tool Database: Continuum of Accountability Assessment Tools Submitted by Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative*, University of Minnesota, School of Public Health. Minneapolis, Minnesota. April 2016.

Notes: Average score and % pre-level for clinics and health systems pre-award by Health Care Home certification status, across all SIM grant programs (HCH n=50, non-HCH n=49). The same organization could have submitted more than one completed tool due to participation in more than one grant program.

Pre-/Post Preliminary Findings for Round 1 of the Practice Transformation Grant Program

One purpose of the Continuum of Accountability Assessment is to track progress of organizations participating in the Minnesota Accountable Health Model along a variety of factors related to participation in accountable care models. Grantees are required to complete the tool at proposal stage and at the end of grant activities. At the time of this report, SHADAC received post-award tools for the 10 grantees who participated in Round 1 of the Practice Transformation grant program, which ended in the summer of 2015. These investments in primary care, behavioral health, and social service providers supported the broad goals of the Minnesota Accountable Health Model through the following activities: preparation for HCH certification or recertification, enhanced coordination of care, integration of primary care and behavioral health, planning for Behavioral Health Homes (BHH), expansion of patient registries, and enhanced analytic capacity. Results of pre-/post-award data are presented below.

As shown in Exhibit D.3, average scores across all grantees for most questions on the tool were higher post-grant than pre-grant award. In other words, there was positive movement along the continuum. It appears that on average the greatest progress was made in the capabilities/functions related to “Delivery and Community Integration and Partnership.” For example, average scores on the Self-

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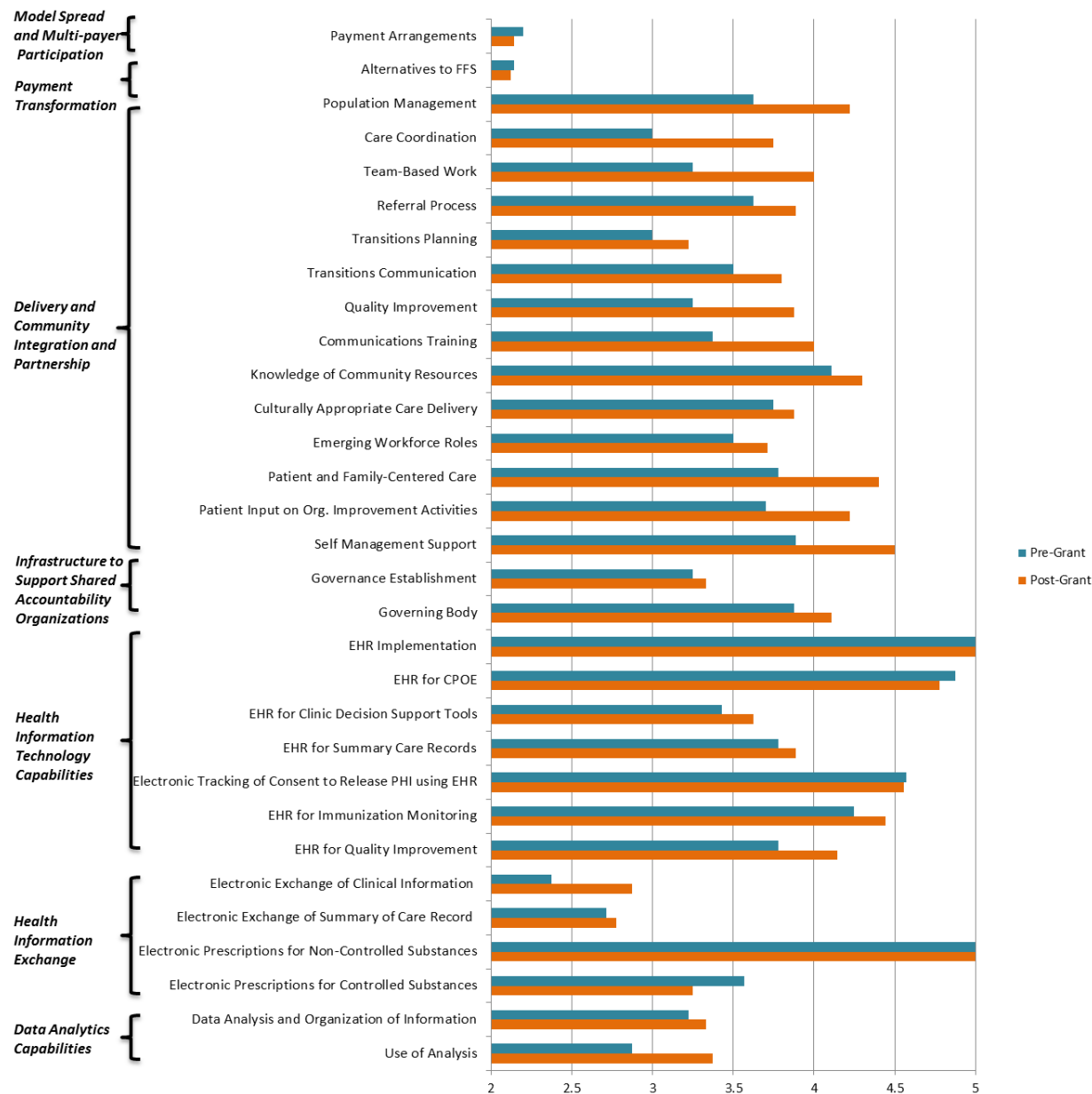
Management Support question went from 3.9 to 4.5 indicating that the average organization moved forward on the continuum, from Level C toward level D. When analyzing progress by individual grantee, three of the ten organizations progressed to the furthest level (Level D) with respect to Self-Management Support (and one organization was already at this level), indicating that they have at least started to “provide self-management support systematically supported and provided by members of their trained service team in patient empowerment, motivational interviewing techniques, problem solving methods and decision making techniques.”

Regarding the Population Management item, or having a process to identify appropriate patients for care coordination, average scores for this question went from 3.6 to 4.2, indicating movement from an informal to a more routine process for this function. Four organizations moved at least one level along the continuum; thus after the grant more than half of the organizations are reporting that they at least “routinely assess patient needs for care coordination using methods such as pre-visit planning, use of registries and team/provider input.”

There was little movement with respect to EHR implementation and electronic prescribing of non-controlled substances, due to organizations already rating themselves at the end of the continuum at baseline. The overall progress related to EHR for clinical support tools, such as reminders, care plans and flow sheets is the result of one organization reporting that it initiated this work through the course of the grant.

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Exhibit D.3. Continuum of Accountability Progress for Round 1 Practice Transformation Grantees



Source: SHADAC, *Assessment Tool Database: Continuum of Accountability Assessment Tools Submitted by Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative*, University of Minnesota, School of Public Health. Minneapolis, Minnesota. April 2016.

Notes: Average score pre- and post-grant for organizations that received Round 1 Practice Transformation funding (n=10).

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APPENDIX E

E-Health (Driver1) Investments

The purpose of the e-Health (Driver 1) investments is to increase providers' ability to securely exchange data for treatment, care coordination, quality improvement, and population health pursuant to state and federal law. Driver 1 supports funding in three areas of e-health investment:

1. Technical Assistance and Education: Privacy, Security and Consent Management;
2. e-Health Roadmap;
3. e-Health Collaborative Grant Program.

1. TECHNICAL ASSISTANCE AND EDUCATION: PRIVACY, SECURITY, AND CONSENT MANAGEMENT (PSCM)

Purpose:

The goals of the PSCM technical assistance and education are multifold: to ensure that health care professionals have access to education and technical assistance on privacy, security, and consent management practices; to identify opportunities for improvement in current patient consent processes for the release of protected health information required for health information exchange; and to provide technical assistance and education to ensure health care professionals across various settings have the access to the knowledge and tools required to use, disclose, and share health information in a safe and secure manner that is consistent with both state and federal law.

Select Requirements:

- **Part A: Review of e-Health Legal Issues, Analysis and Identification of Leading Practice**
 - a. Complete a legal review and analysis of the differences, barriers and tensions between state and federal laws regulations, and rules and policies for HIE required for care coordination activities across diverse health and health care settings.
 - b. Identify leading practices related to e-health privacy, security, and consent management issues and identify opportunities for standardization.
- **Part B: e-Health Privacy, Security and Consent Management Technical Assistance and Education**
 - a. Use information gained in Part A to develop educational tools, tips, guides and materials.
 - b. Address the needs of communities or partnerships that are part of e-Health grant projects and Accountable Communities for Health (ACHs) to ensure safe, secure data practices are followed and effective patient consent for exchange of information.
 - c. Provide technical assistance to organizations, communities or partnerships that are selected to become ACHs to ensure effective patient consent for exchange of

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information, and lead statewide and regional trainings on privacy/security issues covering HIPAA and relevant state laws.

Total Award:

Part A: \$200,000

Part B: \$299,137

Timeframe:

Part A: August 2015 – December 2016

Part B: August 2015 – December 2016

Awardees:

Part A: Gray Plant Mooty

Part B: Hielix, Inc

2. E-HEALTH ROADMAP

Purpose:

The purpose of e-Health Roadmap project is to provide recommendations and actions to support and accelerate the adoption and use of e-health in four priority settings: behavioral health, long-term and post-acute care, local public health, and social services. Through the process of collecting and identifying stories (use cases) that illustrate how an individual moves through the various health and care systems, the Roadmap will emphasize how supporting and accelerating the adoption and use of e-health in these priority settings could improve health outcomes.

Select Requirements:

In order to produce the e-Health Roadmap, the contractor was required to complete the following major tasks:

- Engage setting-specific key stakeholders and facilitate discussion to reach community consensus;
- Identify and describe 10 use cases, which represent the future state of using e-health to participate in the Minnesota Accountable Health Model. At least four of the 10 use cases must involve transitions of care and at least one use case should involve:
 - a. a patient with multiple chronic conditions, including behavioral health as well as physiological health conditions;
 - b. a patient in rural areas, as defined by the Office of Rural Health and Primary Care, MDH;
 - c. an individual and/or patient that is part of a Health Care Home, an Integrated Health Partnership, or accountable care organization and that is receiving social services;

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- d. a patient in Health Professional Shortage Areas or Medically Underserved Areas/Population in Minnesota, as defined by the Office of Rural Health and Primary Care, MDH;
 - e. a patient where smoking, obesity, and/or diabetes is being treated or addressed through care of a provider;
 - f. health information exchange between the setting and a patient's health care home or accountable care organization;
 - g. using e-health for primary prevention (e.g., screenings, immunizations);
 - h. quality improvement or health analytics; and
 - i. health information exchange between the setting and the Minnesota Department of Health, Minnesota Department of Human Services, or other state agency.
- Prioritize three to five of the 10 use cases and compile findings to develop a final Roadmap that will include a narrative report and a visual summary;
 - Develop a Lessons Learned and Evaluation Report; and
 - Disseminate the e-Health Roadmap to the settings.

Total Award:

\$596,726

Timeframe:

January 2015- June 2016

Awardee:

Stratis Health

3. E-HEALTH COLLABORATIVE GRANT PROGRAM

Purpose:

The purpose of this grant program is to support the secure exchange of medical or health-related information between organizations for: a) developing a plan to participate in the Minnesota Accountable Health Model; or b) implementing and expanding e-health capabilities for participation in the Minnesota Accountable Health Model.

Select Requirements:

The original e-Health request for proposal (RFP) asked applicants to meet the following criteria in order to qualify for funding:

- **Community collaboratives:** Individual organizations were not eligible for this grant. Eligible awardees were required to be community collaboratives that had at least two or more organizations;

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- **Priority setting providers:** Every collaborative must include a partner organization from at least one of the four priority settings (Round 2 must include two of the following):
 - a. Local public health departments
 - b. Long-term and post-acute care providers
 - c. Behavioral health providers
 - d. Social service providers
- **ACO participation:** A community collaborative must have at least two or more organizations participating in or planning to participate in an accountable care organization (ACO) or similar health care delivery model that provides accountable care;
- **Development grants:** Development grants were focused on creating a detailed development plan for the implementation of e-health that will advance the community collaborative along the Minnesota Accountable Health Model;
- **Implementation grants:** Implementation grants focus on implementing the adoption and effective use of EHR systems and other health information technology including health information exchange.

Total Award:

Round 1: Approximately \$3.85 million

Round 2: Approximately \$1.02 million

Timeframe:

Round 1:

Development Grants: October 2014 – September 2015

Implementation Grants: October 2014 – March 2016

Round 2:

Implementation Grants: July 2015 – December 2016

Awardees:

E-Health Collaborative Name	# of Partners	Project Description
ROUND 1: DEVELOPMENT GRANTS		
Carlton County Connects	14	Identified how to move forward with the health information exchange (HIE) needed for citizens. The project assessed the current infrastructure, identified gaps in information exchange, reviewed solutions, and defined a process for moving the planning into implementation.
Fairview Foundation	8	Developed a plan for exchanging health information to ensure continuity of care for a post-acute, over age 65 population. The plan focused on understanding the impact of data sharing to improve

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E-Health Collaborative Name	# of Partners	Project Description
		quality and coordination of care through the effective use of health information technology (HIT) during care transitions.
Lutheran Social Services of Minnesota	7	Developed an e-health implementation plan to integrate primary care, behavioral health, and social services for people with disabilities currently served by six community disability partners. The goal is to leverage a state certified HIE to share LifePlan information (a planning tool to help people with disabilities plan for the future and prioritize resources to achieve their goals) with partner organizations.
Preferred Integrated Network	13	Explored how to use a health information exchange and health information technology to better meet the health needs of patients and community members of the PIN Collaborative. The project undertook a multi-pronged approach to better understand the complexity of the PIN partnership from a technology standpoint.
White Earth Nation	5	Focused on the development and implementation of the WECARE (White Earth Collaboration, Assessment, Resource and Education) case management module within the tribal government's software system, RiteTrack. The module is designed to be inclusive of all appropriate tribal programs.
Wilderness Health	9	Developed a work plan for the implementation of a care management and analytical tool that is able to incorporate clinical records with payer claims data and quality benchmark data for a collaborative of independent hospitals in Northeastern Minnesota.
ROUND 1: IMPLEMENTATION GRANTS		
Fergus Falls	8	Expand current health information exchange use/options for collaborative partners. Project focus is on unmet e-health needs which include: inability to incorporate HIE into day to day clinician workflow, consumer engagement in consent management, and the use of the patient portal and the inability to aggregate information for quality improvement and program planning.
FQHC Urban Health Network – FUHN	11	Establish e-health connectivity for collaborative of 10 FQHC organizations in order to permit the exchange of information with other state HIO participant organizations, and help to improve the use of data and care coordination.
Mission Hennepin Collaborative	7	Implement HIT improvements and establish HIE connectivity to enable the five MCHN members (behavioral health providers) to connect with each other and with the Hennepin system, and to develop and exchange a Continuity of Care Document that will support care coordination and improved communication for Hennepin Health enrollees with co-occurring medical, behavioral health, and social complexity.

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E-Health Collaborative Name	# of Partners	Project Description
Northwest Minnesota e-Health Collaborative	15	Implement HIE among all organizations, engage in care coordination, and become an IHP. Collaborative comprised of behavioral health, public health, social services, primary care, long-term care, an ACO, and the three health plans spanning a three-county region that includes Mahnomen, Norman, and Polk Counties.
Southern Prairie Community Care	29	Collaborative of 12 counties and multiple service providers (already established IHP) seeking to move from development to implementation of HIE system to collect, analyze and use data to improve outcomes. Proposing to do population-based based care coordination through HIE.
Winona Regional Care Consortium	4	Expand the use of EHR, HIE, HIT, and leverage the unique telemedicine and monitoring technologies developed and implemented as part of the Beacon program in SE Minnesota.
ROUND 2: IMPLEMENTATION GRANTS		
Beltrami County Behavioral Health	11	Implement a Direct Secure Messaging Exchange solution to improve coordination of community mental health patients triaged to hospitals outside of Beltrami County, and to enable a close-loop referrals process to ensure children's mental health provider referrals are completed.
Carlton County Connects	13	Advance the community's ability to share health information through the implementation of Direct Secure Messaging among collaborative partners. Providers will be able to share important information on patients to improve outcomes and quality, while creating an infrastructure that builds capabilities for the future.
Lutheran Social Service of Minnesota	9	Implement the e-health plan that was developed in Round 1 to fully integrate primary care, behavioral health, and social services for people with disabilities in Minnesota. An exchange system will be implemented among collaborative partners that will be compatible across organizations.
Winona Health Services	5	Expand the Round 1 funded programs to create a basic structure for HIE to support more flexible access to and use of health information (Care Coordination-HIE) for five current collaborative members and potential expansion of six additional members. The project goal is to demonstrate four to six use cases that validate the new support structure for future expanded use.

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APPENDIX F

E-Health Roadmap Community Engagement Report by Rainbow Research

Minnesota Accountable Health Model Community Engagement Evaluation Task

e-Health Roadmap Project Qualitative Study Focus Group Summary

Prepared by Rainbow Research, Inc.
February 26, 2016

Introduction

The e-Health Roadmap Project is a collaborative effort, led by the Minnesota Department of Health (MDH) Office of Health Information Technology and Stratis Health, to convene stakeholders to create a framework for the adoption and use of e-health across four priority settings: behavioral health, local public health, long-term and post-acute care (LTPAC) and social services. The e-Health Roadmap is intended to guide providers and organizations to adopt effective e-health practices to improve care coordination and patient outcomes, leading to healthier communities throughout Minnesota.

Between October and December 2015 Rainbow Research, Inc. planned and conducted key informant interviews and focus groups with participants in the Minnesota e-Health Roadmap Project as a part of the state-led evaluation of the Minnesota State Innovation Model (SIM). The purpose of this evaluation activity is to describe the community engagement efforts that are an integral part of the e-Health Roadmap Project, and explore intended and unintended outcomes and lessons learned from the engagement process.

Community Engagement Model

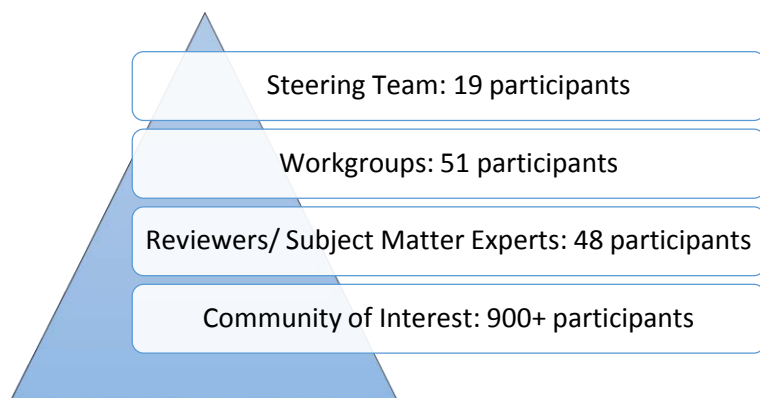
The e-Health Roadmap Project community engagement model is structured to include four tiers of engagement, each with a different degree of activity and time commitment (See Figure 1). The Steering Team meets monthly and is charged with providing leadership and guidance to the e-Health Roadmap process. Four Workgroups, consisting of stakeholders from each priority setting, meet monthly and are charged with developing and prioritizing use cases and creating recommendations for the roadmap. Reviewers and Subject Matter experts are engaged via email to provide feedback on materials and deliverables. Community of Interest participants receive email updates about the e-Health Roadmap Project, and have been invited to attend webinars and other e-health activities. Some individuals

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participated in multiple engagement opportunities. For example, Workgroup chairs also participated in the Steering Team, and many Workgroup members also participated in the Community of Interest. The e-Health Roadmap work is overseen by the Project Oversight Team, which includes staff from MDH and Stratis Health.

In focus groups with Steering Team and Workgroup members, participants were asked to discuss their views on the community engagement approach. Participants were asked to discuss the similarities and differences of the model to other collaborative processes in which they had participated, and the strengths and weaknesses of the approach.

Figure 1: e-Health Roadmap Project Community Engagement Model ⁵⁷



Methods

In December 2015 Rainbow staff conducted five focus groups with members of the e-Health Roadmap Project Steering Team and Workgroups. Rainbow staff worked closely with staff from State Health Access Data Assistance Center (SHADAC) and Stratis Health to develop criteria for participation in the focus groups. Steering Team members were invited to participate in the focus group if they had attended at least half of the program meetings, and were not Workgroup Co-Chairs, MDH or Stratis Health staff. Workgroup members were invited to participate if they were not MDH or Stratis Health staff. Stratis Health staff issued invitations to participate in the focus groups, and shared information about the community engagement evaluation with Workgroup and Steering Team members in the month prior to the focus groups. All focus groups were scheduled immediately following monthly Workgroup and Steering Team meetings at Stratis Health. Steering Team and Workgroup members were invited to participate in the focus groups in person and on the phone. Table 1 summarizes participation for each of the five focus groups.

⁵⁷ Source: *Progress Report and Proposed Next Steps. Minnesota e-Health Roadmap for Behavioral Health, Local Public Health, Long-Term and Post-Acute Care, and Social Services* (July 2015). Stratis Health and Minnesota Department of Health. Web. Dec 2015. < <http://www.health.state.mn.us/e-health/ehealthdocs/roadmapprogress.pdf>

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Table 1: Focus Group Participation

Group	Invited to Participate	Participants	Percent Participation
Steering Team	4	2	50%
Behavioral Health Workgroup	19	5	26%
Local Public Health Workgroup	10	6	60%
LTPAC Workgroup	11	3	27%
Social Services Workgroup	11	3	27%

In addition to facilitating focus groups, Rainbow staff worked with SHADAC staff to conduct a key informant interview with two members of the Project Oversight Team to discuss the background of Stratis' involvement in the SIM e-Health Roadmap project and the community engagement model in use.

Findings

Focus group findings are organized thematically with activities and stakeholder feedback included in each subheading. This section includes participant descriptions and feedback on three tiers of project functioning: the structure of the e-Health Roadmap community engagement model, the work of creating and prioritizing use cases, and Workgroup processes. This section concludes with supports and barriers across these tiers of functioning, and early outcomes and impacts of the work.

Community Engagement Model Structure

Project Oversight Team members noted that Stratis Health's decision to engage in the e-Health Roadmap work stemmed from their relationships with providers in each of the four priority settings and from community support for Stratis Health to pursue the SIM e-Health Roadmap proposal. Project Oversight Team members noted that Stratis Health's greatest achievement in their e-Health Roadmap work had been engaging stakeholders continuously, beginning with project design. Project Oversight Team members noted that initially their community engagement model focused on engaging key stakeholders. However, MDH promoted broadening the community engagement model to include additional opportunities for community participation, i.e., community of interest participants.

Some focus group participants noted that the e-Health Roadmap Project work was structured similarly to other SIM projects, with a governing group and workgroups.

“...All of their SIM projects are structured in this fashion where they have a kind of steering team at the top and the governing body over the top of that and then work groups below that. I see that, a couple different work groups, they're all kind of structured like that.”

Project Oversight Team members also noted that Stratis Health had a long history of engaging community through participation in working groups and steering committees. One Project Oversight Team member noted that this method of community engagement contributes to the sustainability of efforts. Project Oversight Team members suggested that due to the time-limited nature of funding and Stratis Health's role in most health projects, it is necessary for the community to take ownership of the

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work; this requires community learning and buy-in so that the work may continue when Stratis Health's role comes to an end. Project Oversight Team members noted that once the e-Health Roadmap is created, it will be up to organizations to maintain the momentum and pursue funding for continuing the work.

Steering Team participants commented on different roles of the Steering Team and the Workgroups as relating to their positions in the field. Whereas the Steering Team is an interdisciplinary group with participants from the Department of Health, national consultants, large health care providers operating in primary and acute care settings, and the Workgroups are primarily comprised of individuals working in each of the priority settings throughout Minnesota.

"I think [Workgroup members are] the ones that are living this day in and day out in each of this setting. I think it's critical to get their... input into this process. I think we've got some folks on the steering committee that are maybe looking at it from all that bigger picture standpoint.... You got grassroots people that are really down at that level and then you got folks that are higher level and trying to bring all that information together that have a viable plan to go forward."

Community of Interest and Subject Matter Experts

When discussing the structure of engagement in the e-Health Roadmap work, Workgroup participants most often discussed the roles of the Workgroups and the Steering Committee. When asked about the other opportunities for engagement, some Workgroup members noted that they weren't very informed about the roles of Reviewers/ Subject Matter Experts or the Community of Interest members.

"I guess as a worker member, I'm not totally sure what subject matter experts or the community of interest did or how their feedback was collected. I do think I was also a member of the community of interest because I did get emails periodically about what the status of the project was, but I don't believe there was an opportunity to provide feedback. I'm not sure what the subject matter experts were doing."

"I just haven't heard. I know there are list serves and things get sent to [Community of Interest members] but I don't know how actively engaged they are. I mean, I'm on the Workgroup and I'm on the Steering Team but I don't hear about them."

As noted by Project Oversight Team members, Community of Interest members are primarily recipients of information. One Steering Team member noted that it may be helpful to create a new avenue for engagement that is more active than the Community of Interest, but not as time intensive as serving on a Workgroup. The member suggested holding a community meeting or "hearing" as an opportunity for Community of Interest members and other interested stakeholders to give input and feedback about the e-Health Roadmap Project.

The role of Subject Matter Experts/Reviewers is a more active than that of Community of Interest members. Steering Team and Project Oversight Team members discussed participation and input from the Subject Matter Experts as necessary to ensure that the e-health work framed during the process was logistically possible.

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“I think we are getting input from a number of different experts in areas like privacy and some of these issues that have to be factored in as well. Their contribution is absolutely essential.”

Reasons for Participation in the e-Health Roadmap Project

Many Workgroup members noted that they chose to participate in the e-Health Roadmap work because they were passionate about e-Health, and wanted to have a voice in creating a plan for Health Information Exchange (HIE) that would facilitate quality patient-centered care for clients, and also serve to support providers in their priority setting.

“I think we all agree that e-health is an important piece to the healthcare delivery and the quality of life of our clients and people getting better, and that’s kind of what we’re all about.”

“I have also seen the vision and went out and got myself educated early to try to help guide and give us some direction on how to make all this happen.... It’s been quite a process to get as far as we have, and I’ve heard a lot of concerns from our providers as to how this is going to be shaped.”

Workgroup members learned about the e-Health Roadmap project through listservs and participation in other state, local, and organizational e-Health activities or roles. Some members were encouraged to apply to participate by contacts at MDH or Stratis Health, or by their employers. Many of the members were deeply connected in their fields, and participated in multiple e-health initiatives and projects.

Missing Stakeholders

Participants were asked about which stakeholders were not well represented in this engagement process.

Consumers/Clients

Many Workgroup members noted that clients, their family members and unpaid caregivers were absent from the Workgroup process, or they weren’t sure how they were engaged in the e-Health Roadmap work.

“One of the things that we talk about in our office a lot [are] principles of authentic community engagement, and I feel like we reached a professional in different places, but I still don’t know if we ever reached customers... that is, if a patient is really the customer, have we engaged them? I’m not sure if any of those layers included a patient or customer focus. It’s not clear to me if it did.”

For several Workgroups, discussion about client engagement led to questions about the logistics of effectively engaging consumers. Workgroup members noted several challenges to engaging clients in their work, including the challenges of meaningfully including non-experts in a highly technical process with specialized terminology.

“I get the importance of [including consumers]. That would have been really tricky to try and to explain... because there’s still not that clear vision. We’re still not clear where we’re going. I

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don't know if... somebody who wasn't, at least electronically, inter-exchange slightly savvy, would have been able to follow the discussions at all."

Some participants noted that even trained client advocates, like the National Alliance on Mental Health (NAMI), were absent from this work.

Steering Team members and Project Oversight Team members note that there is representation from consumer advocates on the Steering Team, but that engagement is difficult. One Project Oversight Team member noted that it was challenging to engage consumers without the product of a Roadmap in hand, and that consumers would be more involved during the education phase of the project. A Steering Team member noted that despite some challenges to consumer engagement, this model is more consumer-oriented than other similar processes in which they had participated.

"There certainly are consumer representatives.... I have seen that there is a lot more consumer-focused and –facing discussion and outputs than many times when these multidisciplinary team to meet."

Northern Minnesota

Some Workgroup members, as well as Project Oversight Team members, noted the lack of Workgroup participation from individuals working outside of the Twin Cities, especially from Northern Minnesota. While several rural participants noted that the option to call into meetings enabled their participation in the Workgroups, some members suggested that participation from Northern Minnesota might be greater if meetings were occasionally held in a more central location.

Payers

Project Oversight Team members and Steering Team members noted they would like to see more participation from major insurers. Participants noted that Stratis Health reached out to several groups, but they were not able to commit to participating in this process.

"I haven't heard a lot from... the payer communities or the insurance companies, and what their input would be in this as they redesign how they're incentivizing providers to care for patients."

Providers

Project Oversight Team members noted that they would like to see more representation from major health care providers in the e-Health Roadmap work. Some commented that they had reached out to some health care provider organizations, but that these organizations were not ready to commit to participating. Although some statewide care organizations are not participating in the process, Project Oversight Team members noted that they did have representation from other acute and primary care organizations on the Steering Team.

Vendors

One Steering Team member commented that the EHR vendors were not involved in the process. The member suggested that technology developers were often helpful in shaping the technical inputs in commercial situations.

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Priority Use Cases

The primary charge of the Workgroups has been the development and selection of stories to form a basis for the priority use cases that will be used to create one unified e-Health Roadmap across the priority settings. Workgroups identified 70 stories illustrating situations that emerged in each care setting. The Project Oversight Team reviewed and synthesized the stories, resulting in 56 cases. Each workgroup participated in an iterative prioritization process, which included identifying the stories applicable to their setting, adding detail, identifying gaps, and ranking the stories according to criteria generated by their workgroup. This process resulted in 11 stories, and the Project Oversight Team selected eight of these to develop into use cases and undergo a full gaps analysis to inform the development of the e-Health Roadmap.⁵⁸

Project Oversight Team members and Steering Team members noted that Workgroup members became very engaged in the process of prioritizing stories, to the extent that members were lobbying across groups to advocate for certain use cases. Many Workgroup members discussed the benefits of using stories to more easily engage in discussions about the complexities of HIE and patient-centered care.

“I thought the use cases really helped make something that seemed scary and abstract and challenging, really concrete, so I think use cases are a great way to focus. We struggled through them a little bit, but I think in that struggle it became really clear the variation in the system.... It really easily and quickly brings to the fore some of those differences to be attuned to, and also makes something very concrete, which is helpful.”

“I think the use cases were really the key to opening up a way to think about this that I can rationalize....”

Many participants noted that one challenge to participating in the use case process was the lack of clarity about the final product. Workgroup and Steering Team members, as well as Project Oversight Team members, noted that the structure of the work and the end product were not clearly defined at the beginning of the project. Uncertainty, especially about the final Roadmap, introduced challenges to the story creation and prioritization process, and introduced doubts about the usefulness of the end product.

“It seem like we created the structure after the use cases were developed. We talked about what were going to be important elements in any use case, but maybe it would have been better to have more of those discussions up front with the Workgroups before they developed the use cases.”

“Not understanding the final goal and vision while you’re writing the stories at the beginning stifled our stories. ‘Keep it short. Keep it short. We don’t want them too long,’ so we didn’t put what I now think is very pertinent information into them.”

⁵⁸ Source: *Progress Report and Proposed Next Steps. Minnesota e-Health Roadmap for Behavioral Health, Local Public Health, Long-Term and Post-Acute Care, and Social Services* (July 2015). Stratis Health and Minnesota Department of Health. Web. Dec 2015. < <http://www.health.state.mn.us/e-health/ehealthdocs/roadmapprogress.pdf>

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“[We] were charged with the development of a roadmap, and what really is that? I think as we were working, we continued to struggle with, ‘Okay, we don’t [want] this to be a tool to help somebody implement. This is not about that. Then, if we’re designing the roadmap, what is it really then?’ Then when it’s all done, I’m still... trying to really understand the utility of it and the usefulness of it.... Yeah, it’s just still kind of a little bit foggy to me.”

Some Workgroup participants brought up specific challenges related to creating a Roadmap that would address all of the issues specific to their individual priority settings. For example, some participants working in Local Public Health noted challenges related to e-health capturing the dual nature of their work in dealing with both individual- and community-level health issues.

“Our public health is involved on so much more of a larger scale, really, than day-to-day... ‘let’s take care of this pregnant youth, let’s do a home visit for prenatal [care].’ We’re in disaster planning. We’re in flu shot clinics. We are doing programs related to the state-wide health improvement program in trying to reduce obesity. But some of those things that could have implications for information sharing get a little bit lost when we’re starting to just go down to a personal health record.”

Other participants in the Behavioral Health workgroup noted extensive concerns around data privacy for their clients related to the stigmatization of mental health issues.

Creating the e-Health Roadmap

Despite some reservations and concerns about the process, Workgroup members noted the importance of the stories as a tool to adequately convey the gaps and challenges of sharing information across complex systems of care to the groups responsible for implementation.

“I think we are attempting to demonstrate to the folks who are working on health information exchange the complexity of the issue when you begin to have to exchange information amongst multiple different parties to achieve the goal of community care coordination....”

However, as one Steering Team member noted, this work is in the beginning stages of the design process. Looking ahead, many noted that detailed planning and implementation of the Roadmap will still present challenges. Several Workgroup members raised questions about how the roadmap will be used, and concerns about implementation and the sustainability of the project.

“I think the one risk to the use case approach is that we can make some things that are very complicated [seem] really simple in the end.... I think it’s really effective way to engage people around shared goals and to get them to future visioning... Once you got people engaged and they’re connected together on this role, now you need to really dive in and figure out what are the work plans that makes it happen. I’m tentatively optimistic, but also cautious that we don’t underestimate and under-resource the detailed work planning.”

“This is an inherent problem across SIM that we’re dealing with and the reality is, when the money’s gone, there’s a serious concern that we have not established a sustained transition plan.”

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“I think time will tell to see where any of this goes.... And how much of it gets, one, carried forward, two, talked about or even thought about, and if we do get any traction or if this is all just smoke and mirrors at the end of the day.”

Supports & Facilitators

Participants were asked about the tactical supports and facilitators that supported their participation in the e-Health Roadmap work.

Role of Stratis Health

Workgroup and Steering Team members discussed their appreciation for the important role of Stratis Health in facilitating and managing the e-Health Roadmap work. Some commented specifically on Stratis Health’s role in organizing the work across groups, and their work gathering and disseminating materials for the meetings.

“I really appreciate the work that Stratis Health has done to bring us together to do this work.”

“...In terms of the support that Stratis Health provides, I think is excellent. They do all of the work and put it together... it’s massive.”

Project Oversight Team members noted that their role in Steering Team and Workgroup communication and coordination was intensive, and more time consuming than anticipated. While this supported the groups’ work, Project Oversight Team members noted that it detracted from other aspects of the project, such as developing the Roadmap.

Phone Participation

Several participants calling in from rural Minnesota noted the benefits of being able to participate in the Workgroups by phone. While some participants experienced phone participation in meetings as a challenge (discussed further below), some participants commented that the option to call in removed distance as a barrier to participation.

“I wouldn’t have been able to participate had we not had the flexibility to call in, and it’s the first time I’ve ever been a part of group where I haven’t been able to place a name with a face, so that has been interesting.”

Barriers & Challenges

Participants were also asked about barriers and challenges to engaging in the e-Health work, and what additional supports were needed to address those barriers.

Communication

Some Workgroup participants and Project Oversight Team members brought up challenges around communication in the project. For Stratis, the communication needs for the project were larger than expected, including communicating with participants at every level of the community engagement model and working to coordinate progress across the four Workgroups. Project Oversight Team members noted that the level of communication and coordination necessary to conduct the work was not adequately outlined in the Roadmap request for proposal. Workgroup participants noted that their

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communication requirements were unique, as they were asked to submit their emails for review before communicating with other members of their group.

Sharing Information

Some Workgroup and Steering Team participants noted challenges around information sharing, specifically with accessing the SharePoint site and receiving materials far enough in advance of the meetings. Many noted that the SharePoint site was overly cumbersome, and that they often couldn't login to the site.

"I have to say the exchange of the information has been clunky to me. I think we use 'the cloud' and I've been having trouble with 'the cloud' here ever since we started, so I just appreciate when they email me the materials."

Others mentioned that, although they appreciated the work that Stratis Health staff put in to creating and sharing meeting materials, they did not always have enough time to review the materials before the meeting.

"I think at times it might have been helpful if we would have sent some [materials] out a little more in advance of the meeting and with a little more of an outline of what we hope to discuss at the meeting to give people a chance to think it through."

Phone Participation

Though some participants outside of the Twin Cities mentioned that they appreciated being able to call in, many participants also noted challenges to participating in meetings with some participants in the room and others on the phone. Some Workgroup members felt that it was hard for phone participants to fully engage, as they couldn't see what was going on in the room or respond to visual cues. One Workgroup member mentioned a conflict in one meeting that arose because of a miscommunication between individuals on the phone and individuals in the room. One participant suggested that allowing people to join the meetings on video conferencing platforms might address some of the communication problems related to remote participation in the Workgroups.

"I joined a couple [meetings] virtually... you can't hear about every third word... and you have no idea who's [saying?] what."

"[Phone participation] doesn't work, especially on something where it's really complex.... We're not talking about one finite decision that we have to make.... It's a set of complex things where there's all this feedback going on."

Scheduling

Some Workgroup participants noted that scheduling was a barrier to their participation in meetings. They noted that meetings were set by Stratis, and that they did not have the opportunity to provide input into dates or times that were convenient for them. Members had many suggestions for how and when to schedule meetings to increase participation, including using a Doodle poll to select dates and times, holding meetings at the beginning or end of the workday, not holding meetings on Mondays, and scheduling fewer meetings for longer amounts of time.

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“I haven't been able to be a part as much as would I would have liked, is when I get an email telling me when the meeting is, I would say 70% of the meetings I wasn't able to make because of scheduling conflicts. Because it wasn't set up necessary far enough ahead of time or our schedules weren't really checked.”

Despite scheduling challenges, most Workgroup participants agreed that meeting on a monthly basis was necessary to maintain their momentum and do the work.

Early Outcomes

Although the e-Health Roadmap Project is far from being complete, participants were asked to discuss the outcome and impacts of the work that have emerged from the work so far.

Priority Settings at the e-Health Table

Many Workgroup participants noted the importance of the community engagement approach as providing the four priority settings the opportunity to participate in a discussion they had previously felt excluded from. Some participants noted that planning around e-health has been dominated by acute care, and that the services that their settings provide were not considered. Many noted that having the opportunity to finally educate others about their work and voice the e-health needs specific to their fields was an important accomplishment.

“I think it goes back to the earlier conversation... about being at the table. I think that's an accomplishment, just being where we are today, compared to maybe three, four years ago.”

“This is really the first opportunity these four [priority settings] have had to even tell anybody what their needs are. We were always sort of this addendum, ‘Oh, yeah, welcome to public health, behavioral health and long term care. We have to worry about them at some point, but not right now.’ That has been a little frustrating and so this was really a great opportunity for us, I think.”

Achieving Consensus Across Disciplines

Project Oversight Team, Steering Team, and Workgroup members discussed the importance of working through the process of creating and prioritizing use cases to reach consensus on the issues critical to creating one Roadmap that crosses priority areas. Some Workgroup members noted the importance of educating Stratis Health and MDH staff about the issues specific to their priority setting as a necessary step in building understanding and agreement across disciplines. As one Project Oversight Team member noted, Workgroup members worked across priority settings to advocate for the issues that were important to them, further building understanding of other disciplines.

Workgroups, Steering Team and Project Oversight Team members were able to successfully craft, revise and prioritize stories to create cases that crossed priority settings and included almost every pertinent issue. As one Project Oversight Team member noted, when looking at the final cases it is impossible to tell which priority setting created the story because they are all about integrated care. One Steering Team member noted that one of the strengths of the model was being able to reach agreement across the priority settings.

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“I think the items of work that we've accomplished with the user stories and then developing a consensus about the key issues.... I feel like this has been good work.”

“One of the things I noticed as the work groups deliberated is that they came from really different places and ended up almost all in the same place by the time they were done. I think that having that be the case means that when they then go out to their communities they're trusted as proud leaders... [in] the communities that they're in. Their ability to spread this road map and plan is going to be one of the huge benefits of this project in this way of getting information.”

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APPENDIX G

Team-Based Integrated/Coordinated Care Investments

The purpose of the Driver 3 Grant Investments is to assure that an expanded number of patients are served by team-based integrated and coordinated care. Driver 3 consists of several different grant programs:

1. Emerging Professions Integration;
2. Emerging Professions Toolkit;
3. Practice Transformation;
4. Practice Facilitation; and
5. Learning Communities.

1. EMERGING PROFESSIONS INTEGRATION GRANT PROGRAM

Purpose:

The goal of the Emerging Professions Integration Grant Program is to expand the number of patients served by team-based coordinated care by integrating emerging professions into the workforce. Grant funds are focused on three emerging professions: community health workers (CHW), community paramedics (CP), and dental therapists (DT)/advanced dental therapists (ADT). The program consists of three rounds of grant funding.

Select Requirements:

- Emerging professional must be a new hire or an existing employee moving into a new role and have the appropriate training and credentials in one of the three mentioned emerging professions;
- Eligible applicants may receive funding for only one round of the Emerging Professions Grant Program.

Total Award:

Round 1: 5 awards totaling \$150,000

Round 2: 4 awards totaling \$120,000

Round 3: 5 awards totaling \$148,061

Timeframe:

Round 1: July 2014 – June 2015

Round 2: October 2014 – September 2015

Round 3: September 2015 – August 2016

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Awardees:

Grantee	Emerging Profession	Description
ROUND 1:		
Children's Dental Services	ADT	Hired an advanced dental therapist to serve underserved children and pregnant women.
HealthEast Care System	CP	Hired a CP to do post-discharge follow-up for visits for a vulnerable mental health and chemical dependency population.
MVNA	CHW	Incorporated a CHW into MVNA's home-based palliative care and behavioral health services programs.
Well Being Development	CHW	Hired a CHW to work in a mental health clubhouse in Ely.
West Side Community Health Services	DT	Hired a DT working toward completing their ADT clinical hours to serve underserved children and pregnant women in the diverse community of St. Paul's East Side.
ROUND 2:		
Essentia Health	CP	Transitioned four CPs to fill one FTE to decrease non-emergency calls, visits to the emergency department, and hospital readmissions.
Hennepin County	CHW	Hired a CHW to work with the behavioral health population in the Hennepin County jail system to prevent a "revolving door" of reoffenders.
Northern Dental Access Center	DT	Hired a DT to provide dental care to low income and underinsured people in Northwest Minnesota.
Ringdahl Ambulances Inc.	CP	Hired a CP to reduce hospital readmissions and inappropriate emergency department visits and ambulance services in the Fergus Falls and Pelican Rapids area.
ROUND 3:		
Community Dental Care	ADT	Hiring an ADT for the Robbinsdale Clinic to provide preventive and restorative care to low income, minority, and medically underserved populations.
Hennepin County	CHW	Hiring a CHW to work in the Public Health Tuberculosis and Refugee Health Clinic with refugees. The goal is to collaborate with a public health nurse to develop a plan of care, facilitate adherence to medical appointments, link clients to needed services, help them to understand medications, and provide access to resources.
North Memorial Health Care	CP	Hiring two CPs who will each work part time to fulfill one FTE position. CPs will work with Essentia Clinics in Crow Wing County/Brainerd area serving individuals considered high risk, high utilizers, with multiple co-morbidities and members of an Integrated Health Partnership.
Northwest Indian Opportunity Industrial Center	CHW	Hiring CHW to work in clinic with American Indians from four reservations/tribes providing health and social services related to navigation, advocacy, and education.
Open Door Health Center	CHW	Hiring a bilingual CHW to work in a mobile clinic serving residents in Marshall, Gaylord, Dodge Center, and Worthington. CHW will provide education, screening, follow-up services, referrals, link clients to resources, etc.

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2. EMERGING PROFESSIONS TOOLKIT PROGRAM

Purpose:

The goal of the Emerging Professions Toolkit Program is to develop tools and resources to aid in the integration of the three emerging professions – community health worker, community paramedic, and dental therapist /advanced dental therapist – into the workforce. The toolkits are intended to inform potential employers how to hire emerging profession practitioners, how to successfully integrate them into care coordination models, and how to communicate potential benefits from hiring an emerging professional - benefits to the organization, care delivery team, and patients and clients served by the emerging profession practitioner.

Total Award:

\$297,480

Timeframe:

The contracts began in July and August 2015. The toolkits will be available on the MDH website in the fall of 2016.

Awardees:

Awardee	Emerging Profession	Description
Halleland Habicht Consulting	ADT	Will develop the Dental Therapy Toolkit. HHC will partner with the University of Minnesota School of Dentistry and Normandale Community College to develop the toolkit
The Paramedic Foundation	CP	Will develop the Community Paramedic Toolkit
WellShare International	CHW	Will develop the Community Health Worker Toolkit. Will partner with the Minnesota Community Health Worker Alliance in developing the toolkit

3. PRACTICE TRANSFORMATION GRANT PROGRAM

Purpose:

The Practice Transformation grant program supports providers and teams in primary care, social services, and behavioral health to allow team members to participate in transformation activities that help remove barriers to the integration of care. Three rounds of Practice Transformation Grants have been awarded.

Select Requirements:

- The Practice Transformation Grants were targeted to four types of entities either in Minnesota or serving Minnesotans:

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- a. Primary Care provider or practice seeking to transform their practice to a certified Health Care Home or implement integration of social services or behavioral health;
- b. Social Service providers working with primary care or behavioral health to implement integrated services;
- c. Behavioral Health providers working with primary care providers to implement integrated services such as Behavioral Health Homes; or
- d. Tribal primary care and behavioral health providers.

Total Award:

Round 1: 10 grants totaling \$194,768

Round 2: 12 grants totaling \$281,521

Round 3: 24 grants totaling \$239,793

Timeframe:

Round 1: February 2015 – July 2015

Round 2: September 2015 – June 2016

Round 3: January 2016 – June 2016

Awardees:

Applicant	Setting	Description
ROUND 1:		
Dakota Child and Family Clinic	Primary Care	Moved all small clinic operations to cloud based applications
Guild, Inc.	Behavioral Health	Prepared and implemented a Behavioral Health Home (BHH) and continue progress toward a more culturally diverse workforce by exploring the emerging role of CHWs
Murray Co.	Social Services	Redesigned workflows and clinic practices to provide quality care to an increasing number of diabetic patients. Increase efficiency of admitting patients to care coordination
Native American Community Clinic	Primary Care	Developed a work plan for integrated care visits between primary and behavioral health, implement team based care, improve documentation of patients through a registry and referrals, and improve the quality reporting measures
Sanford	Primary Care	Strengthened care coordination for patients diagnosed with diabetes and depression internally and externally. Improve depression screening and management. Support a Care Coordination Assistants so RN Health Coach can focus on the patients with the highest risk. Improve routine and preventive diabetes surveillance
South Lake Pediatrics	Primary Care	Enhanced efficiency and quality method of tracking, managing and care coordination of behavioral health. Complete the development of a software program called Vis Forms which will be utilized for care coordination workflow management and can potentially be integrated with Electronic Medical Records (EMR)

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Applicant	Setting	Description
South Metro Human Services	Behavioral Health	Met with consumers and internal and external stakeholders, redesigned the clinical systems work, and developed new data collection or management tools. This will assist in hiring care coordinators, enter into contracts with other providers, improve Health Information exchange, and expand quality improvement systems
Univ. of Minnesota Community University Health Care Center	Primary Care and Behavioral Health	Hired a consultant to further refine and integrate nurse and psychosocial care coordination roles and ensure Health Care Homes (HCH) recertification
Well Being Development	Behavioral Health	Developed an actively involved Community Care Team Behavioral Health Network to address unmet behavioral health needs of adults located in rural NE Iron Range communities. Another goal is to increase the integration of medical and behavioral health services in the region
Zumbro Valley Health Center	Behavioral Health	Developed a centralized document that incorporates all care at Zumbro. Complete Health Care Home certification. Create a patient registry for co-occurring and/or co-morbid conditions to evaluate outcomes and monitor preventive care
ROUND 2:		
First Light Health System	Behavioral Health	Implementing and growing the Care Coordination Program to reach a greater number of patients. Become a certified HCH and improve Medicare billing
Fraser	Behavioral Health	Implementing a BHH. This will be done by developing a registry framework that serves the needs of populations in their care setting; developing use cases that can promote the safe, secure sharing of health data between behavioral health and medical office settings; and creating an interoperable system between behavioral health and medical settings
Lac qui Parle Clinic	Primary Care	Becoming a certified HCH. Steps that will be taken to do so is implement a project management team, establish a quality improvement team, develop work flows for the clinic HCH population, and hire a care coordinator to develop a model for the clinic population
Lutheran Social Service of Minnesota	Behavioral Health	Utilizing a consultant to assist in surveying behavioral services offered in four disability organizations connected with LSS and improve a “disability-competent” behavioral health services to persons with disabilities
Mankato Clinic	Primary Care and Behavioral Health	Developing an integrated model of care that supports patients who are medically ill with comorbid psychiatric illnesses and those patients whose primary illness is psychiatric; achieve better health outcomes while reducing the overall cost of care through initiatives which improves access to care and internal and external care coordination
North Metro Pediatrics	Behavioral Health	Working towards becoming a BHH. Improve coordination of medical and mental health services within the clinic, patients, and with caregivers. Align EHRs for primary care and behavioral health. Improve coordination of referrals to specialty mental health providers

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Applicant	Setting	Description
Open Door Health Center	Behavioral Health	Leadership team and consultant are providing a thorough assessment of workflow in medical and behavioral health to review processes and protocol to ensure that all patients are receiving care in the most effective and efficient manner as possible
South Lake Pediatrics	Behavioral Health	Preparing for BHH requirements by adding a system to identify, record, and monitor patients that will help specifically with the management of BHH patients. A workflow process will also be created for both internal and external resources. An annual budget will also be developed specifically for BHH patients
Southdale Pediatric Associates	Primary Care	Achieving HCH certification by working on five HCH standards through the work of a project team at three locations. Employ a consultant to assist with EMR training and technical support with staff
Touchstone Mental Health	Behavioral Health	Preparing for implementation of BHH certification. Develop an effective quality improvement team and track three initial quality improvement indicators. Draft a care plan that will be developed and reviewed by consumers and family members
Univ. of MN-CUHCC	Behavioral Health	Hiring a consultant to work with the Children's Mental Health Team, do an environmental scan, and identify promising interventions to address mental health diagnosis or past histories of childhood events and trauma. Educate patients on appropriate emergency use around common childhood illnesses and improve health indicators for children and adolescents with high BMI's
Zumbro Valley Health Center	Behavioral Health	Developing EMR based tools to define populations to be served, create methods to better gauge accurate total costs of care delivery, and utilize quality improvement teams to monitor problem-prone areas of care delivery processes

ROUND 3:

These awards support each grantee's participation in the Behavioral Health Home First Implementers group and the implementation of an action plan to move them toward Behavioral Health Home certification. Each received a six month grant with a maximum award of \$10,000 per recipient.

- Amherst H. Wilder Foundation, St. Paul
- Fairview University of Minnesota Medical Center-Counseling Center, Minneapolis
- Fraser, Minneapolis
- Guild, Inc., St. Paul
- Lakeland Mental Health Center, Fergus Falls
- Mental Health Resources, Inc., St. Paul
- Mental Health Systems, PC, Edina
- Natalis Outcomes, St. Paul
- Northland Counseling Center, Inc., Grand Rapids
- Northwestern Mental Health Center, Crookston

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- Range Mental Health Center, Virginia
- Range Regional Health services, Hibbing
- Sanford Medical Center, Thief River Falls
- South Central Human Relations Center, Owatonna
- South Lake Pediatrics, Minnetonka
- South Metro Human Services, St. Paul
- Southwestern Mental Health Center, Luverne
- Stellher Human Services, Inc., Bemidji
- Touchstone Mental Health, Minneapolis
- University of Minnesota/Community University Health Care Center (CUHCC), Minneapolis
- Vail Place, Hopkins
- Western Mental Health Center, Marshall
- Woodland Centers, Willmar
- Zumbro Valley Health Center, Rochester

4. PRACTICE FACILITATION GRANT PROGRAM

Purpose:

The Practice Facilitation grantees are to use a range of organizational assessments, project management, quality improvement, and practice improvement approaches and methods to build the internal capacity of a practice to help it engage in improvement activities over time and support it in reaching incremental and transformative improvement goals.

These grants were awarded to two major entities to then work with the provider organizations.

Total Award:

\$966,601

Timeframe:

June 2015 – December 2016

Awardees:

Institute for Clinical Systems Improvement (ICSI)

Institute for Clinical Systems Improvement (ICSI) is a non-profit health care quality improvement organization located in Bloomington, Minnesota that unites clinicians, health plans, employers, community stakeholders, and consumers to bring innovation and urgency to improve health, optimize the patient experience, and make health care more affordable. The proposed practice facilitation project between ICSI and Stratis Health will help eight primary care and specialty clinics expand the number of patients who are served by team-based integrated/coordinated care in Minnesota. They will work with participating provider organizations to identify project goals and measures in relationship to

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the targeted areas of: total cost of care; Health Care Homes; integration of health care with behavioral health, social services, long term care and post-acute care services; integration of non-physician health care team members; expanded community partnerships; health IT; and chronic care management.

National Council on Behavioral Health

National Council on Behavioral Health is a non-profit located in Washington D.C. that is engaged in creating healthy and secure communities through a system that holds the needs of the consumer paramount, with a network of more than 2,200 member organizations offering behavioral healthcare services. The National Council will work closely with 15 care teams committed to being early adopters of the Minnesota Accountable Health Model. This practice facilitation initiative will guide participants through on the elements of infrastructure development, including health information exchanges and options for financial sustainability, designing efficient and effective care delivery systems, and enhancing the patient experience. Each of the participating teams will identify at least two community partners such as hospitals, social services organizations, or facilities providing long-term care and/or post-acute care services.

5. LEARNING COMMUNITIES

Purpose:

Learning Communities are learning teams who have common goals or interests, share best practice knowledge, and are actively engaged in implementing transformation in a focused, structured environment with the goal to advance patient centered, coordinated, and accountable care.

Total Award:

Round 1: \$149,930

Round 2: \$49,860

Timeframe:

Round 1: February 2015 – October 2015

Round 2: April 2015 – December 2015

Round 1 Awardees

The three first round grantees are described in more detail below based on a review of grantees' proposals, quarterly reports, and final reports. Due to the diversity across the three grantees, each will be described in turn.

Center for Victims of Torture

The goal of this learning community was to improve the coordination and integration of behavioral health services for war-traumatized refugee population in St. Cloud. The learning community targeted refugees and their families, refugee resettlement workers, public health staff, primary and dental care clinics, social service providers, and behavioral health providers.

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Minnesota Academy of Pediatrics Foundation (MAPF)

The goal of this learning community was to implement a pediatric learning collaborative that engages HCH and non-HCH pediatric providers in clinic-based services for integration of pediatric primary care with behavioral health screening/counseling/referral/follow-up, and increasing knowledge of quality improvement techniques.

Rainbow Research

Rainbow Research partnered with the Minnesota Community Health Worker Alliance and the Paramedic Foundation to convene organizations in their fields as part of a learning community focused the emerging professions of community health worker (CHW) and community paramedics (CP). The goal was to strengthen understanding of these emerging professions and to bring a knowledgeable group together to identify key issues and outline practical solutions to current challenges to the full integration of these professions into primary care, behavioral health, and Minnesota's health care delivery systems.

Round 2 Awardee

Institute for Clinical Systems Improvement

The Institute for Clinical Systems Improvement (ICSI) will primarily serve clinics outside the metro area and will focus on building foundational capabilities for HCHs and other transformation by supporting the development of team and process skills, enabling independent rural practices to achieve more sustainable change.

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