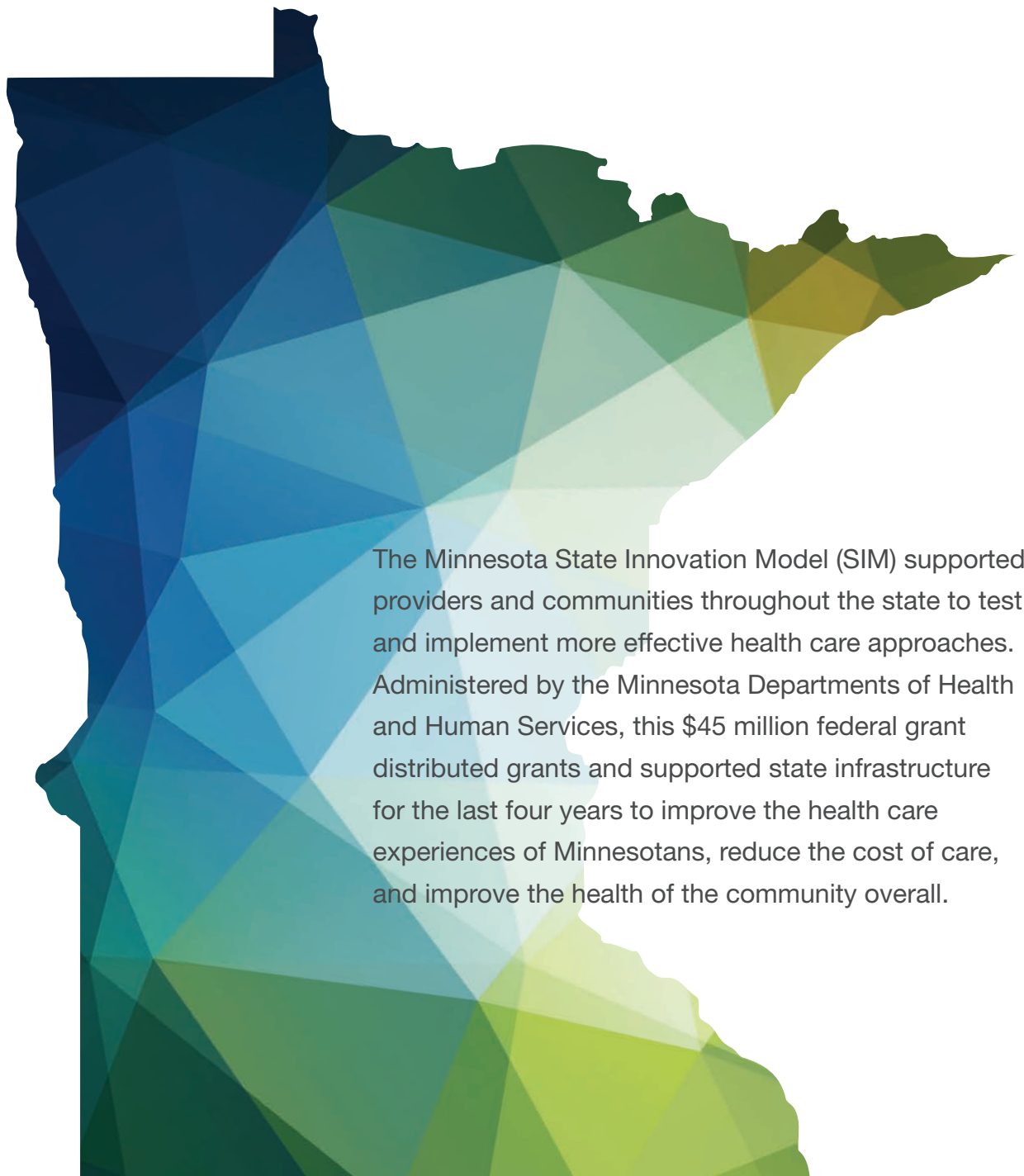**MINNESOTA**
ACCOUNTABLE HEALTH MODEL

MINNESOTA FORWARD:

Carrying on Minnesota's Accountable Health Model

Unique partnerships building more efficient, effective health care

MINNESOTA
ACCOUNTABLE HEALTH MODEL

The Minnesota State Innovation Model (SIM) supported providers and communities throughout the state to test and implement more effective health care approaches. Administered by the Minnesota Departments of Health and Human Services, this $45 million federal grant distributed grants and supported state infrastructure for the last four years to improve the health care experiences of Minnesotans, reduce the cost of care, and improve the health of the community overall.

The SIM team worked with providers, community partners, and stakeholders to implement innovative ways to use local strengths to reimagine health care and promote wellness. Providers, agencies and communities across Minnesota applied for SIM funding, and SIM grant awardees created programs to:

- Address coordination of care by pairing traditional clinic care with local community resources
- Reimagine the ways health care payments are made, focusing on quality rather than quantity of treatment
- Explore ways patient data can stay with the patient, wherever they are receiving services.

Here's what they achieved as of July 2017:

- 465,000 Minnesotans receive care through a Medicaid accountable care organization.
- 88 percent of organizations can engage in health information exchange.
- Integrated Health Partnerships surpassed the cost savings goal of $100 million, and as of 2016, have reached a cost savings of $212.8 million.
- 15 Accountable Communities for Health were established by 2015.
- 57 percent of providers are health care home or behavioral health home certified.

Following are the grant awardee stories, their accomplishments, their setbacks and their lessons for the future of health care in the state. Their experiences and research pave the path for health care innovation throughout Minnesota.

The State Innovation Model focused on five drivers for better health:

1. E-health uses the power of information to promote better health by giving providers and patients the right information at the right time, while also safeguarding privacy.

2. Integrated data approaches harness the power of data to identify health problems and solutions for individual patients, groups of patients and communities.

3. Patient-centered, coordinated care puts patients at the center of a team of health care and health care service professionals. This team helps patients meet their health goals by connecting the dots to services in and outside the clinic.

4. Community-driven solutions allow local public health, rural and urban counties, providers, health advocates, school districts, correctional facilities, and other partners to identify and implement opportunities for better health, especially for those in the community who are falling through the cracks.

5. Payment and accountability are brought together so the state of Minnesota pays for value – best outcome at the best price – rather than volume in health care.

Ninety-eight (98) fiscal agents received over 150 awards from the state. In addition, almost 400 organizations collaborated with these fiscal agents, for a total of 495 organizations participating in SIM.
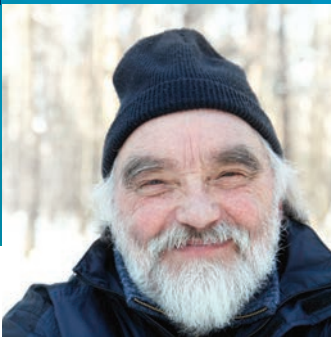
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ACCOUNTABLE COMMUNITIES FOR HEALTH GRANTS

ROUNDS 1 AND 2

The locally planned and led Accountable Communities for Health (ACH) projects focus on local conditions, identifying a target population with substantial health and social needs and bringing together community partners to address those needs. The projects mix together various elements of health innovation and reform, allowing Minnesota to uncover the best approaches for improving health outcomes and achieving health equity.

The target population can be people in a geographic area, a patient population or a segment of a community. In order to address the target population's specific needs, each ACH project features a unique mix of partner organizations that contribute to a person's health, such as local public health boards, behavioral health organizations, social services organizations, long-term care facilities, primary care facilities and schools. The ACH projects use formal business agreements with these community partners to integrate services for the target population through enhanced referrals, transitions management and implementation of new practice guidelines.

About $5.6 million, or 14 percent, of Minnesota's SIM funds was dedicated to supporting 15 Accountable Communities for Health projects. The participating ACH sites span diverse geographic regions and varied target populations. Collectively, ACH projects coordinate care among 180 clinical and social service providers for more than 100,000 people, the vast majority of whom are on Medicaid.

SIM funding breakdown:
- **12 grantees received Round 1 funding to support and implement an ACH within their community.**

- **Three previously funded community care teams (CCT) – Essentia Health-Ely Clinic, Hennepin County Medical Center and Mayo Clinic – received sole-source funding to further the development of the CCT model.**

- **Six of the 15 grantees received Round 2 funding in order to support further development of their ACH, building and strengthening its infrastructure, continuing the development of services and supports that have a positive effect on health, and promoting sustainability.**

One out of every three students participating in the Northwest Metro Healthy Student Partnership ACH health screening received a referral for follow-up through school and/or community-based resources.

Allina Health Systems

(Northwest Metro Healthy Student Partnership ACH)

Anoka-Hennepin School District
Funding: ACH Round 1

Target population
11,950 high school students in the Anoka-Hennepin School District.

Program goals
To make a lasting impact on health behaviors and health outcomes of Anoka-Hennepin School District high school students.

Program summary
The Northwest Metro Healthy Student Partnership ACH expanded student health screening and promoted healthy behaviors through in-school activities. To assess student health, surveys were distributed to high school students in the Anoka-Hennepin School District. The surveys screened students in areas of mental, physical, relationship and emotional health and the social determinants of health. From this information, the ACH was able to link students to relevant school and community-based resources. Students were provided with comprehensive follow-up, support and care coordination through linkages to health coaching, primary care, behavioral health, and community and social services resources.

Key partners include Alexandra House, Allina Health, Anoka-Hennepin School District, Banfill-Locke Center for the Arts, Chef Marshall O'Brien Group, Emma B. Howe YMCA, HealthPartners, Headway Emotional Health Services, Northwest Metro Alliance, Penny George Institute for Health and Healing, River Trail Learning Center at L.O. Joan, University of Minnesota Extension, and Youth First Community of Promise.

Lessons and outcomes
Of the 2,088 students who participated in the health screening during the 2015-2016 academic year, a total of 729 referrals were made through the health survey. This represents an average of one referral for every three students that participated. Additionally, information gleaned is being used to structure proactive health programming per school. For example, since 1 in 3 students at Anoka High School indicated they want more information about healthy eating, the Healthy Student Partnership health coach provided a presentation to the class on healthy eating strategies, in addition to meeting with students in small groups.

Contact
For more information, email Craig Malm at craig.malm@allina.com.

HIGH SCHOOL **STUDENTS**

Resources
"Healthy Student Partnerships: Exploring the Intersection of Health Care and Education"
Karen Manikowski, MPH, CHES, project manager, Healthy Student Partnership
Minnesota Learning Days 2017 (April 5, 2017)
www.hchsimlearningdays.org/handouts/Healthy%20Student%20Partnerships%20Exploring%20the%20Intersection%20of%20Healthcare%20&%20Education_KarenManikowski_Final.pdf

This PDF presentation shows how health care systems, such as Allina Health, can successfully partner with school districts and community-based organizations to enrich health services available to students and families. It provides a summary of the Healthy Student Partnership, including project planning, implementation, successes, challenges and opportunities for replication in your community.

CentraCare Health

(CentraCare Health Foundation ACH)

Stearns County
Funding: ACH Round 1

Target population
Somali, East African and Latino patients identified as having uncontrolled diabetes or a risk of developing diabetes. In 2016, the focus expanded to include at-risk patients in other minority communities.

Program goals
To reduce the incidence of unmanaged diabetes in the Latino, Somali and East African patient populations.

Program summary
To inform this grant project, CentraCare Health Foundation surveyed patients about different aspects of health care access, conducted two focus groups with both Somali and Latino patients about their health care needs, and provided home visits to members of the target population. The CentraCare Health Foundation then hired a Latino community health worker and two Somali and East African community health workers to visit patients in their homes and help them navigate the health-care system.

DIABETES
PATIENTS

In order to identify patients who would benefit from community care coordination, the team assessed data in the clinic diabetes registry from providers and public health agencies. Once a patient was identified, the community health workers coordinated care among the primary care provider, diabetes educator, pharmacist, home health care coordinator and other community resources. Using a home-visit model, the community health workers met patients where they live. In some cases, the workers even accompanied patients to the pharmacy, lab or imaging for further educational instruction. The team also used the electronic medical record (Epic) to stratify patients and document patient visits. This allows all members of the team to provide consistent and coordinated care.

Lessons and outcomes
The CentraCare team increased awareness of diabetes education, nutrition and exercise issues among the target population and provided team-based care to more than 600 people.

One of the greatest accomplishments of this program was a partnership with Second Harvest Food Shelf to provide healthy food to diabetic patients to help them control their blood sugar. When patients expressed food insecurity, they were given boxes of healthy food and enrolled in a healthy food access program.

Contact For more information, call Dawn Moen at 320-251-2700, extension 77529.

Resources
"Longitudinal Plan of Care: Patient and Provider Views"
Jane Kluge, RN, BSN, ambulatory care management coordinator, CentraCare Health
Minnesota Learning Days 2017
www.hchsimlearningdays.org/handouts/
Longitudinal%20Plan%20of%20Care%20
Patient%20Provider%20Views%20ADA%20
Compliant.pdf

This PDF presentation explores each area of the patient care plan in the electronic health record Epic, comparing the differences and similarities of a patient's longitudinal plan of care from the patient and provider views and looking at how the plan benefits patient care across the health system. It also details who can document or modify care plans.

Essentia Health-Ely Clinic

(Ely Community Care Team)

Greater Ely Area
Funding: Community care team sole source and ACH Round 2

Target population

People in Babbitt, Ely, Embarrass, Soudan, Tower, Winton and surrounding townships, with a special emphasis on individuals and families in poverty or experiencing mental illness.

Program goals

To maximize capacity to meet wellness needs through collaboration between health care, education, nonprofits and other community resources; improve health and wellness outcomes for individuals and families through coordination of services; and increase community wide health promotion through resources, education and outreach.

Program summary

Guided by a community care team, the project focused on identifying and addressing gaps in care across the rural community, successfully connecting professional community partners to community members and providing services to underserved populations. The team used a care facilitation model to improve health (including behavioral health). This model ensures the needs of community members are identified and addressed in a timely, comprehensive manner that includes referral, collaborative care and follow-up.

A community care team is a strong inter-organizational and interdisciplinary network that gives equal voice to community members, health care and behavioral health entities, and other services such as housing and education. Throughout the grant period, the community care team used evaluation and feedback at all levels to guide its development.

Lessons and outcomes

As a result of the community care team care facilitation model, interactions among inter-organizational and multidisciplinary members of the care network increased and the number of emergency room visits and inpatient visits decreased.

The community care team contributed to the overall body of evidence on the value of inter-agency collaboratives and networks and the successful strategies to address the social determinants of health with an article in the Journal of Health Care for the Poor and Underserved (see the article on innovations in frontier communities in the resource section).

The team plans to expand the community care team model throughout Essentia Health's East Market primary care sites and continue to support community care team grant-funded positions. The Ely community care team also supported the development of other community health networks in the Upper Midwest. The team will sustain its work through a Hub and Spoke Model.

Contact

For more information, contact Essentia Health-Ely Clinic Care Team Leader Heidi Favet, CHW, at heidi.favet@essentiahealth.org or 218-365-7980.

Resources

"Pathway's Community HUB Manual: A Guide to Identify and Address Risk Factors, Reduce Costs, and Improve Outcomes"
Agency for Health Care Research and Quality
https://innovations.ahrq.gov/sites/default/files/Guides/CommunityHubManual.pdf

The Pathways Community HUB Manual helps service providers and community organizations create a HUB to coordinate the delivery of health care and social services. The content was developed by the Pathways Community HUB Certification Program and the Community Care Coordination Learning Network.

"Connecting Those at Risk to Care: The Quick Start Guide to Developing Community Care Coordination Pathways"
Agency for Health Care Research and Quality
https://innovations.ahrq.gov/sites/default/files/Guides/CommHub_QuickStart.pdf

This guide helps community care coordination initiatives identify at-risk individuals, clarify their risk factors and ensure those risk factors are addressed using pathways and a pay-for-performance methodology. The content was developed by the Pathways Community HUB Certification Program and the Community Care Coordination Learning Network.

"Innovation in frontier communities to improve patient outcomes and reduce health care costs: Networks and care coordination"
Conway, P., Favet, H., Uhrich, J., Hall, I., Palcher, J., Olimb, S., Tesch, N., York-Jesme, M. E., Bianco, J., and the Ely community care team. (2016) Journal of Health Care for the Poor and Under served, 27(4S)
https://doi.org/10.1353/hpu.2016.0181
(Note: Readers may need to pay or have a subscription to this publication in order to access the article.)

Members of the Essentia Institute of Rural Health, Essentia Health-Ely Clinic, and the Northern Lights Clubhouse partnered to write this article to describe the results of implementing a Community Care Team that uses collaboration and care coordination to improve patient outcomes and reduce emergency room use in Ely, Minnesota.

Generations Health Care Initiatives

(Together for Health at Myers-Wilkins ACH)

Hillside Neighborhood in Duluth, Minnesota
Funding: -ACH Rounds 1 and 2

Target population
445 students and 1,300 family members from the Myers-Wilkins Elementary School in Duluth's Hillside Neighborhood, an under-resourced community with a large number of low-income working families, people of color, people who are homeless, people who were formerly incarcerated and people who are unemployed.

Program goals
To improve the health and wellness of students, family and neighbors of the Myers-Wilkins Elementary School through a community care coordination model and targeted community health initiatives.

Program summary
Together for Health at Myers-Wilkins ACH developed a Community Health Team to guide its work in developing population-based prevention strategies. It also developed a Care Coordination Team in order to effectively coordinate the delivery of health and social services offered in the school and community. Additionally, parents and community members served as community consultants on the ACH Leadership Team.

One of the major features of this project was the addition of two new positions, a family health coordinator and a community health worker. These staff members directly connect with the population and serve as liaisons to community services.

The second round of funding allowed the ACH to expand care coordination services and population-based prevention strategies. Through this process, the ACH strengthened relationships with organizations that promote greater economic security and educational opportunities for those experiencing inequities.

Lessons and outcomes
In 2016, Together for Health at Myers-Wilkins ACH held 21 community health events and reached more than 1,300 people (some duplicated). The ACH helped 225 people through direct service from the family health coordinator or community health worker.

Overall, the ACH provided an opportunity for cross-sector collaboration and community engagement focused on improving the health and wellness of a specific under-resourced neighborhood in Duluth, Minnesota. An important outcome of this work has been building momentum to scale up the Myers-Wilkins Community School Collaborative to the Duluth Community School Collaborative, incorporating Lincoln Park Middle School (in its first year as a community school) and Denfeld High School (launching fall 2017). The partnerships created through the Together for Health at Myers-Wilkins ACH will be the basis for the health-related partnerships for the Duluth Community Schools initiative.

Contact
For more information, contact Generations Health Care Initiatives Program Director Mary Rapps at mary.rapps@ghci.us or 218-336-5706.

Hennepin County

(Hennepin County Correctional Clients ACH)

Hennepin County
Funding: ACH Round 1

Target population
The corrections population at the Hennepin County Adult Corrections Facility and Hennepin County Jail who needs stable housing and wants to work upon release.

Program goals
To improve enrollment in health care programs, improve health outcomes, reduce homelessness, increase employment and reduce recidivism among clients at the Hennepin County Jail and Adult Corrections Facility.

Program summary
People in the corrections population experience or are at high risk for homelessness, unemployment, behavioral health issues and recidivism. A high number of formerly incarcerated people are disconnected from primary care and community health resources and use costly crisis care instead. To address these issues, the Hennepin County Correctional Clients ACH worked to link health care coordination, behavioral health supports, employment services, housing and life-skills building for people released from the Hennepin County Adult Corrections Facility and the Hennepin County Jail.

While at the correctional facility, people learned about the coordinated approach and available services. If interested, they were referred to a vocational counselor for an intake meeting. The vocational counselor helped them set goals and seek training. A community health worker helped provide disease and health education and set up medical appointments as needed upon release. The team assisted with re-enrollment in medical benefits. If housing was needed, care team members coordinated with two shelter programs to ensure immediate placement upon release. The work of the care team depended on ongoing communication from the initial meeting with the individual through the individual's release, integration back into the community and job placement.

Lessons and outcomes
The Hennepin County Correctional Clients ACH faced many challenges to program implementation and information gathering, complicated by barriers such as access to working phones and stable housing among members of the target population. Despite these challenges, the program saw some positive results: 59 individuals worked with an employment specialist, at least 14 individuals secured stable housing upon release and continued to work with an employment specialist, and at least 3 individuals obtained employment.

Contact
For more information, email Renee Levesque at Renee.Levesque@hennepin.us.

COMMUNITY
OUTREACH

Hennepin County Medical Center

(Brooklyn Park ACH)

Hennepin County
Funding: Community care team sole source and ACH Round 1

Target population

1,500 people at Hennepin County Medical Center's Brooklyn Park Clinic enrolled in the Integrated Health Partnership with a diagnosis of depression.

Program goals

To improve the clinic-community care coordination delivery model for people with depression who live, work, go to school or receive health care in Brooklyn Park.

Program summary

The ACH aligned workflows for depression screening and treatment across clinic and social service providers.

While any service provider can identify and refer a patient to care coordination, the primary focus of this project was to identify and coordinate care for extreme and high-risk patients. Upon arrival, patients are now asked to complete the Patient Health Questionnaire (PHQ)-2 depression screening test. If the PHQ-2 result indicates that a patient may be experiencing depression, the patient then completes the PHQ-9 and is evaluated by the provider for depression. Next, the care team works with the patient and family to address any social service needs.

The ACH also developed an online system-of-care partnership tool. This tool helps facilitate referrals, ensuring that individuals and families obtain clinical, school and social service support when needed. This system allows a provider to view available resources, connect with the resources to determine if the referral was fulfilled and follow-up with patients.

Lessons and outcomes

In 2016, the clinic screened 9,736 people with the PHQ-2 depression tool. Of those, 561 had a positive screening result, completed the PHQ-9 and were connected to appropriate mental health services.

Contact

For more information, email Kristen Godfrey Walters at Kristen.GodfreyWalters@hcmed.org.

Lutheran Social Service of Minnesota

(ACH for People with Disabilities)

Anoka, Dakota, Hennepin, Ramsey and Washington counties
Funding: ACH Rounds 1 and 2

Target population

6,600 people served by members of the Altair Accountable Care Organization who live with a diagnosis of an intellectual disability, a mental health need, a physical disability or a combination of these conditions.

Program goals

To provide the best services possible to people with disabilities while improving health and creating ways to lower the total cost of care.

Program summary

The ACH for People with Disabilities brought together six nonprofit disability service providers and clinicians with Bluestone Physician Services in order to advance the integration of health and social services for people with disabilities. The ACH implemented a LifePlan model of care coordination, which allows members of the care team to work with each client to create a unique LifePlan that

reflects the client's individual circumstances. The LifePlan goes beyond acute and chronic care by taking into account a person's needs in housing, employment, physical health, social well-being and behavioral health. For example, a client's LifePlan might identify physical fitness as a priority and set an exercise plan with the supports necessary to make it happen. A dashboard tool prioritizes LifePlan goals and tracks outcomes over time.

With the second round of funding, the ACH encouraged accountable care organization partners to collect, analyze and report utilization and quality data for members of the target population. The ACH then used available data and screening tools to identify and address social determinants of health among target patients.

Lessons and outcomes

Through the grant period, 12 LifePlan leads and 40 facilitators were trained to work with people with intellectual and developmental disabilities and to facilitate the LifePlan processes. As of December 2016, more than 300 Altair patients had completed LifePlans. Additionally, the LifePlan model of care coordination has received national interest as a replicable and scalable model across the United States from organizations such as Lutheran Social Service of Illinois and the Rehabilitation and Community Provider Association in Pennsylvania as well as attendees at an Open Minds meeting on SIM Projects.

Contact

For more information, contact Altair Accountable Care Organization Executive Director George Klauser at George.klauser@lssmn.org or 651-969-2288.

PREVENTIVE
SCREENING

As of December 2016, more than 300 Altair patients had completed a custom LifePlan, unique to their specific needs.

Mayo Clinic

(Mayo Clinic, Olmsted Medical Center, Olmsted County Public Health Community Care Team)

Olmsted County
Funding: Community care team sole source and ACH Round 2

Target population

Approximately 545 community-dwelling, primary care patients at the Mayo Clinic or Olmsted Medical Center health care home who have multiple chronic health conditions, are 40 or older and are enrolled in nurse care coordination. This population was later expanded to include any adult primary care patient with multiple chronic conditions and unmet health-related social needs (e.g., financial stress or social isolation), difficulty engaging with their plan of care, or other issues that complicate their care or health.

Program goals
To provide more efficient and effective community-wide care coordination to community-dwelling adults with multiple chronic health conditions and health-related social needs.

Program summary

The community care team and Accountable Community for Health is a collaborative of the Mayo Clinic and Olmsted Medical Center health care homes, Olmsted County Public Health, the Intercultural Mutual Assistance Association, and the Elder Network. Working as a collaborative team, these organizations linked chronically ill adults, their support persons and nurse care coordinators with community services.

The team used a wraparound process to support patient self-management of chronic health conditions. This process included a 12-week intervention program that featured two group sessions and weekly individual sessions. These sessions helped patients connect with and use community services to help meet their priority needs. The care team met with the patient to jointly review patient and family strengths, identify needs, and develop an action plan with shared responsibilities for the patient and team members. This process helped increase social support from the family and community resources.

Lessons and outcomes

As a result of the intervention program, Mayo Clinic saw positive improvements in patients' physical and mental health, resilience, well-being, and assessment of the care they received. On average, clients were referred to four health or community services through their participation in the community care team and Accountable Community for Health.

This work highlighted the need to educate providers about the program and to facilitate referrals. Based on this need, Mayo Clinic developed a community care team implementation toolkit, a community care team training manual and website, a promotional video and a community-facing website.

Contact

For more information, call Olmsted County Public Health Preventive Health Nurse Manager Tanya Harder, MSN, PHN, CCM, at 507-328-7500.

Resources

Community care team training module website Mayo Clinic, Olmsted County Public Health and Olmsted Medical Center
http://cctreference.wixsite.com/cctmn

This website contains information about community care teams, training modules for those interested in forming a community care team and many other helpful resources. The team plans to provide the community care team training manual and a supplemental video about community care teams on this site in the near future. You can also view the video at www.youtube.com/embed/zxTz0-psOTI?rel=0.

New Ulm Medical Center

(New Ulm Care Coordination ACH)

Greater New Ulm Area
Funding: ACH Round 1

Target population

Medicaid patients, including people who are low-income, over the age of 65 and people with disabilities.

Program goals

To reduce emergency room use and inpatient admissions and improve health outcomes for Medicaid patients by increasing home care and rehabilitation referrals, breast and colon cancer screenings and care coordination for those with chronic conditions.

Program summary

The New Ulm Care Coordination ACH worked collaboratively to identify and treat high-risk or high-need Medicaid patients. The ACH used a wide range of strategies such as patient registries, physician or staff referrals, and tracking emergency room visits to identify patients who could benefit from coordinated care. To prevent readmissions, the ACH proactively contacted and worked with patients determined to be high risk after the patients were discharged from care. The ACH also identified four low-income neighborhoods in the New Ulm area that had a high prevalence of chronic illness and emphasized community engagement for these neighborhoods. This allowed ACH staff to build relationships within the community and gain a greater understanding of the barriers individuals face in improving health.

Lessons and outcomes

Patients with asthma, chronic obstructive pulmonary disease, depression and diabetes had observable health improvements. Additionally, breast and colon cancer screening rates improved and emergency room visits and hospitalizations decreased.

At the end of the grant period, Medicaid patients showed either no disparities when compared to the general population or reduced disparities in all of the measures that the ACH committed to improving. All measures but one also saw improvements in Medicaid patients.

Contact

For more information, contact Operations Director Carisa Buegler at carisa.buegler@allina.com or 507-217-5210.

North Country Community Health Services

(North Country ACH)

Clearwater, Hubbard, Beltrami and Lake of the Woods counties and the White Earth Tribe
Funding: ACH Round 1

Target population

At-risk youth or youth in crisis who are struggling with mental health issues.

Program goals

To improve the region's capacity to support at-risk youth and youth in crisis who are struggling with mental health issues.

Program summary

The North Country ACH used the Rice County Public Health Model for Mental Health to work toward its goals. This model addresses four key areas of mental health care: prevention, promotion of mental health and well-being, crises intervention, and care and advocacy. In order to impact students in multiple ways and at multiple levels, the ACH used a three-tiered approach, collaborating with schools to work with students schoolwide, in small groups and on an individual level. In addition to serving students directly, the ACH worked to make regional changes to the mental health system through promoting communication, strategic planning and sharing best practices among organizations.

Lessons and outcomes

The ACH took steps to improve the region's capacity to support mental health services. For instance, the ACH developed a plan to communicate with partners to keep the region informed of its activities. It also trained youth and school personnel in social emotional learning in three counties and provided education to community groups such as law enforcement, social services and other organizations working with youth.

Contact

For more information, contact North Country Community Health Services Administrator Bonnie Engen at bonnie.engen@co.clearwater.mn.us or 218-694-6581.

County Public Health

(Greater Fergus Falls ACH)

Otter Tail County
Funding: ACH Rounds 1 and 2

Target population

Low-income residents in the area, particularly the uninsured and Minnesota Health Care Programs enrollees. Target subset: those served by the Fergus Falls Salvation Army and A Place to Belong.

Program goals
To address the needs of Minnesota Health Care Programs enrollees through care coordination, particularly clients who access services at the community Salvation Army and A Place to Belong. To create a "rural health model that works."

Program summary

Elderly and low-income populations often experience gaps in care. In 2015, the Greater Fergus Falls ACH partners participated in the development of a community care team that spans the continuum of care, including acute care, behavioral health, long-term care, transitional care and a community paramedic program.

The ACH then developed a workflow, eligibility criteria and a referral process for Community Care Team participants to allow for a more efficient and patient-centric experience. All individuals that go through the Community Care Team get referred to a health care home at Lake Region Healthcare to help assess their health care and social services needs. If the medical home care coordinator identifies mental health or substance use issues to be the main driver of health care costs and use, the client is referred to the behavioral health home at Lakeland Mental Health Center. This process allows for a more efficient and patient-centric means of providing care by attempting to reduce duplication of services while providing the client with the right service when they need it. This approach ensures that multiple programs and organizations share responsibility for meeting a patient's needs.

Key partners of this ACH include A Place to Belong, Lake Region Healthcare, Lakeland Mental Health Center, LB Homes, Partnership4Health Community Health Board, Pioneer Care, Otter Tail County, Ringdahl Ambulance, Salvation Army, and the University of Minnesota.

Lessons and outcomes

This ACH conducted focus groups with Medicaid participants enrolled in care coordination to understand their care experience. The ACH leadership team plans to use the focus groups to inform their sustainability planning and to get more buy-in from their partners beyond the grant period.

Contact

For more information, email Joanna Chua at JMChua@lrhc.org.

Southern Prairie Community Care

(SPCC)

12-county area in Southwestern Minnesota
Funding: ACH Round 1

Target population

Residents at risk for developing Type 2 diabetes in the 12-county Southern Prairie Community Care area, specifically recent immigrants to the United States, those with a lower socioeconomic status, those who receive services at mental health centers and those 60 years old and older.

Program goals

Develop a 12-county initiative focused on strategies to prevent Type 2 diabetes in those at risk for the disease.

Program summary

In 2015, the Southern Prairie Community Care ACH reviewed claims data for Medicaid participants with high emergency department use. This information was used to offer these individuals the ACH diabetes risk assessment. A member of the care team called people who completed the diabetes risk assessment and offered care coordination, enrollment in a free "I Can Prevent Diabetes" class and other education on diabetes prevention.

In 2016, the ACH added a care coordination screening form to identify potential care coordination clients at diabetes risk-assessment screening sites. Staff at three mental health centers received lifestyle coach training and can now help Medicaid patients complete the diabetes risk assessment and care coordination screening form.

In 2017, Southern Prairie Community Care's integration care team outreach coordinator began making outreach calls to the people identified with pre-diabetes, hypertension or obesity. The coordinator then offered people an opportunity to connect with one of the care coordinators and enroll in a lifestyle change course.

Lessons and outcomes:

Through this grant, the ACH was able to connect face to face with more than 300 people. The ACH also contacted more than 1,500 people through direct mail and phone calls, and 104 of these people agreed to connect to a care coordinator.

Through working with members of the community, the ACH learned that the time commitment for diabetes classes was a barrier to class attendance and the needs of diverse cultures went unmet. Based on this feedback, staff decided to offer alternative education opportunities. Multiple alternative curricula were identified and implemented to support efforts to reduce the onset of Type 2 diabetes. The staff also began developing new partnerships across the region and addressing diversity through inclusive practices.

Contact

For more information, email Samantha Nelson at samantha.nelson@southernprairie.org.

SPECIAL NEEDS ASSESSMENT

UCare Minnesota

(UCare-FUHN ACH)

Twin Cities Metro
Funding: Community care team sole source

Target population

People with disabilities who are eligible for Medicaid and enrolled in Special Needs Basic Care. (Special Needs Basic Care individuals are persons with physical disabilities who also frequently have behavioral health, social support, and other medical and functional needs.)

Program goals

To link health plan and clinic care coordination and care management with outreach to other external care managers at the county or in disability services agencies as appropriate.

Program summary

At the beginning of the grant period, the ACH partners developed a new understanding of their respective care coordination models and methods and shared service and quality data. They discussed considerations for selecting the target population, and chose a target population of patients with depression or anxiety. Four Federally Qualified Health Center Urban Health Network (FUHN) clinics stepped forward to serve as the leads in a pilot project to test care coordination processes and workflow mapping in 2015. Unfortunately, changes in Minnesota state contracting in 2015 ended a contract between the state and UCare to serve Prepaid Medical Assistance Program beneficiaries in Hennepin and Ramsey counties. In response, UCare and FUHN leadership had to retool the target population, scope and partners for this project in early 2016.

Five FUHN clinics worked with UCare to design a pilot for care management support among individuals enrolled in Special Needs Basic Care. UCare provided lists of selected Special Needs Basic Care enrolled patients attributed to each clinic to a key clinic contact. A care coordinator or nurse manager from each clinic reviewed the list and selected a set of 40 or more patients based on selection criteria agreed upon by the five clinics and UCare. The team then created a panel management data spreadsheet, specific project components and activities, measures for tracking and evaluation, and other project processes. Each clinic began the pilot according to their own capacity and care coordination, outreach, and patient panel management processes, protocols and workflows.

Lessons and outcomes

At the end of the grant period, 155 of the 209 baseline Special Needs Basic Care patients, or 74 percent, were still enrolled and attributed to the five FUHN clinics participating in the pilot project. The other 54 patients, or 26 percent, were no longer in the pilot group due to aging off of the program or being transferred, termed or deceased.

Significant cross-organizational shared learnings and insights from the field emerged. The ACH project informed both plan and clinic networks on capacity, care model and areas for linking at the systems level.

Contact

For more information, email Rob Burkhardt at rburkhardt@ucare.org.

Unity Family Healthcare

(doing business as CHI St. Gabriel's Health)

Morrison County Community Based Care Coordination ACH)
Funding: ACH Round 1

Target population

Medicaid beneficiaries age 55 and older with multiple opioid prescriptions and later expanded to include patients at CHI St. Gabriel's Health who use multiple prescription opioids.

Program goals

To coordinate chemical dependency treatment, interventions and access to prescription drugs for the elderly population and further address and expand health care for people who misuse prescription narcotics and have developed an addiction.

Program summary

The Morrison County ACH formed a Controlled Substance Care Team that includes a social worker, registered nurse health navigator, pharmacist in residency and two physician champions. This team works closely with patients and providers to deliver a high level of care that promotes wellness and safety. With an emphasis on face-to-face contact, open communication and access to care team members, the team encourages and validates patients as they share their pain story and identifies needs such as mental health, housing, insurance and transportation, making and following up on referrals.

The Morrison County ACH also formed a Prescription Drug Task Force. The interdisciplinary task force is made up of hospital and clinic staff, law enforcement personnel, military officials, emergency room physicians, the county attorney, Morrison County Public Health staff, and many other professionals.

For the last two years, the ACH has educated the community and patients on the safe use of medications, built awareness about locking up narcotics to secure them, led local-level policy changes, increased the use of the Minnesota Prescription Monitoring Program, and reduced opioid prescribing by family practice physicians.

Lessons and outcomes

At the end of the second year, the ACH had served 92 percent of its target population of 500 people. Coborn's Pharmacy, the ACH's pharmacy partner, observed a 20 percent decrease in the number of narcotics prescriptions filled within ten months of the start of the program. Of the target population, 127 patients completely discontinued opioid use, resulting in a decrease of 26,376 prescribed opioid doses over a three-month period.

The Prescription Drug Task Force won the 2016 Rural Health Team Award. The annual award, which is sponsored by the Minnesota Department of Health's Office of Rural Health and Primary Care, the Minnesota Rural Health Association, and the National Rural Health Resource Center, recognizes organizations for outstanding service to rural Minnesota communities.

Contact

For more information, email Kathy Lange at KathleenLange@catholichealth.net.

Resources

TheWholeCommunity (YouTube Video)
CHI St. Gabriel's Health
www.youtube.com/watch?v=HiE8OA6hupI

This video provides background information about opioid abuse in the Morrison County area and steps that the Morrison County ACH has taken to combat the problem.

Chronic Opioid Use, Addiction and Heroin – A Care Team Approach
Marya Albrecht, Heather Bell, Kurt Devine, Kimberly Moffitt and Theresa Sweeney
St. Gabriel's Health, Family Medical Center
Minnesota Learning Days 2017
www.hchsimlearningdays.org/handouts/Chronic%20Opioid%20Use%20Addiction%20and%20Heroin%20-%20A%20Care%20Team%20Approach.pdf

This PDF presentation examines a patient-centric care model designed for those prescribed chronic pain medicine and those with addictions in a primary care setting. The presentation outlines the roles and significance of care team members and describes how community partnerships are integral to ongoing care management for patients prescribed chronic opioids.

Vail Place and North Memorial Hospital

(Total Collaborative Care ACH)

Northwestern Hennepin County
Funding: ACH Round 1

Target population

Individuals with mental illnesses, many of whom are on Medicaid and included in North Memorial's Integrated Health Partnership Program.

Program goals

To improve transitions of care, streamline referrals for high-risk populations and develop a coordinated care model for individuals experiencing co-occurring behavioral health and medical issues resulting in over-utilization of health care services and poor health outcomes.

Program summary

Vail Place, North Memorial Hospital and Broadway Family Medicine Clinic - University of Minnesota Physicians developed a coordinated care model for individuals who have serious mental illnesses, frequent hospitalizations and frequent emergency room visits. The ACH offers several team-based approaches to care to reduce the overutilization of health care services, improve health outcomes and make connections to community-based services and programs. These approaches include a program designed to provide rapid access to case management services to individuals with serious and persistent mental illnesses and accompanying physical health complications hospitalized on the psychiatric inpatient unit. Patients get referred for case management as soon as possible to guarantee the case manager meets with the patient while still hospitalized. This program allows for same day or next day intake, improved referral wait times, transitions of care and efficient discharge planning.

COORDINATED
CARE MODEL

The ACH also developed a care navigation service to help bridge care beyond clinic walls. The care navigation service works with individuals who may not meet eligibility criteria for case management but whose health is impacted by multiple social determinants of health. It helps connect individuals to resources, including housing, benefits and treatment options. This service is a collaborative effort among Broadway Family Medicine Clinic care coordinators, North Memorial Hospital community paramedics, a mental health and addiction clinic psychiatric team, an ER team and others to ensure individuals get connected to community resources.

A cross-sector interdisciplinary care team, called the Rising Risk Team, uses data (e.g., utilization patterns, diagnostic information) to identify individuals with complex care needs based on a

practice known as "hotspotting." These individuals are then connected to appropriate resources, supports and programs.

Lessons and outcomes

Sustaining these care models continues to be a priority. Overall the project resulted in increased services, a 77-percent reduction in follow-up hospitalizations and a 51 percent reduction in ER visits.

Vail Place received the Community Collaboration and Inter-Agency Cooperation Award at the 2016 Minnesota Association of Community Mental Health Programs conference, highlighting the work of the Total Care Collaborative ACH. Members of the Total Care Collaborative have been invited to share the work of the ACH at a variety of conferences, including a webinar sponsored by Stratis Health's Quality Innovation Network, reaching healthcare providers in Minnesota, Wisconsin and Michigan.

Contact

For more information, email Shelly Zuzek at szuzek@vailplace.org.

Resources

"Total Care Collaborative, A SIM ACH: Interventions, Impact and Outcomes"
Emily Hedlund, North Memorial Health Care;
Rebecca Nixon, North Memorial Clinic;
Khalea Zobel, Broadway Family Medicine;
and Shelly Zuzek, Vail Place
SIM Learning Days 2017
www.hchsimlearningdays.org/handouts/Total%20
Care%20Collaborative%20A%20SIM%20ACH%20
Interventions%20Impact%20and%20Outcomes.pdf

This PDF presentation provides an overview of successful Total Care Collaborative programs, interventions and outcomes as well as case examples.

Additional ACH Resources

To access some of the tools that ACH grantees used during the grant process or to find more information about Accountable Communities for Health, visit the resources below.

Partnership Self-Assessment Tool
The Center for the Advancement of Collaborative Strategies in Health
https://atrium.lib.uoguelph.ca/xmlui/bitstream/handle/10214/3129/Partnership_Self-Assessment_Tool-Questionnaire_complete.pdf?sequence=1&isAllowed=y

The Partnership Self-Assessment Tool was designed by the Center for the Advancement of Collaborative Strategies in Health to help partnerships understand how collaboration works and what it means to create a successful collaborative process; to assess how well collaborative processes are working; and to identify specific areas to focus on that can improve the collaborative process. The tool measures a key indicator of a successful collaborative process - the partnership's level of synergy. It identifies the partnership's strengths and weaknesses in areas known to be related to synergy: leadership, efficiency, sufficiency of resources, administration and management. It also measures partners' perspectives about the partnership's decision-making process, the benefits and drawbacks they experience as a result of participating in the partnership, and their overall satisfaction with the partnership.

The Minnesota Accountable Health Model: Continuum of Accountability Matrix
Minnesota Department of Human Services and Minnesota Department of Health
www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_188556

Through the Minnesota Accountable Health Model, Minnesota is working to achieve the vision of the Triple Aim: improved consumer experience of care, improved population health, and lower per capita health care costs. This matrix tool illustrates the basic capabilities, relationships and functions that organizations or partnerships should have in place in order to achieve the long-term vision of the Minnesota Accountable Health Model. It is designed to help the state identify criteria and priorities for investment and lay out developmental milestones that indicate organizations or partnerships are making progress toward the vision.

Community-Based Care Coordination Toolkit
Stratis Health
www.stratishealth.org/expertise/healthit/carecoord/

The Community-based Care Coordination Toolkit provides tools for use at different stages in the development of a community-based care coordination program, including how to begin a program. The tools focus on people, functions, policy and processes to achieve success in the community-based care coordination environment. Within this toolkit, many of the ACH grantees used:

- The Care Coordination Process at a Glance
- Approaches to Patient Communications
- Establishing the Care Team - Roles and Communications
- Community-based Care Coordination Program Workflow and Tools

Culture Care Connection
Stratis Health
www.culturecareconnection.org

Culture Care Connection is an online learning and resource center developed by Stratis Health. The website aims to support health care providers, staff and administrators in their ongoing efforts to provide culturally-competent care in Minnesota.

Community Engagement Strategies:
Opportunities to Participate
Minnesota Department of Health
www.health.state.mn.us/communityeng/needs/
strategies.html

Significant challenges confront communities and organizations wanting to involve the general public in charting their future. This website offers information on a variety of strategies to best bring together community members, decision-makers and policy-makers for effective decision-making.

Aim for Impact and Sustainability resource page
National Rural Health Resource Center
www.ruralcenter.org/rhi/network-ta/aim-for-impact

The Aim for Impact and Sustainability page on the National Rural Health Resource Center's website includes technical assistance resources, tools, educational webinars and services created for rural health networks. This resource includes tools related to:

• Enhancing leadership awareness, alignment and capabilities
• Planning and aligning vision, strategy and initiatives with goals
• Engaging members, partners and communities for improved population health
• Evaluating progress, managing knowledge and utilizing tools and resources
• Developing workforce capacity and a quality-focused, change-ready culture
• Improving processes, services and products continuously
• Calculating and communicating value and impact

CONTINUUM
CARE

"Our role in the community is to improve the health of the community we serve, be partners in the communtiy we serve...going outside of our walls is important because we can't just be that place people come when they're sick..."

Lee Boyles, President/CE-CHI. St. Gabriel's Health, The Whole Community, https://www. youtube.com/watch?v=HiE8OA6hupI 1:25 mark

DATA ANALYTICS CONTRACT

This contract sought a vendor to help the Department of Human Services provide data analytics to the Medicaid accountable care organizations participating in its Integrated Health Partnership (IHP) program. The contractor also needed to provide consultative services to improve the information the Department of Human Services gives IHPs and technical support to the IHPs as they worked to identify opportunities for cost and care transformation.

3M

Statewide

Target population

The participants of the Integrated Health Partnerships program.

Program goals

To expand the analytics, consultation and technical assistance given to Medicaid accountable care organizations and providers.

Program summary

3M worked with the Department of Human Services to develop a technical assistance plan for both the Department of Human Services and the IHPs. In 2016, 3M created a strategic opportunity analysis using enhanced claims and membership data provided by the Department of Human Services. The analysis was used to identify systemwide opportunities and provide actionable information about individual IHP performance compared to other IHPs. The analysis resulted in a report that identifies potentially preventable events, potentially preventable admissions, potentially preventable readmissions and potentially preventable emergency department visits in the IHP Partner Portal.

3M also provided quarterly support at IHP Data User Groups meetings with presentations on best practices, industry standards and examples of work done in specific analytical areas. 3M also engaged with individual IHPs to provide consultation on software issues, implementation and usage options, and troubleshooting.

Lessons and outcomes

3M offered several recommendations to make the reports the Department of Human Services gives IHPs more insightful and actionable. For example, providing expected values in some report metrics allows IHPs to compare themselves to their peers.

The 3M strategic opportunity analysis shared information on how IHPs perform on the various potentially preventable events and where there may be room for improvement to provide better patient care and reduce unnecessary medical costs. The Department of Human Services is working to incorporate the information on potentially preventable events into reports that can be provided to IHPs on an ongoing basis, allowing them to track their performance over time.

Contact

For more information, contact 3M Engagement Leader Bob Pirtle at rpirtle@mmm.com or 913-233-8828 or Department of Human Services Care Delivery and Payment Reform Manager Mathew Spaan at mathew.spaan@state.mn.us.

TECHNICAL SUPPORT

E-HEALTH GRANTS

ROUNDS 1 AND 2

E-Health is the adoption and use of electronic health records systems and other health information technology to manage patient information and move needed information securely among providers based on patient needs and privacy preferences to help people make the best health decisions. The ability to exchange information about treatment and care coordination and use analytic tools to manage cost and risk for specific groups is critical to improving health care quality.

MINNESOTA

This grant provided funding to community collaboratives to explore and expand their e-Health capabilities. In the first round of grants, 12 grantees received a total of $3.8 million in funding: 6 to develop e-Health capabilities and plan for health information exchange and 6 grantees to implement e-Health projects and health information exchange.

In the second round of grants, two development grantees received additional funding to implement the plan they created in Round 1. One implementation grantee (Winona Health) received Round 2 funding to continue to implement its original Round 1 e-Health plan. Additionally, one new e-Health grantee received funding.

Fairview Health Services, Ebenezer

Twin Cities Metro
Funding: e-Health Round 1

Target population

People in need of post-acute or continuing long-term care in the Burnsville area, primarily those older than age 65.

Program goals

To develop a plan for exchanging health information to ensure continuity of care. To reduce inefficiencies in work processes, improve communication among clinical staff and providers, and provide optimal health outcomes.

Program summary

This project was designed to better understand the impact of data sharing on the quality and coordination of care during care transitions through the effective use of health information technology. In order to develop a plan for exchanging health information, Fairview Health Services, Ebenezer used consultants as their subject matter experts for health information exchange work. The Fairview Senior Services Leadership Committee served as the sponsor and decision-making oversight team. In order to carry forward their progress across the entire Fairview system, Fairview Ebenezer prioritized open communication between the various parts of the Fairview Health System.

Findings and outcomes

At the end of the grant period, Fairview Health Services, Ebenezer created an action plan to implement its proposed health information exchange strategies, focusing on current electronic health records and capabilities. Due to the large and complicated health information exchange processes within the broader Fairview system, Fairview Health Services, Ebenezer struggled with implementing this plan. Fairview Health Services, Ebenezer continues to work with Fairview IT to find ways to expand the health information exchange effort.

Resources

Leveraging Grants to Drive the Momentum Toward Interoperability
Mary Chapa, Ebenezer Society, Fairview Health Services; Coral Lindahl, Fairview Health Services, Ebenezer
Minnesota e-Health Summit 2015
www.health.state.mn.us/e-health/summit/2015/docs/b11chapalindahl.pdf

In this PDF presentation, two Minnesota Accountable Health Model (SIM) e-Health Grant recipients share lessons learned from establishing relationships and governance plans for health information exchange. Learn how a physician-led accountable care organization and an integrated delivery system's long-term care leaders are expanding and including more health care providers and community as they develop implementation plans for health information exchange to support accountable health.

Connecting Long-Term Care with the Continuum Under the State Innovation Model
Dave Carlson, Touchstone Mental Health; Mary Chapa, Fairview Health Services, Ebenezer Society, Fairview Health Services; Coral Lindahl, Fairview Health Services, Ebenezer; Harriet Wicklund, LB Homes
Minnesota e-Health Summit 2015
www.health.state.mn.us/e-health/summit/2015/docs/w03carlson.pdf

In this PDF presentation, staff from Fairview Health Services, Fairview Health Services, Ebenezer and Touchstone Mental Health share some of the real-world challenges facing long-term care providers in adopting and using e-Health. These providers share some of the benefits, challenges and lessons learned through their experiences implementing a SIM grant, as well as their perspectives on using and implementing e-Health as long-term care providers.

Federally Qualified Health Center Urban Health Network

(FUHN)

Twin Cities Metro
Funding: e-Health Round 1

Target population
Medicaid enrollees attributed to FUHN through the Integrated Health Partnership project.

Program goals
To work with all 10 Federally Qualified Health Centers in Minnesota that make up FUHN to create a health information exchange. The Health Information Exchange will support the efforts of the network's case managers and care coordinators to better understand each patient's history and provide better care.

Program summary
FUHN drafted a comprehensive assessment report to determine the current state and capacities of each of the clinics to engage in meaningful care co-ordination. In addition, several tools were developed to help strengthen care coordination. For instance, a health information technology identification and stratification tool was developed using data analytics software. This tool helped define interventions to decrease avoidable emergency room use, improve diabetes care management and better track pain management and the use of opioid prescriptions.

FUHN also trained care coordination staff members to use motivational interviewing techniques and LEAN methods to improve care. Additionally, FUHN hired a care coordination team funded partially by this e-Health Grant ($164,718) and partially by a Medica Foundation Grant ($100,000). In spring 2017, FUHN began the selection process for a Minnesota state-certified Health Information Organization.

Findings and outcomes
Developing statewide health information exchange capacity and capability provided to be a demanding undertaking, and connecting providers to health information exchange options is more complicated than originally anticipated. Through this process, FUHN learned that it takes a lot of time to figure out what's needed - and even more time to plan for implementing a solution that will be embraced by an already overburdened workforce.

Resources
Using Data to Drive Population Health and Quality Improvement in an FQHC Network
Lois Brown and Indi Lawrence, Indian Health Board; Lisa Moon, Advocate Consulting LLC
Minnesota e-Health Summit 2017
www.health.state.mn.us/e-health/summit/2017/docs/s09.pdf

The Federally Qualified Health Center (FQHC) Urban Health Network is the nation's first virtual FQHC led Medicaid accountable care organization. This PDF presentation introduces how the 10-member FQHCs use claims data along with their electronic health records to target and drive population health and quality improvement projects. These projects focus on delivering quality care, developing care management strategies and reducing the total cost of care for the underserved populations they manage.

HEALTH INFORMATION
EXCHANGE

Integrity Health Network

(Carlton County)

Carlton County
Funding: e-Health Round 1

Target population

The citizens of Carlton County and surrounding areas.

Program goals

To define health information exchange options for collaborative partners and to develop a health information exchange implementation plan, timeline and budget.

Program summary

Carlton County Connects (15 organizations including all four SIM priority settings) pulled together key health care providers to identify how to move health information exchange forward. Plans for the adoption and use of health information exchange among project partners were completed with a formal gap analysis. The organizations identified gaps in information exchange, assessed the current health information infrastructure, reviewed solutions and defined a process for moving the planning into implementation. Monthly meetings, individual needs assessments and the development of use case scenarios helped educate participants about health information exchange and ways it will improve care delivery.

Findings and outcomes

Most of the grant partners had little familiarity with health information exchange before this project. The grant provided the opportunity for community partners to collaborate around a common goal of improving communication among community partners to provide higher quality, cost-effective care to the citizens of Carlton County. This development grant work supported Integrity Health Network's application for a Round 2 e-Health SIM grant, which it was awarded to implement the development plan outlined in Round 1.

Resources

Silos, Fiefdoms and Frustrations
Melissa Larson and Bruce Penner, Integrity Health Network and Integrity Health Innovations
Minnesota e-Health Summit 2015
www.health.state.mn.us/e-health/summit/2015/docs/b11pennerlarson.pdf

In this PDF presentation, staff from Integrity Health Network and Integrity Health Innovations cover some of the barriers, strategies and lessons they learned in planning and implementing a health information exchange.

Connecting Rural Communities to Support Accountable Care: Critical e-Health Lessons Learned
Melissa Larson, Integrity Health Network; Cassandra Beardsley, Wilderness Health; Anne Schloegel, Minnesota Department of Health
Minnesota Rural Health Conference 2015
https://minnesotaruralhealthconference.org/sites/default/files/presentations/2015/2F%20Connecting%20Rural%20Communities-Critical%20e-Health%20Lessons%20Learned%20Anne%20Schloegel.pdf

This PDF presentation explores how rural partnerships and community collaboratives are developing health information exchange capacity. It features lessons learned from staff at Integrity Health Network and Wilderness Health - two SIM Minnesota e-Health Grant projects.

RURAL
PARTNERSHIPS

Integrity Health Network

(Carlton County)

Carlton County
Funding: e-Health Round 2

Target population
The residents of Carlton County and surrounding areas.

Program goals
To advance the community's ability to electronically share health information through the implementation of direct secure messaging, allowing providers to share important information on patients to improve outcomes and quality while creating an infrastructure that builds capabilities for the future.

Program summary
This project worked to implement direct secure messaging among organizational partners. Carlton County Connects partners began by participating in one-on-one interviews and discussions. Participants used these conversations to address barriers and questions about moving forward with direct secure messaging and create a shared understanding of existing technology infrastructure. A state-certified Health Data Intermediary, was the direct secure messaging vendor for this project and worked closely with community partners to use their native capabilities. This reduced costs and eliminated duplicate efforts across the community. One key feature enabled by the direct secure messaging is advanced exchange solutions including admission, discharge and transfer alert notifications.

Findings and outcomes
All partners successfully implemented direct secure messaging and are currently working toward introducing admission, discharge and transfer alert notifications.

Resources
Health Information Exchange Implementation in a Rural Setting and the Impact of Formal Workflow Redesign

Bruce Penner, Integrity Health Network; Lisa Moon from Advocate Consulting, LLC.
Minnesota e-Health Summit 2016
www.health.state.mn.us/e-health/summit/2016/docs/s01.pdf

Carlton County Connects, a collaboration of health care, public health and social care organizations in Carlton County, worked to build a countywide health information exchange approach starting with direct secure messaging and laying the foundation for more robust health information exchange. Learn about the implementation progress, including lessons learned that may be used in other counties and regions. In addition, understand how the project helped quantify the need for and value of formal workflow redesign using research results.

Lutheran Social Service of Minnesota

(Altair Accountable Care Organization)

Twin Cities Metro
Funding: e-Health Round 1

Target population
People with disabilities currently served by the six community disability partners that make up the Disability Community Collaborative.

Program goals
To streamline processes, coordinate communications throughout the care team, ensure the continuity of care and services to participants, and provide access to more detailed metrics about the people receiving services.

Program summary
To begin, Altair ACO hired a consultant to interview each collaborative member. These interviews helped assess how each member organized information. It also helped assess the different levels of electronic readiness across the collaborative, develop a plan to

standardize data sets and determine how to leverage the information currently available from each organization. Altair ACO then created an electronic portal that allows collaborative members to share participant information, including costs and progress. This portal also gives participants the ability to search for services online and provide feedback. Key performance and quality metrics can be met through data analytics, and quality improvement and social and clinical data could be integrated to a State-Certified Health Information Exchange Service Provider. The health care home care coordination staff, facility staff and primary care team will be the primary managers of the information.

Findings and outcomes

This grant project allowed the Disability Community Collaborative to thoroughly assess the needs of each member and develop a plan that made the best use of current systems and resources. It provided the foundation for an e-Health development plan that builds upon the current systems, bringing them together in a way that is complementary but not duplicative. The plan also allows for flexibility to build in additional partners in the future.

By the end of the grant period, all members had implemented an electronic health record, were in the process of implementing one or had purchased one with the plan to implement it in 2015. This development grant work supported Lutheran Social Service of Minnesota's application for a Round 2 e-Health SIM grant, which it was awarded to implement the development plan outlined in Round 1.

Resources

Exchanging Data to Facilitate Coordination of Long-Term Services and Support
Executive Director George Klauser, Altair ACO; Nathan Tyler, RBA Consulting
Minnesota e-Health Summit 2015
www.health.state.mn.us/e-health/summit/2015/docs/b08klausser.pdf

In this PDF presentation, learn how the Altair ACO developed a plan for a compatible exchange system across six disability service providers. The presentation covers how the community was involved in the

system design and ways it will benefit people with disabilities, disability service providers and health care systems as social services and health care are aligned.

Lutheran Social Service of Minnesota

(Altair Accountable Care Organization)

Twin Cities Metro
Funding: e-Health Round 2

Target population

People with disabilities currently served by the six community disability partners that make up the Disability Community Collaborative.

Program goals

To implement a health information exchange solution that connects to a State-Certified Health Information Exchange Service Provider. The partner organizations, through shared health and health-related information, will support a service delivery model that facilitates improved coordination to help provide the right services and care at the right time to improve quality of life for individuals with disabilities while helping reduce costs

Program summary

With the grant funds, Altair ACO built out the care coordination use case with the health information exchange service provider. The project design was developed, tested and finalized. All Altair ACO members successfully connected to the exchange.

Altair ACO also connected to pharmacies in the area through Simply Connect, a State-Certified Health Data Intermediary. This connection supports the "change in medication" notification and ensures that the Altair ACO members always have the most up-to-date version of dispensed medication from

the pharmacy. Altair ACO users have access to this data via query and appropriate alerts for significant events.

As the project progressed, Altair ACO strived to leverage care coordinators in an increased role. Since the care team has this pertinent data available to them, the organizations can leverage a disability competent care coordinator to customize services provided to the individual. The e-Health toolset, built within the exchange portal, can now be leveraged by care coordinators to significantly impact outcomes.

Altair ACO used funding to educate and engage staff, self-advocates, guardians, county and state staff, and other key stakeholders to empower individuals to leverage the data and toolset now available. Altair ACO also conducted a news and social media campaign

Findings and outcomes

With the grant funds, Altair ACO built out the care coordination use case using health information exchange. All Altair ACO members are connected to the exchange portal. After implementing the event notification use case, the care and service team is aware of the overall status and wellbeing of individuals supported in near real time. The care team also has the ability to proactively intervene or respond to an event in an appropriate manner and engage supports that match the care plan and wishes of the people supported.

Before the e-Health project, care coordinators were barely involved in the care of the person receiving services and each individual could have five or more care coordinators assigned to them. With e-Health, Altair ACO can identify a primary care coordinator to manage everything for an individual because the coordinator has real-time access to data and real-time notifications if there is an urgent need.

Resources

How to Successfully Engage the Community in Care Coordination
George Klauser, Lutheran Social Service of Minnesota and Altair ACO; Nate Tyler, Simply Connect

Minnesota e-Health Summit 2017
www.health.state.mn.us/e-health/summit/2017/docs/s04.pdf

Learn how a new model for the disability population helps guide decision-making by engaging clients, exchange partners and others to better coordinate care. This PDF presentation walks through case studies in implementing a system, process, engagement and technology to provide community-based care coordination.

Connecting Communities to Address Behavioral Health Disparities
George Klauser, Lutheran Social Service of Minnesota and Altair ACO; Nathan Tyler, Altair ACO
Minnesota e-Health Summit 2016
www.health.state.mn.us/e-health/summit/2016/docs/s02.pdf

In this PDF presentation, Altair ACO shares experiences working with behavioral health providers to develop skills and health information exchange capabilities for population health management. Altair ACO's goal is for people with disabilities to be proactively assessed for behavioral health issues and enrolled in the appropriate service programs to monitor their progress and achieve better health outcomes.

Empowering the Patient
George Klauser, Lutheran Social Service of Minnesota and Altair ACO; Nate Tyler, Simply Connect
Minnesota Learning Days 2017
www.hchsimlearningdays.org/handouts/Empowering%20the%20Patient.pdf

Using the disability population as an example, this PDF presentation highlights a model that empowers patients and guardians to make decisions on their individual care plans. The presentation explores designs, lessons and examples of model implementation.
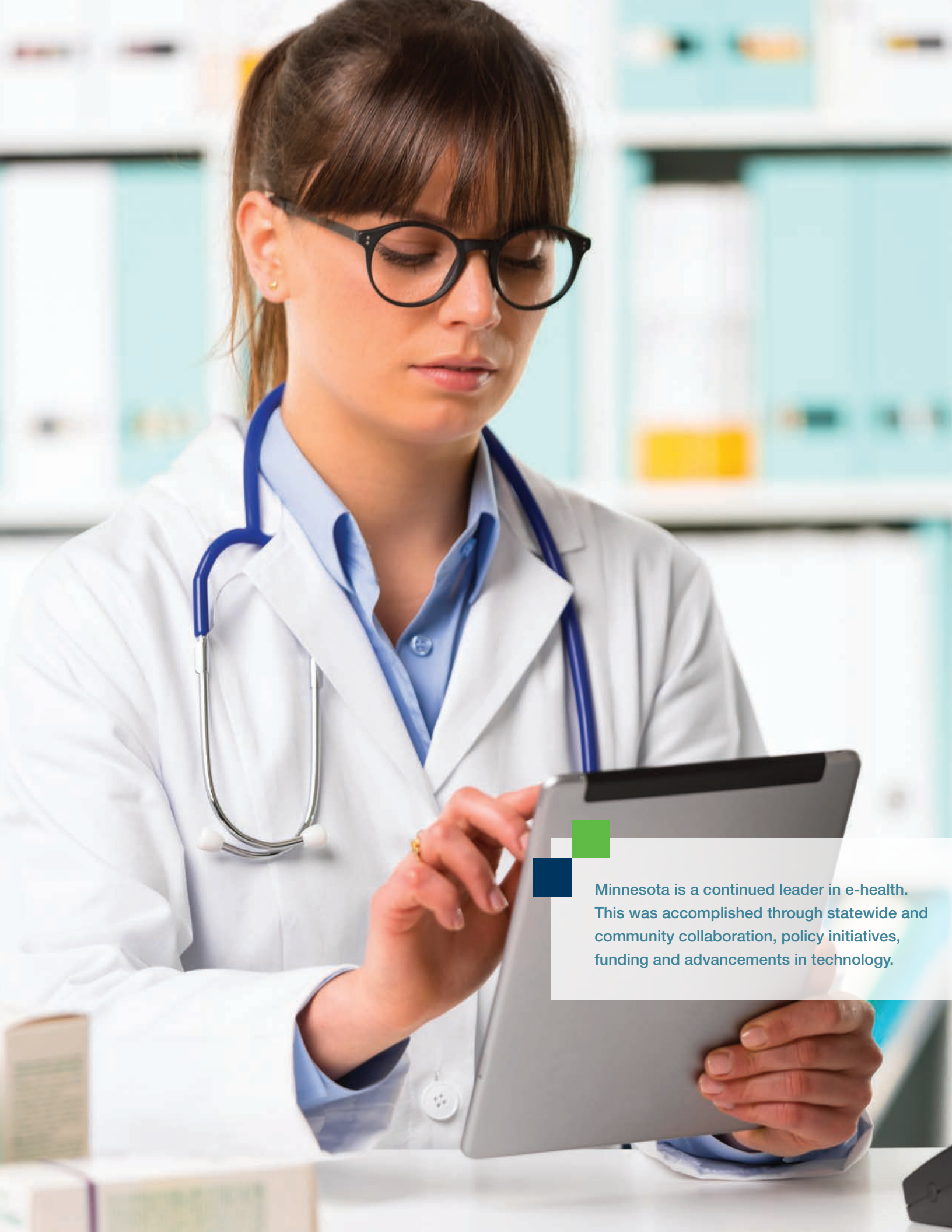
Minnesota is a continued leader in e-health. This was accomplished through statewide and community collaboration, policy initiatives, funding and advancements in technology.

Medica Health Plans

Dakota County
Funding: e-Health Round 1

Target population
Medicaid-eligible adults with serious mental illness and children with serious emotional disturbance in Dakota County.

Program goals
To explore how to use health information exchange and health information technology to better meet the health needs of patients and community members. To map the current business processes used in the provision of care for this member population in order to better define these processes on paper and look for opportunities to exchange health information between entities electronically.

Program summary
Medica, in collaboration with its Preferred Integrated Network program partners, used a multipronged approach to better understand the complexity of the network partnership from a technology standpoint. The grant project started with a research phase where staff conducted stakeholder interviews and mapped out high-level process workflows for enrollment, intake and transfers. Next, staff consolidated research findings into *four priority initiatives:*

1. Centralizing patient data and member information

2. Standardizing required documents

3. Increasing end-to-end patient visibility so all stakeholders understand each other's role and avoid duplicating services

4. Creating process changes throughout the network.

With these priority initiatives in mind, staff developed three high-level system designs for improving e-Health across the network:

1. A centralized database using health information technology to help populate

2. Integration with the state's system of record enrollment (MMIS)

3. Standardizing efforts by focusing Preferred Integrated Network training, processes and required documentation on triggering events in the member's life.

Findings and outcomes
Using the research, plans and lessons listed above, Medica created a thorough development plan.

Northwestern Mental Health Center

Crookston
Funding: e-Health Round 1

Target population
People who receive long-term care, supports and services either in a facility-based setting or within the community.

Program goals
To implement health information exchange among all collaborative organizations, engage in care coordination and become an Integrated Health Partnership.

Program summary
Northwestern Mental Health Center created three workgroups to help lead this project: a care coordination workgroup, an information technology workgroup, and a privacy and security workgroup. Due to changes and withdrawals in the vendor market, Northwestern Mental Health Center faced many challenges securing a vendor. Although the

process took longer than originally anticipated, the Governing Board voted unanimously to contract with a Minnesota State-Certified Health Information Organization. Northwestern Mental Health Center is working to advance care coordination efforts, identify gaps in care, improve clinical outcomes and address quality reporting requirements.

Findings and outcomes

The collaborative has made significant progress in establishing a shared vision for the exchange and use of health information in the community of Crookston and beyond.

Otter Tail County Public Health

Otter Tail County
Funding: e-Health Round 1

Target population

Those in need of or experiencing care transitions across the health care continuum.

Program goals

To support the secure exchange of medical or health-related information in a seamless manner across the settings of primary care, hospital, home health, long-term care, behavioral health, public health and human service providers.

Program summary

The Fergus Falls Community of Practice is a collaboration made up of meaningful use providers, including a primary care clinic, hospital, behavioral health center and behavioral health hospital, as well as providers of mental health services related to crisis support and detox, long-term care services, home health, hospice, human services and public health. Reflecting their history of cooperation and collaboration, the partners created an interagency service agreement for this project. That document was replaced in June 2016 by a charter agreement to define partner roles and expectations.

With funding, each member of the collaborative was held accountable for moving forward on implementing the health information exchange areas that apply in their work setting. A project manager met with each partner to create a dashboard and timeline to complete their required objectives for the project. Otter Tail County Public Health also worked with a State-Certified Health Data Intermediary, to increase the use of direct secure messaging as the new norm for secure communication of Protected Health Information during care transitions. The collaborative continues to work on receiving information for home visits, nursing home transitions, and alerts for hospital admissions and emergency room visits electronically.

Findings and outcomes

The meaningful use requirement for electronic transmission of continuity of care documents aligned well with this project goal. The partners discovered that direct secure messaging works best when embedded or integrated within electronic health record systems. Otherwise, the workflow can be even less efficient than faxing.

Resources

Using Health Information Exchange to Move to Accountable Health - Fergus Falls area Health Information Exchange Community of Practice
CIS Director Wade Jyrkas, Lake Region Healthcare; Director/CHS Administrator Diane Thorson, MS, RN, PHN, Partnership4Health, Otter Tail County Public Health
Minnesota e-Health Summit 2015
www.health.state.mn.us/e-health/summit/2015/docs/b01thorsonjyrkas.pdf

In this PDF presentation, a rural Minnesota collaborative shares insights about its community-focused health information exchange project. Staff discuss how to connect health and health care providers including local public health, hospitals, clinics, long-term care and behavioral health organizations. Learn how to apply their lessons learned to your organization or community.

Connecting Long-Term Care with the Continuum Under the State Innovation Model
Dave Carlson, Touchstone Mental Health; Mary Chapa, Ebenezer Society, Fairview Health Services; Coral Lindahl, Ebenezer; Harriet Wicklund, LB Homes
Minnesota e-Health Summit 2015
www.health.state.mn.us/e-health/summit/2015/docs/w03carlson.pdf

In this PDF presentation, staff from Fairview Health Services, Fairview Ebenezer and Touchstone Mental Health share some of the real-world challenges facing long-term care providers in adopting and using e-Health. These providers share some of the benefits, challenges and lessons learned through their experiences implementing a SIM grant, as well as their perspectives on using and implementing e-Health as long-term care providers.

Southern Prairie Community Care

12-County Area in Southwestern Minnesota
Funding: e-Health Round 1

Target population
The rural and underserved populations that comprise the 12-county region served by Southern Prairie Community Care, an Integrated Health Partnership specifically focused on people with multiple chronic problems, including mental illness and chemical dependency.

Program goals
To move from development to implementation of a health information exchange system to collect, analyze and use patient data to improve outcomes.

Program summary
Before this SIM grant, the 12 organizations that make up Southern Prairie Community Care worked together to define the communities' needs, develop a collective understanding of underlying issues and

create an effective action plan for implementing health information exchange. To implement this plan, Southern Prairie Community Care created a Population Health Record and Health Information Exchange Workgroup. This group helped to further refine the Southern Prairie Community Care vision and guiding principles for health information exchange. Working with two State-Certified Health Data Intermediaries, Southern Prairie Community Care set up the Care-Trac Health Information Organization.

Findings and outcomes
After working through this process, Southern Prairie Community Care encourages organizations interested in health information exchange to contact the State-Certified Health Information Organizations and review the health information exchange services available. The technical and financial benefits of joining an existing health information organization include avoiding upfront financial and resource costs of setting up a health information exchange environment and leveraging the technical knowledge and experience of the health information organization.

Resources
Using Health Information Exchange and Data Analytics to Support Accountable Health
Susan Voigt, Minnesota Community Healthcare Network; Will Muenchow, Southern Prairie Community Care; Anne Schloegel, Minnesota Department of Health's Office of Health Information Technology
Minnesota Learning Days 2017
http://hchsimlearningdays.org/handouts/SIM_LearningDaysWorkshop_HIE_04-05-2017.pdf

This PDF presentation provides an understanding of how health information exchange and data analytics will help achieve more coordinated care, improve health and create cost-savings. Learn about Minnesota's approach to health information exchange and the current status, along with lessons learned from grant-funded health information exchange implementation projects.

Moving from Accountable Care to Accountable Health Using Health Information Exchange - Southern Prairie Community Care
Community Health Improvement and Health Information Exchange Senior Vice President Elizabeth Cinqueonce, Southern Prairie Community Care Minnesota e-Health Summit 2015
www.health.state.mn.us/e-health/summit/2015/docs/b06cinqueonce.pdf

A community-focused health information exchange project shares insight on how health and health care providers including local public health, hospitals, clinics, long-term care and behavioral health organizations can use health information exchange to support accountable care arrangements. Learn how Southern Prairie Community Care, an Integrated Health Partnership, is applying lessons learned to meet the needs of accountable health.

Touchstone Mental Health

on behalf of Minnesota Community Healthcare Network

Hennepin County
Funding: e-Health Round 1

Target population
A high-risk population of diverse, love-income and vulnerable people who have co-occurring medical, behavioral health and social complexity, specifically those enrolled in the Hennepin Health or Hennepin County Medical Center Integrated Health Partnership demonstration projects or who are served by Hennepin County Medical Center and its primary care and specialty clinics.

Program goals
To implement health information technology improvements and establish health information exchange connectivity to enable the five Minnesota Community Healthcare Network members to connect with each other and with the Hennepin Healthcare system. The network intended 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.

Program summary
The Minnesota Community Healthcare Network's health information exchange implementation encountered major delays due to difficulties engaging one of its primary electronic health record vendors, which is used by three of the five Minnesota Community Healthcare Network agencies. Eventually the Minnesota Community Healthcare Network was able to re-engage the electronic health record vendor mid-year to work on developing an interface to the network's chosen State-Certified Health Data Intermediary. This connection includes the ability to send continuity of care documents and admission, discharge and transfer messages.

Minnesota Community Healthcare Network also explored alternative health information exchange strategies. When new State-Certified Health Information Organizations joined the market, Minnesota Community Healthcare Network decided to join one which will eventually allow access to information at any of the State-Certified Health Information Organizations.

Findings and outcomes
The Minnesota Community Healthcare Network is continuing discussions with an HIO currently testing a data analytics solution, to determine a future connection viability.

Resources
Using Health Information Exchange to Move to Accountable Health - Mission Hennepin Project
Dave Carlson, Manager of Technology Services, Touchstone Mental Health; Michael Scandrett, JD, LPaCAlliance, Halleland Habicht PA.

Minnesota e-Health Summit 2015 (June 16, 2015)
www.health.state.mn.us/e-health/summit/2015/
docs/b01scandrettcarlson.pdf

In this PDF presentation, a Minneapolis-based behavioral health network shares insights about its community-focused health information exchange project. Staff discuss how to connect health and health care providers including local public health, hospitals, clinics, long-term care and behavioral health organizations. Learn how to apply their lessons learned to your organization or community.

Using Health Information Exchange and Data Analytics to Support Accountable Health
Susan Voigt, Minnesota Community Healthcare Network; Will Muenchow, Southern Prairie Community Care; Anne Schloegel, Minnesota Department of Health's Office of Health Information Technology
Minnesota Learning Days 2017
http://hchsimlearningdays.org/handouts/SIM_
LearningDaysWorkshop_HIE_04-05-2017.pdf

This PDF presentation provides an understanding of how health information exchange and data analytics will help achieve more coordinated care, improve health and create cost savings. Learn about Minnesota's approach to health information exchange and the current status, along with lessons learned from grant-funded health information exchange implementation projects.

Connecting Long-Term Care with the Continuum Under the State Innovation Model
Dave Carlson, Touchstone Mental Health; Mary Chapa, Ebenezer Society, Fairview Health Services; Coral Lindahl, Ebenezer; Harriet Wicklund, LB Homes
Minnesota e-Health Summit 2015
www.health.state.mn.us/e-health/summit/2015/
docs/w03carlson.pdf

In this PDF presentation, staff from Fairview Health Services, Fairview Ebenezer and Touchstone Mental Health share some of the real world challenges facing long-term care providers in adopting and using e-Health. These providers share some of the

benefits, challenges and lessons learned through their experiences implementing a SIM grant, as well as their perspectives on using and implementing e-Health as long-term care providers.

White Earth Nation

White Earth
Funding: e-Health Round 1

Target population
Members of the White Earth Nation and their families residing on or near the White Earth Reservation.

Program goals
To bring all tribal health programs to the same level of understanding, compliance and use of the electronic health record and the WECARE case management system and to investigate opportunities for future health information exchange with state and federal programs.

Program summary
The central efforts of the White Earth Nation focused on developing and implementing the White Earth Coordination, Assessment, Resource and Education case management system (WE CARE). WE CARE uses care coordination software to enable assessment, collaboration, plan development and outcome tracking. To begin investigating how to expand and standardize the use of WE CARE, White Earth conducted a survey among the tribal health programs to assess the current use and understanding of WE CARE. Staff members also met to define policies, practices and procedures for the WE CARE program.

Findings and outcomes
White Earth created a development plan for the WE CARE system.

Wilderness Health

The Greater Two Harbors Area
Funding: e-Health Round 1

Target population

People in Northeastern Minnesota and North-western Wisconsin, a population of approximately 450,000 people.

Program goals
To develop a work plan for the implementation of a care management and analytical tool that incorporates members' clinical records with payer claims data and quality benchmarks to work together on population health initiatives.

Program summary

Wilderness Health spent considerable time developing several legal documents, including member data-sharing agreements and a Privacy and Security Manual. In addition, Wilderness Health reviewed a contract from its electronic health record vendor and began contract implementation. Participating in the electronic health record's "Community Care Medical Record" will enable the collaborative to conduct analytics on its shared patient population, improve care for patients through coordinated care and participate in accountable care organization model payment programs. Wilderness Health also established an IT subcommittee made up of representatives from each of its member organizations, and developed a privacy and security workgroup made up of subject matter experts. Health information exchange assessments were completed with each participating site.

Findings and outcomes

Wilderness Health created a development plan to guide future implementation of this health information exchange as part of this e-Health project. At the end of the grant cycle, Wilderness Health began implementing the projects and had started training on care plans with a few pilot clinics.

Resources

Connecting Rural Communities to Support Accountable Care: Critical e-Health Lessons Learned
Melissa Larson, Integrity Health Network;
Cassandra Beardsley, Wilderness Health;
Anne Schloegel, Minnesota Department of Health
Minnesota Rural Health Conference
https://minnesotaruralhealthconference.org/presentations/2015

This PDF presentation explores how rural partnerships and community collaboratives are developing health information exchange capacity and features lessons learned from staff at Integrity Health Network and Wilderness Health - two SIM Minnesota e-Health Grant projects.

Winona Health

Winona
Funding: e-Health Rounds 1 and 2

Target population

Individuals who have demonstrated high historical use of health care or other support resources. For instance, those who have a high use of emergency room services, inpatient admissions, 911 services or other available support resources. Program participants must also be served by at least two active Winona Regional Care Consortium members.

Program goals
To create community-based care coordination that includes the use of health information exchange to electronically share relevant information between multiple parties with shared responsibility for the care of program participants.

Program summary

By combining funding from Rounds 1 and 2 of the e-Health Grant, Winona Health used information received via health information exchange to develop

a new care coordination database and communication structure that has not been implemented in any other community operation. This new health information exchange structure includes using a State-Certified Health Data Intermediary and the public health department's electronic health record. It is called the Care Coordination Health Information Exchange, or CC-HIE. The CC-HIE supports the electronic transfer of data from the collaborative participants' electronic health records, the ability to store an expanded profile of patient reports and other care documents, and the manual entry of data as needed. Winona Health also used funding from Round 2 of to develop a Care Collaboration Console. This resource allows providers to send patient data as well as receive or query data. Additionally, funds that were reserved from Grant 1 and Grant 2 are covering the continuing development work and will sustain operations through the end of 2017.

Findings and outcomes

Winona Health continues to work with situations that require multiple consent forms to be in compliance with Minnesota privacy laws. There are also preliminary conversations with the others in the community that may benefit from a connection to the CC-HIE.

Resources

Minnesota e-Health Summit: Using Information to Advance Population Health
Rachelle Schultz, President and CEO, Winona Health Services
Minnesota e-Health Summit 2015
www.health.state.mn.us/e-health/summit/2015/docs/w02schultz.pdf

In this PDF presentation, learn how Winona Health used e-Health and data analytics to help achieve more coordinated care and improved population health.

Investments in e-Health are vital as information needs to be shared among a broad array of settings to facilitate care management. SIM dollars have supported that goal by funding e-Health grants to support secure exchange of medical or health-related information between ACOs or ACO-like organizations, and use of HIE to identify health improvement and coordination opportunities and readiness to prepare for potential participation in accountable communities for health.

Beltrami County Area Behavioral Health PACT

Beltrami County
Funding: e-Health Round 2

Target population
Beltrami County residents with behavioral health issues that require care coordination or referrals among various systems.

Program goals
To implement direct secure messaging at each provider clinic and agency; begin effective exchange within the partner community and key community trading partners; establish workflows to manage referrals and transfers of care using direct secure messaging; evaluate intentional, sustainable health information exchange solution strategies to support accountable care organization collaborative participation; and select and establish a roadmap for sustainable communitywide health information exchange connectivity solutions, objectives and population needs.

Program summary
At the beginning of the grant period, the Beltrami County Area Behavioral Health Practice Alignment and Collective Transformation (PACT) led a readiness and preparedness development training for all PACT team members. This helped all team members fully understand goals and objectives of the grant program, technologies and expectations. PACT also held PACT member bimonthly meetings and PACT Leadership team monthly meetings. These meetings featured collaborative discussions on a wide range of topics, including the use of direct secure messaging, issuing status updates and moving core work plan objectives. Through working with an electronic health record vendor and State-Certified Health Data Intermediary, community partners significantly increased direct secure messaging use among member providers for exchange of patient records requests, referrals and transfers of care.

Findings and outcomes
Between January 2017 and April 2017, PACT recorded a 40 percent increase in the number of direct secure messages exchanged. This number is projected to increase over the next few months. After working together to solve technical barriers and issues throughout this project, PACT also observed an increase in interactive participation and collaboration among partner agencies.

SUSTAINABLE
SOLUTIONS

Additional e-Health Resources

For more information about e-Health, visit the resources below. You may also find helpful information related to e-Health in the "Additional Health Information Exchange Resources" and "Additional Privacy, Security and Consent Resources" sections in this directory.

Minnesota e-MN e-Health website
Minnesota Department of Health and Minnesota e-Health
www.health.state.mn.us/e-health/

The Minnesota e-Health website has information about e-Health activities, resources, publications, toolkits, rules and laws, opportunities and more.

Health IT - Tools and Resources
Stratis Health
www.stratishealth.org/expertise/healthit/

Stratis Health is working to advance e-Health and health information technology across the continuum of care and throughout communities to improve the quality, safety and efficiency of care for patients. This website provides concise, actionable tools and resources to assist health care organizations in planning for and optimizing use of health IT. To access these tools and resources, visit the "Tools and Resources" section of the website.

2017 e-Health Summit Breakout Presentation Materials
Minnesota Department of Health and Minnesota e-Health
www.health.state.mn.us/e-health/summit/2017/presentations.html#session

The 2017 e-Health Summit provided participants with tools and resources to guide success in implementing electronic health records and other health information technology. The summit explored how optimizing the use of electronic health record systems and other health IT to connect health information is transforming health care and advancing population health. It also delved into challenges and opportunities for connecting the continuum of care in the context of the 2017 theme: "Connectivity. Equity. Health." Many of these presentations are saved and accessible on this website.

E-HEALTH ROADMAP CONTRACT

Minnesota's e-Health work included creating a roadmap to advance e-Health in four priority settings: behavioral health, local public health, long-term and post-acute care, and social services. The MN e-Health Roadmap (the Roadmap) describes a path forward and a framework to enable providers in these settings to effectively use e-Health to participate in the Minnesota Accountable Health Model. A set of Roadmap tools helps providers exchange data for treatment, care coordination, population health and quality improvement.

Stratis Health

Statewide

Target population

Behavioral health, local public health, long-term and post-acute care, and social service providers.

Project summary

The Roadmap process was designed to integrate the diverse issues of the four priority settings. A steering team of 19 individuals and workgroups of over 50 subject matter experts from the priority settings met more than 40 times from January 2015 to June 2016. The steering team and workgroups identified more than 70 use cases, each an individual's story that shows challenges in care coordination and collecting, using and sharing information. Eight use cases were selected for deeper analysis and discussion.

The analysis and discussion of the priority use cases identified two key themes:

1. Person-centered view of e-Health
2. Collecting, sharing and using information

The priority use cases also identified similar e-Health related challenges for care coordination and collecting, using and sharing information. The e-Health related challenges and the two key themes led to the development of 10 recommendations for providers within the priority settings.

Findings and outcomes

The Roadmap provides a starting point and a path forward for the priority settings. The next steps are to share and implement the Roadmap, which requires the effort, collaboration and support of local, state and national partners. Sharing the Roadmap will create awareness and support to develop resources for the priority settings. As the Roadmap is implemented, sharing stories and lessons learned will be vital to support and accelerate the adoption and use of e-Health to achieve healthier individuals and communities.

Contact

For more information, contact mn.ehealth@state.mn.us.

Resources

Minnesota e-Health Roadmap
Stratis Health
Minnesota Department of Health and Minnesota Department of Human Services
http://www.health.state.mn.us/e-health/roadmap/docs/ehlth_roadmap_final.pdf

The Minnesota e-Health Roadmap for behavioral health, local public health, long-term and post-acute care, and social service providers includes use cases, a person-centered view, 10 recommendations and more than 40 actions to support and accelerate the adoption and use of e-Health. The Roadmap also includes resources for providers and more than 35 actions for partners to support the implementation of the Roadmap.

SHARING
INFORMATION

E-LEARNING MODULES CONTRACT

This grant focused on the learning needs of behavioral health and health care providers, systems and stakeholders trying to provide increasingly coordinated, value-based and accountable health care. The grantee created accessible e-learning training modules to support Minnesota's Integrated Health Partnerships (IHP), Behavioral Health Home Services (BHH), and Health Care Homes (HCH).

LearningLens

E-Learning Modules Contract
Statewide

Target population:
Integrated Health Partnerships, Behavioral Health Homes and Health Care Homes in Minnesota.

Program goals:
To develop, produce and deliver up to 45 accessible eLearning training modules to Support Minnesota Integrated Health Partnerships (IHP), Behavioral Health Homes (BHH) and Health Care Homes (HCH).

Program summary:
LearningLens, a Minneapolis-based eLearning company that provides custom training and learning, and the Department of Human Services together developed online learning tools to provide support and information about IHP, BHH and HCH program policies, procedures and practices. Staff from the Department of Human Services drafted the content for these learning modules. LearningLens then reviewed the information for good instructional design, created graphics and handled all technical aspects of creating the modules.

Learnings and outcomes:
When the online modules are complete they will be stored in learning management systems at both the Minnesota Department of Human Services and the Minnesota Department of Health. This grant program will end in December 2017.

For more information about this grant program, or to learn how to access the e-learning modules, contact Traci Warnberg-Lemm at Traci.Warnberg-Lemm@state.mn.us or 651-431-5621

EMERGING PROFESSIONS INTEGRATION GRANT

ROUNDS 1, 2 AND 3

The Emerging Professions Integration Grant Program focuses on expanding the number of patients served by team-based integrated and coordinated care by supporting emerging providers. The Minnesota Accountable Health Model identified three emerging professions that it wanted to test for integration into the health care workforce: community health workers, community paramedics, and dental therapists and advanced dental therapists. Each emerging profession was evaluated for how its integration into a team environment can change the team's overall capacity and patient outcomes.

Three rounds of grant funding supported the integration of emerging professions into the health care workforce. A total of 14 organizations were awarded 12 months of start-up funds to support salary and fringe benefits for the emerging professional.

Children's Dental Service

*North Minneapolis, Northeast Minneapolis
and St. Cloud*
Funding: Round 1 grant

Target population
Low-income children and pregnant women in
need of dental care.

Program goals
**To hire an advanced dental therapist
as a member of the dental team; to
increase access to dental services
across the state and improve the oral
health of low-income children and
pregnant women; to increase oral
health literacy to reduce the rate of
new dental disease in low-income
children and pregnant women; and to
effectively establish the use of an
advanced dental therapist as a model
for providing cost-effective dental care.**

Program summary
Children's Dental Service hired an advanced dental
therapist. Throughout the grant period, the ad-
vanced dental therapist worked with approximately
six to eight patients every day.

Children's Dental Service held daily clinical huddles
with staff members to integrate the advanced dental
therapist into the rest of the care team. Children's
Dental Service also arranged for a senior dentist
to review treatment plans in the initial weeks and
arranged access to a dentist to help with fearful
or uncooperative children for the first few months.
Having these work systems in place helped the
advanced dental therapist fully integrate into the rest
of the team and encouraged regular opportunities
for communication among staff.

Findings and outcomes
Progress was made in all of the listed goals. As a re-
sult of hiring an advanced dental therapist, the clinic
was able to deliver services in 10 new locations,
conduct stakeholder meetings, update a manual

for the integration of advanced dental therapists in
schools and provide a full range of dental care ser-
vices at roughly 50 percent of the cost of a licensed
dentist. The advanced dental therapist employed
at Children's Dental Service saw more than 2,000
patients in her first year of work, established pro-
ductive working relationships with colleagues, and
received positive feedback from patients and staff.

Contact
For more information, contact Will Wilson at
will.wilson@state.mn.us or 651-201-3842.

HealthEast Care System

St. Paul
Funding: Round 1 grant

Target population
Mental health and chemical dependency patients
preparing for discharge from the inpatient Mental
Health and Addiction Care Program at St. Joseph's
Hospital. Clients were from diverse, low-income,
and underserved communities and often had multi-
ple chronic conditions.

Program goals
**To hire a community paramedic to
improve health for patients recently
discharged from the hospital who
struggle with mental health or chemical
dependency.**

Program summary
The grant provided start-up funds for HealthEast
Care System to hire four part-time community
paramedics to fill one full-time position. (Each
community paramedic worked approximately 10
hours per week.) In order to improve transitions of
care for mental health and chemical dependency
patients discharged from mental health or addiction
care, community paramedics visited patients in their
homes or community settings within 48-72 hours of
discharge. There, community paramedic addressed
the patient's discharge plan, ensured medication

compliance and referred patients to follow-up visits with primary care, behavioral health and other services.

Findings and outcomes

Over the course of the grant period, 90 unique patients were visited by a community paramedic and 106 patients completed their initial visit. The community paramedics program helped increase medication compliance, seven-day mental health follow-up and 21-day primary care follow-up. The community paramedics' one-on-one interaction supported patients by helping them better understand discharge notes and take medications properly. Over the course of this grant period, community paramedics prevented at least 30 medication errors during visits.

Contact

For more information, contact Will Wilson at will.wilson@state.mn.us or 651-201-3842.

MVNA

Hennepin County
Funding: Round 1 grant

Target population

140 individuals with low incomes and complex care needs, including those living with chronic conditions and those with both behavioral and physical needs.

Program goals

To hire and integrate a community health worker into a home visiting health care team; to increase the number of clients who follow through on initial post-hospital discharge clinic visits, help clients meet their plan of care goals and reduce the rate of client hospital readmission.

Program summary

MVNA took time to experiment with where the community health worker could work within the broader organization because the role of the worker is deliberately broad. MVNA found that the community health worker was able to lift different tasks from providers' workloads such as communication with clients, which allowed nurses and social workers to work at the top of their licenses. By providing a critical level of support to these staff members, the community health worker became an important member of the health care home team.

MVNA ensured there was daily collaboration among every member of the team. This helped integrate the community health worker into the rest of the staff structure, avoid duplicating services and ensure that client needs were met.

Findings and outcomes

Over the course of the grant period, the community health worker met with a total of 148 patients. Because the community health worker allowed others to work at the top of their license, the medical social worker saw a 19 percent increase in the number of patient visits. Additionally, approximately 85 percent of clients successfully attended their first post-hospital clinic visits, and 76 percent of clients completed their care plan goals while working with the community health worker.

Contact

For more information, contact Will Wilson at will.wilson@state.mn.us or 651-201-3842.

Well Being Development

Greater Ely Area
Funding: Round 1 grant

Target population

Adult behavioral health patients who often live below the poverty level and who were served by the Northern Lights Clubhouse, a client-led, behavioral health community center operated by Well Being Development.

Program goals
To hire a community health worker to improve health care, lower health costs, increase preventative care and reduce health disparities among the target population.

Program summary
Well Being Development hired a community health worker to work with clients at the Northern Lights Clubhouse and to get them connected to other services. In order to connect with existing clients, the community health worker made phone calls to engage existing clubhouse members. The community health worker also made outreach calls to engage potential or inactive clients.

To better coordinate care and services, the community health worker participated in the broader Ely Community Care Team and attended monthly meetings to discuss the needs of clients. The community health worker also led education sessions for clubhouse members, ranging from cooking classes to information about arthritis.

Midway through the grant program, the employed community health worker was promoted within the organization and left the community health worker position. Because Ely is located in a rural part of the state, far from a community health worker training site, Well Being Development was unable to find another community health worker to fill the position. However, the executive director of Well Being Development stepped in and completed the work plan, meeting many of the intended goals and outcomes.

Findings and outcomes
Well Being Development found that embedding a community health worker within the Northern Lights Clubhouse allowed the organization to meet the needs of the members and the mission of the clubhouse in general. The community health worker helped increase collaboration with other service organizations in the area, resulting in greater outreach for clubhouse programming and an increase in referrals to resources. The community health worker also engaged potential clubhouse members and re-engaged inactive members.

After the grant period ended, Well Being Development planned to continue providing educational classes as a regular part of Northern Lights Clubhouse programming and to continue providing care coordination services.

Contact
For more information, contact Will Wilson at will.wilson@state.mn.us or 651-201-3842

West Side Community

Twin Cities Metro
Funding: Round 1 grant

Target population
Patients in the St. Paul area, focusing specifically on children from diverse backgrounds from low-income, mostly uninsured families.

Program goals
To hire a dental therapist to increase access to quality dental care for underserved patients and increase the capacity of the dental team.

Program summary
West Side Community hired a dental therapist at the beginning of the grant period. Before working as a dental therapist, the individual had worked as a registered dental hygienist at West Side. Because the dental therapist had existing working relationships with the staff, the therapist integrated smoothly into the West Side Community system.

Findings and outcomes
During the grant period, the dental therapist performed more than 200 full series X-rays and more than 200 sealants in addition to numerous other procedures. Because the dental therapist performed many of these procedures, West Side Community found that this emerging profession improved access to care and allowed more time for dentists to pursue more complicated procedures.

The work of the dental therapist alleviated apprehension about the dental therapist position among other dental professionals. West Side Community showed that dental therapists have an important role to play on a dental team and that the position does not encroach on other professions in the dental field. Additionally, patients were very accepting and appreciative of the dental therapist.

Contact

For more information, contact Will Wilson at will.wilson@state.mn.us or 651-201-3842.

Essentia Health - Ada Clinic

(Bridges Medical Center)

Norman County
Funding: Round 2 grant

Target population

Patients with chronic diseases or complex diagnoses, including patients who are medically underserved due to social, economic or access issues and vulnerable patients with identified special needs or risks.

Program goals

To hire four part-time community paramedics to decrease avoidable ambulance calls, emergency room visits and hospital admissions; and to attract and improve the retention of qualified pre-hospital emergency personnel in a low volume, medically underserved rural setting.

Program summary

The community paramedics in the Essentia Health - Ada Clinic program provided medication reviews, home safety inspections, post-discharge follow-up and education, medication reconciliation, in-home blood draws for lab work, wound and post-surgical site assessment and dressing changes, and in-home health screenings, such as blood pressure checks, weight monitoring and other vital signs. Medical staff, including providers, specialists and nurses, referred patients to the program. If referrals from these providers were low, the community paramedics took on more community projects, including public education in CPR and first aid.

Findings and outcomes

Although there were a few delays due to staffing changes and other unpredicted obstacles, once started, the community paramedics were initially on track to connect with at least two referrals per week. Unfortunately, part way through the grant, Essentia Health began requiring that recipients of community paramedic services get charged $25 per 15 minutes of care. Because the service was not covered by insurance, this led many patients to decline additional services or avoid participation in the program. The Essentia Accountable Care Organization stepped in and eventually the Essentia Health system began offering community paramedic services at no cost to individual patients.

Although referrals were still slower than anticipated, this grant allowed Essentia Health - Ada Clinic to build partnerships and lay the foundation for moving forward with this program. Toward the end of the grant period, Essentia Health - Ada Clinic began reaching out further to other organizations, such as nursing home discharge teams and area clinics.

Throughout the grant period, the program was well received by the clients and community partners who worked with the community paramedics. As the grant came to a close, Essentia Health decided to use the lessons learned from this grant and incorporate them into a regional community paramedic delivery model.

Contact

For more information, contact Will Wilson at will.wilson@state.mn.us or 651-201-3842.

Hennepin County

Hennepin County
Funding: Round 2 grant

Target population
People in the Hennepin County Jail with behavioral health needs.

Program goals
To hire a community health worker to work with the behavioral health population in the Hennepin County Jails and in the community upon release, to prevent recidivism.

Program summary
Initially, Hennepin County had a hard time finding a community health worker to fill the position. In order to publicize this position, Hennepin County Medical Center's jail medical team revised the position requirements and contacted local technical colleges that offer community health worker certification in order to fill the position.

When Hennepin County did hire a community health worker, he began working with people at the Hennepin County Public Safety Facility. The community health worker connected clients to community medical and mental health resources. Partway through the program, this community health worker left the position.

Hennepin County hired a new community health worker who assessed the needs of clients and provided them with referrals and connections to community medical and mental health services. The second community health worker encouraged clients to connect with these services and helped clients apply for health care benefits.

Findings and outcomes
By the end of the grant period, the second community health worker was assigned as a primary worker for nine clients and as a secondary worker for seven clients. This community health worker came to the position with a lot of existing experience and served as a valuable consultant to members of the team.

Because it took a long time to hire and train for the position, long-term data about clients is currently unavailable. However, the position continued after the grant period.

Contact
For more information, contact Will Wilson at will.wilson@state.mn.us or 651-201-3842.

Northern Dental Access Center

Bemidji area
Funding: Round 2 grant

Target population
More than 60,000 people within driving distance of Bemidji who are enrolled or eligible for enrollment in Minnesota Health Care Programs, which is roughly 35 percent of the region's population.

Program goals
To hire a dental therapist who can treat patients and collaborate with dentists to help them work at the top of their licenses.

Program summary
Northern Dental Access Center used multiple volunteer dentists to supervise the dental therapist. This added complexity that required legal clarification and increased supervision between the dentists and the dental therapist and between the dental therapist and front desk staff. Patient volume rose from an average of 70 appointments per month to 114 appointments per month by the end of the grant period.

Findings and outcomes
Northern Dental Access Center supports the concept of dental therapy and expressed a desire to hire a dental therapist with training as a dental hygienist. The team believes the dental hygienist training would maximize the skills of the Dental Therapist role, especially during no-shows. Through this process, Northern Access Dental Center learned
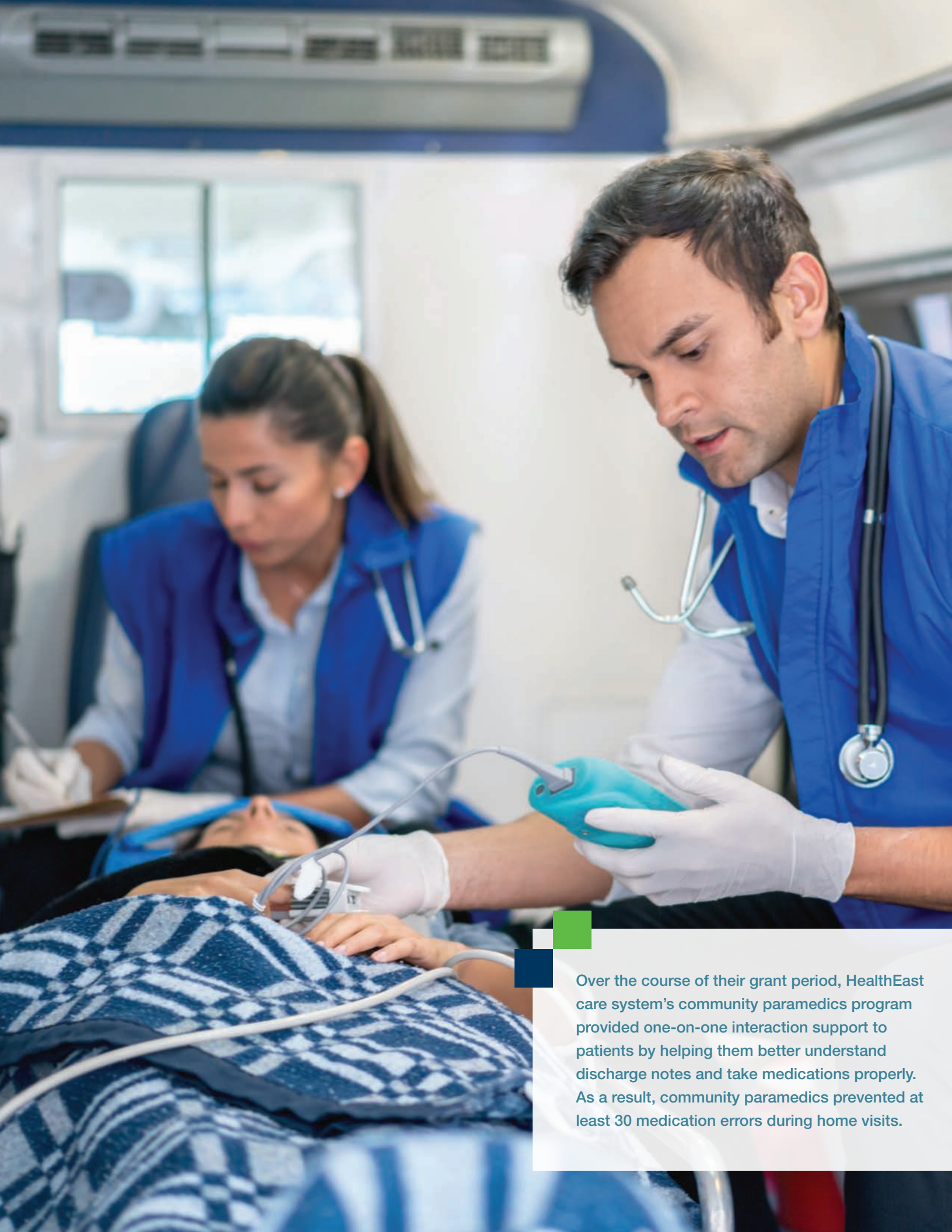
Over the course of their grant period, HealthEast care system's community paramedics program provided one-on-one interaction support to patients by helping them better understand discharge notes and take medications properly. As a result, community paramedics prevented at least 30 medication errors during home visits.

that integration of the role may require additional time and effort if the dental therapist has a more limited skillset. The team found that the onboarding period may be similar to that of a new dentist and is generally longer than for a dental hygienist or dental assistant. The organization learned lessons about using dental therapists in settings with largely volunteer dentists.

Contact
For more information, contact Will Wilson at will. wilson@state.mn.us or 651-201-3842.

Ringdahl Ambulances

Pelican Rapids and Fergus Falls
Funding: Round 2 grant

Target population
People in the Pelican Rapids and Fergus Falls communities, especially focusing on those with chronic conditions or complex health issues and low incomes, but who are not eligible for health care home services.

Program goals
To hire and integrate a full-time community paramedic into the health care team to provide coordinated care across multiple community settings.

Program summary
Ringdahl Ambulances hired a full-time community paramedic and two part-time community paramedics to form a Community Paramedic Program. This team of community paramedics provided patients with screenings, wound care, medication assistance, connections to services, chronic disease monitoring, education and liaison services among patients and their health care providers.

Clients were told that they could call the Community Paramedics Program at any time with any nonemergent questions and concerns. To educate providers

and the public about the Community Paramedic Program, Ringdahl Ambulances promoted the program at staff meetings for health care workers, community health meetings and conferences. The community paramedics also held blood pressure and blood glucose screenings biweekly at a local social club for adults living with mental illness called A Place 2 Belong and at the Salvation Army.

Outcomes
Over the course of the grant period, the community paramedics employed by Ringdahl Ambulances worked with a total of 70 clients. Typically, the community paramedics met with each of these clients at least once per week. Clients provided positive feedback, and as a result, providers increased their referrals to the program. This project worked alongside the Accountable Community for Health in the area, which maximized the ability of both projects to address the broad needs of clients.

Contact
For more information, contact Will Wilson at will. wilson@state.mn.us or 651-201-3842.

Community Dental Care

Twin Cities Metro
Funding: Round 3 grant

Target population
Low-income, minority and medically underserved families and children in Minneapolis and the surrounding communities.

Program goals
To hire an advanced dental therapist for the Robbinsdale clinic to increase access to dental care among the target population and to improve the cost effectiveness of dental care by performing preventive and restorative procedures, allowing staff dentists to work at the top of their license.

Program summary

To prepare for the onboarding of an advanced dental therapist, Community Dental Care adjusted its electronic health record so it could track services provided by the professional. The organization then hired an advanced dental therapist to work at the clinic, but unfortunately, she left the position shortly after starting. The second advanced dental therapist that Community Dental Care hired completed clinical training at the Robbinsdale clinic and transitioned smoothly. A team of doctors and dentists coached the advanced dental therapist and made sure she was an integrated part of the team. The advanced dental therapist had a desk alongside the doctors and was accepted by the rest of the Community Dental Care staff.

Because the Robbinsdale clinic was new and less well-established, the clinic was not getting as many referrals as anticipated. For this reason, the advanced dental therapist transferred to the St. Paul clinic where she served a greater number of children and families.

Outcomes

Over the course of this grant period, the advanced dental therapist completed 1,527 fillings and stainless steel crowns, 258 sealants, 375 cleanings, 365 fluoride varnish applications and hundreds of other procedures. By providing these services, the advanced dental therapist allowed the other dentists to focus on more involved procedures. Although Community Dental Care intends to continue to employ advanced dental therapist in the future, it continues to explore the most efficient and cost-effective way to use these employees.

Contact

For more information, contact Will Wilson at will.wilson@state.mn.us or 651-201-3842.

CHRONIC
DISEASE

Hennepin County Public Health Clinic

Twin Cities Metro
Funding: Round 3 grant

Target population

Refugee populations in the metro area who have recently arrived in the United States, particularly those from Somalia, Ethiopia, Eritrea and other East African nations.

Program goals

To hire a full-time community health worker to help the large Minneapolis refugee population navigate the health care system, while increasing their knowledge of health prevention and chronic disease management.

Program summary

The Hennepin County Public Health Clinic hired a Somali community health worker who shares the language and culture of the majority of the population served by this clinic. The community health worker helped the clinic's refugee clients navigate the complex health care system, find a primary care provider, follow through with a referral or get a prescription filled. In addition to providing care coordination and referrals to primary care, behavioral health and social services, the community health worker also provided culturally appropriate education regarding healthy lifestyles, diet, weight control and exercise for people with diabetes, hypertension and other chronic health concerns.

Outcomes

After the community health worker started, the Hennepin County Public Health saw more than a 75 percent increase in the number of refugee patients screened at the clinic. In response to this significant increase in patients, the community health worker began meeting with at least one member of each refugee family during the first screening visit with a public health nurse. This allowed the community health worker to efficiently initiate patient relationships while assessing general family supports and challenges.

The community health worker is now a valued member of the care team. At the end of the grant period, the community health worker moved to a two-year limited duration position at the Hennepin County Public Health Clinic, with the goal of a permanent position in the future. Clinical staff have also benefited greatly from the community health worker's perspective and advice on providing chronic disease care and education in a culturally effective manner.

Contact
For more information, contact Will Wilson at will.wilson@state.mn.us or 651-201-3842.

North Memorial Health Care

Central Minnesota
Funding: Round 3 grant

Target population
Members of the Essentia Health Integrated Health Partnership population, specifically those who have asthma. Later the target population was shifted to target people transitioning from hospital to home.

Program goals
To partner with the Essentia Clinics in the Crow Wing County and Brainerd area and hire a community paramedic to work in this rural part of the state.

Program summary
Before this grant program, North Memorial Health Care had a strong Community Paramedics Program in place. However, it tended to focus on urban populations. In order to bring community paramedic services to rural parts of the state, North Memorial Health Care partnered with Essentia Clinics to hire and train two part-time community paramedics and later added a third part-time, experienced community paramedic from the area to deliver care in rural Central Minnesota.

Although the original target audience focused on members of the Integrated Health Partnership population who had asthma, this population had lower engagement and need than anticipated. The community paramedics then shifted their focus to care for people transitioning from hospital to home.

To keep everyone on the same page, the partner organizations held group meetings and weekly care conference huddles. North Memorial Health Care and Essentia Health connected their Information Technology departments. As a result, staff have full access to both electronic health records moving forward. As the program went on, the collaboration continued to shape and mold the operational workflows that outlined their approach to delivering patient care.

Findings and outcomes
In addition to employing successful community paramedics, this grant also helped create a strong partnership between North Memorial Health Care and Essentia Health. At the end of the grant period, these organizations created a contractual agreement for continued community paramedic services in the next year.

Contact
For more information, contact Will Wilson at will.wilson@state.mn.us or 651-201-3842.

Northwest Indian Opportunity Industrialization Center

Bemidji
Funding: Round 3 grant

Target population
Members of the American Indian community residing within the 60-mile radius of Bemidji who need help navigating the health care system.

Program goals
To hire a community health worker who can work as an intermediary between the target population and the health care system to ensure that the member gets connected to proper care.

Program summary

The Northwest Indian Opportunities Industrialization Center used the grant funds to hire a community health worker. The center intended for the community health worker to provide services to Northwest Indian Opportunities Industrialization Center members who have difficulties navigating the local health system or who face barriers in accessing the health care system, such as issues with insurance, billing and other administrative processes.

Findings and outcomes

Northwest Indian Opportunities Industrialization Center experienced challenges getting their community health worker enrolled as a Medicaid provider, which hindered the grant. However, the community health worker did engage medical professionals and tribal community members to facilitate healing for clients across two cultures and also helped make progress towards intertribal dialogue. Lessons learned from hiring and integrating a community health worker are shifting into a new venture for the grantee, and are helping focus planning around culturally appropriate services for the American Indian community in the area.

Contact

For more information, contact Will Wilson at will.wilson@state.mn.us or 651-201-3842.

Open Door Health Center

South Central Minnesota
Funding: Round 3 grant

Target population

Low-income individuals in South Central Minnesota.

Program goals

To hire a community health worker in a federally-qualified health center and integrate community health worker services into the mobile delivery model to provide education, follow-up care, support and resources to low-income and minority people living in rural southern Minnesota.

Program summary

Using grant funds to supplement operational dollars, Open Door Health Center hired a community health worker to join the medical and dental mobile health care teams. The community health worker provided care coordination, education on appropriate use of health care services and promotion of healthy behaviors to patients of the mobile health and dental clinics.

The community health worker spent the biggest share of time conducting follow-up visits for patients with referrals and offering support and resources to patients experiencing challenges related to social determinants of health (e.g., lack of sufficient food or unstable housing). Because the community health worker was bilingual, this information could be shared with patients and their families in English or Spanish.

Outcomes

An existing high demand in these communities for these services made managing the demand for the community health worker an initial challenge. The community health worker had meaningful interactions with more than 150 clients and families, which included ongoing navigation, referral and support. The community health worker successfully built trusting relationships with many patients and their families, which helped increase knowledge of the role. This will continue to have a long-term impact and benefit for Open Door Health Center.

Having a mobile community health worker made a significant difference for mobile medical and dental providers during the grant period, who appreciated having the community health worker on the team.

Contact

For more information, contact Will Wilson at will.wilson@state.mn.us or 651-201-3842.

By hiring a bilingual community health worker and integrating services into the mobile delivery model, Open Door Health Center was able to provide critical support and follow-up care to residents in rural Minnesota.

EMERGING PROFESSIONALS TOOLKIT CONTRACT

MINNESOTA

In order to further support the use of emerging professions, Minnesota released an RFP for vendors to create toolkits to help providers hire and utilize employees in three emerging professions: community health workers, community paramedics and dental therapists. Three toolkit contracts, one for each profession, were awarded in 2015.

WellShare International with the Minnesota Community Health Worker Alliance

Statewide

Target population

Employers and prospective employers interested in hiring a community health worker.

Program goals

To create a toolkit to help providers hire and utilize community health workers.

Program summary

WellShare International, in partnership with the Community Health Worker Alliance, developed a community health worker toolkit. WellShare International has more than 30 years' experience recruiting, training and employing over 8,000 community health worker s in low-resource settings. It has adapted, tested and evaluated its community health worker model in the United States, Southeast Asia, Central America and Africa.

WellShare created and hosts the CHW Peer Network, which includes more than 200 community health worker s who work with Minnesota's diverse populations. The Community Health Worker Alliance was originally formed to develop the standard curriculum for community health workers. The organization now serves as a catalyst, convener, partner and expert for integration of community health workers. Membership includes community health workers their supervisors and employers, and academic institutions that provide the community health worker curriculum.

Findings and outcomes

The Community Health Worker Toolkit provides practical guidance for organizational and practice integration of community health workers. It also helps readers understand the education and competencies of community health workers. Specifically, the toolkit aims to assist employers in

understanding: program planning and stakeholder engagement, emerging scope of practice, roles and responsibilities, education and workplace training opportunities, hiring and onboarding practices, financial sustainability of a community health worker position, return on investment, and evaluation of community health worker program outcomes.

Contact

For more information, contact Will Wilson at will.wilson@state.mn.us or 651-201-3842.

Resources

Community Health Worker Toolkit
WellShare International with the Minnesota Community Health Worker Alliance
Minnesota Department of Health and Minnesota Department of Human Services
www.health.state.mn.us/divs/orhpc/workforce/emerging/chw/2016chwtool.pdf

The Paramedic Foundation

Statewide

Target population

Employers and prospective employers who are interested in hiring a community paramedic

Program goals
To create a Toolkit to help providers hire and utilize community paramedics.

COMMUNITY
PARAMEDIC

Program summary

The Paramedic Foundation includes a group of experts in community paramedicine including an expert on reimbursement and health reform, a leader in community paramedicine education, an early innovator in establishing a local community paramedicine program, a leader in community paramedicine medical direction and emergency medical services (EMS) services, and a former state EMS director and leader in the community paramedicine movement worldwide. Collectively they have helped scores of agencies design and implement a community paramedicine program.

Findings and outcomes

The toolkit contains a series of helpful tools and resources that can be used by a wide variety of stakeholders, but primarily prospective employers interested in hiring and integrating a community paramedic in their organization. The tools are intended to be both actionable and measurable. They are intended to help streamline an employer's decision-making and the successful adoption of a community paramedicine program. The toolkit also includes references, resources and examples to help planners get started quickly.

Contact

For more information, contact Will Wilson at will.wilson@state.mn.us or 651-201-3842.

Resources
Community Paramedic Toolkit
The Paramedic Foundation
Minnesota Department of Health and Minnesota Department of Human Services
www.health.state.mn.us/divs/orhpc/workforce/emerging/cp/2016cptoolkit.pdf

Halleland Habicht Consulting, University of Minnesota School of Dentistry and Normandale Community College

Statewide

Target population

Employers and prospective employers interested in hiring a dental therapist.

Program goals

To create a toolkit to help providers hire and utilize dental therapists.

Program summary

Halleland Habicht and Consulting is a law firm that has worked on various health reform issues. The organization collaborated with the University of Minnesota School of Dentistry and Normandale Community College, which is part of Minnesota State Colleges and Universities, to develop the Dental Therapy and Advanced Dental Therapy Toolkit. Individually and collectively, the organizations have a history of collaborating with the Minnesota Department of Health, the Department of Human Services, the Safety Net Coalition and Minnesota Oral Health Coalition on various dental issues and projects including the enactment of the dental therapy law, working with the Minnesota Board of Dentistry on education and licensing for dental therapists, and developing public program reimbursement policies.

Findings and outcomes

This Toolkit provides information for prospective dental employers to help them assess the potential benefit of hiring a dental therapist and, if they decide to hire one, to shorten the learning curve by providing information and resources that will be useful in recruiting and hiring a dental therapist and integrating them into their dental teams.

Contact

For more information, contact Will Wilson at will.wilson@state.mn.us or 651-201-3842.

Resources

Dental Therapy Toolkit

Halleland Habicht Consulting, University of Minnesota School of Dentistry and Normandale Community College

Minnesota Department of Health and Minnesota Department of Human Services

www.health.state.mn.us/divs/orhpc/workforce/emerging/dt/2017dttool.pdf

DENTAL
THERAPY

FOOD SECURITY SERVICES GRANT

MINNESOTA

Significant drivers of health and health care costs are outside the scope of health care alone. Unmet health-related social needs, such as food insecurity and inadequate or unstable housing, may increase the risk of developing chronic conditions, reduce individuals' abilities to manage chronic conditions, increase health care costs and lead to avoidable health care utilization. The purpose of this grant was to help a food security service provider facilitate nutrition referral services in a health care setting and collect data on the impact of nutrition services on patient and system outcomes.

Second Harvest Heartland

Isanti, Anoka, Chisago and Dakota counties;
St. Cloud area; Twin Cities Metro

Target population

People who are food insecure, focusing specifically on people with diabetes and lipid metabolism disorders.

Program goals

To improve food security among hungry people, improve patient outcomes and demonstrate the return on investment of food security interventions.

Program summary

Second Harvest Heartland partnered with two Integrated Health Partnerships to implement four related but distinct food security interventions. First, Second Harvest Heartland partnered with CentraCare Health to conduct a food intervention research study. This study measured the effect of a monthly supplemental healthy food intervention combined with clinical specialty care and education on secondary health outcomes and health care costs in diabetic and lipid metabolism disorder patients at CentraCare Health.

The second intervention tested the effects of a Prevention Health Desk program at CentraCare Health. Through this intervention, clinical staff worked to integrate social determinants of health into standard health screenings and appointments. They then "prescribed" resources such as food, housing and employment assistance - similar to how a doctor prescribes medication.

The third intervention established and expanded Second Harvest Heartland's electronic infrastructure to help identify and recruit food insecure families, in partnership with Hennepin County Medical Center's Analytic Center of Excellence.

Finally, work from the third intervention was used to inform a randomized control trial with 300 food insecure diabetes patients to be operated by Second Harvest Heartland and Hennepin County Medical Center.

Findings and outcomes

Early in the study, Second Harvest Heartland recognized that it was crucial to have correct contact information in the electronic medical record. In response, staff created an updated database of patient contact information on the medical provider's behalf in order to reach patients eligible for food insecurity services.

So far, both the research study and the Prevention Health Desk program at CentraCare Health indicated a greater need to address food insecurity for CentraCare Health's patients. Second Harvest Heartland and CentraCare Health are currently discussing additional programming and food resources to make available in the clinic setting for all patients who need food resources.

Contact

For more information, contact Alexandra de Kesel Loftus at alofthus@2harvest.org.

HEALTH INFORMATION EXCHANGE AND DATA ANALYTICS GRANT PROGRAM

The goals of this grant program were twofold. First, to support Minnesota's market-based health information exchange approach by developing better ways to securely exchange health information between and among organizations. This includes data about specific transactions to support care coordination and population health.

Second, the grant supported data analytics to better integrate and aggregate clinical, administrative and financial data to inform decisions. Six organizations received grants.

Integrity Health Network

Carlton County

Target population

The residents of Carlton County.

Program goals

To enable admission, discharge and transfer alerts across Carlton County Connect partners to improve care coordination, connect to a state-certified Health Information Organization, and standardize use of admission, discharge and transfer alerts in the care coordination workflow.

Program summary

The Carlton County Connect project includes 13 participating organizations. These organizations represent a broad spectrum of health care delivery in the county including clinics, public health, long-term care, behavioral health and social services. In order to enable admission, discharge and transfer alerts across the partners, this grantee implemented a product across hospitals (Mercy Moose Lake and Community Memorial) and across all partners.

The team is still working to identify a sponsor in the community to lead the Health Information Origination portion of the grant. The community meets monthly to identify, define and resolve any challenges collaboratively.

Findings and outcomes

Integrity Health Network suggests having both a community sponsor for the project, as well as an IT lead who understands and can sustain the ongoing work. Integrity Health Network also recommends keeping messages simple and consistent so all partners can benefit from the project work and lessons to develop best practices.

Integrity Health Network found that identifying leadership in the communities upfront when embarking on this type of a grant could impact the speed of the deliverable.

Contact

For more information, contact the Minnesota Department of Health's Office of Health Information Technology at mn.ehealth@state.mn.us or 651-201-5979.

Lakewood Health System

Cass, Crow Wing, Morrison, Todd and Wadena counties

Target population

The patient population served by the Lakewood Health System in the counties of Cass, Crow Wing, Morrison, Todd and Wadena.

Program goals

To implement enhanced data analytics projects in order to increase patient monitoring, improve care management and increase patient engagement.

Program summary

Lakewood Health System hired a consultant to help build registries and organize the quality measurement system. These registries align with the Minnesota Community Measures and will help Lakewood Health System monitor compliance with accountable care goals. This additional monitoring will allow the organization to better evaluate its intended outcomes and enhance the quality care provided to patients. Lakewood Health System also chose to purchase Crimson, a software platform that will enable the organization to perform data analytics with its current IT staffing.

In order to better engage and connect with every patient, Lakewood Health System increased the patient base in the patient engagement platform. Funding from this grant also trained staff in how to use these technologies to manage care.

Findings and outcomes

Lakewood Health System found that recruiting and retaining qualified IT staff is a challenge in rural

Minnesota, especially for data analytics. Software to assist in population health management is key in helping with the needs of patients. Lakewood Health System recommends that other rural health providers look closely at software packages to help with data analytical needs when faced with hiring challenges.

Contact

For more information, contact the Minnesota Department of Health's Office of Health Information Technology at mn.ehealth@state.mn.us or 651-201-5979.

Lutheran Social Service of Minnesota

(Altair Accountable Care Organization)

Anoka, Dakota, Hennepin, Ramsey and Washington counties

Target population

6,800 people with intellectual and developmental disabilities currently being served by the Altair Accountable Care Organization (ACO).

Program goals

To identify areas of risk for individuals receiving services and to tailor services to help reduce barriers and total cost of care.

Program summary

With SIM funding, Altair ACO added data-driven events to its e-Health system, including admit, discharge and transfer messages and change in medication notifications. With this expansion, Altair ACO can analyze population health data at a very granular level. For instance, Altair ACO can now track which medications affect behavior, the impacts of those changes, and the barriers Medicaid recipients experience due to certain social determinants of health. By aggregating this data, Altair ACO will be able to better identify areas of risk for individuals receiving services and tailor services to help reduce identified barriers and total cost of care.

Funding also supported the health information exchange to ensure that any updates for an individual's care plan get sent to directly to service providers and the individual's care coordinator.

Findings and outcomes

Lutheran Social Service and Altair ACO found that user acceptance testing was helpful for participating organizations. Lutheran Social Services' software vendor kicked off the data analytics project with a large, cross-sector stakeholder meeting (including nonAltair ACO members). Having providers from within the same geography but different disciplines, including primary and acute care, behavioral and mental health, aging services, social services, and home health, in the same room was useful for discussing the problems that each face around data and data goals and highlighted a variety of new approaches.

Contact

For more information, contact the Minnesota Department of Health's Office of Health Information Technology at mn.ehealth@state.mn.us or 651-201-5979.

Minnesota Community Health Network

Twin Cities Metro

Target population

People who have serious mental illness or substance abuse disorders within the 11-county metropolitan area.

Program goals

To begin development of population health management in the behavioral health domain.

Program summary

This project moved through four phases. First, a population health readiness evaluation assessed care coordination assets and resources in Minnesota Community Health Network agencies.

Information systems and assets were analyzed and opportunities to leverage health information exchange were identified.

Second, Minnesota Community Health Network then used the findings from the evaluation to structure an approach to care management. This involved an exploration of key collaborative initiatives, establishment of a population health workgroup, utilization of information systems to capture care management activities and outcomes, and consultation on software application issues.

Third, Minnesota Community Health Network facilitated discussions on care management and population health among its members and staff. At these community meetings, staff members reviewed the results of initial data analysis findings. Minnesota Community Health Network then utilized a collective consensus decision-making process to identify at least one population health initiative to focus on. From there, staff explored timelines and resources needed to implement improvements.

Finally, Minnesota Community Health Network began developing a strategy for client attribution and population segmentation. The organization created mapping rules to help assign attributed clients to care. It also began finding ways to better segment care coordination interventions and develop a client registry.

Findings and outcomes

Minnesota Community Health Network found that it is important to build the strategic vision for how data analytics and population health management can improve the health of clients and reduce the total cost of care. The organization also found that it is important to build a short-term implementation plan that includes small manageable steps that demonstrate value to partner agencies, ensuring they stay engaged in the initiative. Minnesota Community Health Network also recommends including subject matter experts in specific domains on the program team to participate in the population health meetings.

Contact

For more information, contact the Minnesota Department of Health's Office of Health Information Technology at mn.ehealth@state.mn.us or 651-201-5979.

Northwestern Mental Health Center

Crookston

Target population

People aged 45 and older who receive long-term care (6-12 months), supports (2 or more) and services either in a facility-based setting or within the rural northwest Minnesota community.

Program goals

To expand a care coordination model to improve engagement with patients and communication among partners.

Program summary

Northwestern Mental Health Center used funding to expand participation. This expansion allows all counties who are part of the Northwest Minnesota Council of Collaboratives to connect to the Health Information Organization and provide coordinated care. Currently, the Health Information Organization representative participates in monthly meetings to provide updates on progress, address challenges and further refine the ongoing work plan. Representatives of Kittson, Mahnomen, Marshall and Pennington counties also participate in monthly board meetings and monthly care coordination team meetings and provide orientation to the overall project and logistics.

Northwestern Mental Health Center plans to replicate the care coordination process with these expanded counties and continue to pilot their workflow by securing and implementing a health information exchange coordination tool. They will continue the onboarding processes to gather data from partners prior to beginning analytics.

Finally, the center plans to purchase the up-front data analytics package to improve population and community health outcomes.

Findings and outcomes

Northwestern Mental Health Center found that the process to get everything started within the original timeline can take longer than anticipated. The organization also found that participating partners' competing projects can generate competition for staff and electronic health record vendor resources.

Contact

For more information, contact the Minnesota Department of Health's Office of Health Information Technology at mn.ehealth@state.mn.us or 651-201-5979.

INFORMATION
EXCHANGE

Southern Prairie Community Care

Marshall

Target population

Patients served by Northern Minnesota Network clinics, often those who face transportation barriers in this rural part of the state.

Program goals

Southern Prairie Community Care will work the Northern Minnesota Network to facilitate health information exchange implementation.

Program summary

Southern Prairie engaged the electronic health record vendor for Northern Minnesota Network clinics to understand the electronic health record's specific interoperability requirements. From there, Southern Prairie Community Care and the Northern Minnesota Network worked through the technical requirements and validated use cases for the project. The team also captured functional requirements and confirmed basic assumptions to create the statement of work and interface requirements. Lastly, the team purchased the necessary admission, discharge and transfer alerts and continuity of care interfaces for the Northern Minnesota Network.

Findings and outcomes

Within the first three months of the grant period, Southern Prairie Community Care had onboarded an additional six organizations. This was the organization's first opportunity to onboard clients. Southern Prairie Community Care found that when onboarding new organizations, it is helpful to engage the participants' electronic health record as soon as possible. If they do not have the necessary interfaces, it may require a six to eight week turnaround for those interfaces to be installed.

Contact

For more information, contact the Minnesota Department of Health's Office of Health Information Technology at mn.ehealth@state.mn.us or 651-201-5979.

Additional health information exchange resources

For more information about health information exchange, visit the resources below. You may also find helpful information related to health information exchange in the "Additional e-Health Resources" and "Additional Privacy, Security and Consent Resources" sections in this directory.

Health Information Exchange Resources website
Minnesota Department of Health
www.health.state.mn.us/e-health/hie/index.
html#resources

The Minnesota health information exchange website has general information about health information exchange as well as activities, resources, state-certified providers and more.

Getting the Information Needed for Better Health: Using Electronic Health Information Exchange in Minnesota
Minnesota Department of Health and Minnesota e-Health Initiative
http://www.health.state.mn.us/e-health/hie/docs/factsheet.pdf

This easy-to-read fact sheet walks through some of the health information exchange basics. Why do we need health information exchange? Who does it benefit? What are health information exchange options in Minnesota?

Minnesota Health Information Exchange Framework and Guidance to Support Accountable Health
Minnesota Department of Health and Minnesota e-Health Initiative
http://www.health.state.mn.us/e-health/hie/docs/hieframework.pdf

The Health Information Exchange Workgroup, chartered by the Minnesota e-Health Initiative Advisory Committee, was tasked to develop a framework to promote accountable health in Minnesota. This document provides recommendations for health information exchange to help support and achieve accountable health.

Health Information Exchange in Minnesota
Anne Schloegel, Minnesota Department of Health; Joe Wivoda, National Rural Health Resource Center
Minnesota Rural Health Conference, 2016
https://minnesotaruralhealthconference.org/sites/default/files/2016/presentations/5E.%20HIE%20and%20Care%20Coordination.%20Schloegel%20Wivoda.pdf

This PDF presentation highlights many of the challenges and successes of health information exchange in rural Minnesota. It also walks through a few solutions, recommendations and best practices for implementing e-Health initiatives across the state.

Connecting to Statewide Health Information Exchange in Minnesota (PDF)
Anne Schloegel and Melinda Hanson, Minnesota Department of Health
www.mnhima.org/Webinar_ConnectingtoStatewideHIEinMinnesota_01_31_2017.pdf

This PDF presentation walks through how and why providers should connect for statewide health information exchange. It touches on many of the advantages, limitations, progress, gaps and challenges of the current HIE system. It also highlights how health information exchange work can help to advance the Minnesota Accountable Health model and provides resources for getting involved in health information exchange work.

INTEGRATED HEALTH PARTNERSHIP DATA ANALYTICS GRANTS

Eligible applicants for this grant had contracts with the State to participate in the Integrated Health Partnerships (IHP) program, which aims to improve the quality and value of care provided to people served by public health care programs. In order to advance data analytics within these Integrated Health Partnerships, each IHP accountable care organization was expected to use grant funding to integrate, aggregate or use clinical, administrative and financial information in organization and provider decision-making processes in a systematic and meaningful way. IHPs were able to partner, employ or subcontract with other organizations in order to accomplish their proposed projects. The grants ended September 2017.

Allina Health

IHP

Minneapolis

Target population
Members of the Medicaid population receiving primary care services from the Allina Health IHP.

Program goals
To create tools to manage, inform, track and measure quality initiatives for the attributed population; evaluate the impact of specific interventions; and develop a comprehensive cost model for the Allina Health IHP population.

Program summary
Courage Kenny Rehabilitation Institute published a case finding and outcomes dashboard for IHP attributed patients. This dashboard integrates a patient's electronic health record, DHS care management report and claims data into one comprehensive tool.

Courage Kenny also created an IHP "flag" on the Allina inpatient census dashboard. This flag allows providers to identify IHP attributed patients in the hospital in real time. The flag immediately notifies primary care clinic care coordinators if an IHP patient has been admitted to the hospital. Using risk predictors from the care management report and inpatient utilization, Courage Kenny created a top 50 list of the highest risk IHP patients.

In July 2016, Courage Kenny began working in partnership with the wider Allina IHP toward shared goals and objectives for the data analytics grant project. In order to maintain consistent processes for planning, implementing and measuring interventions across all Allina Health IHPs, IHP leadership developed a governance structure, including an analytics work group and an operations work group. After the Allinawide IHP data was successfully loaded into the Enterprise Data Warehouse, IHP leadership developed an analytics structure that includes stakeholders from all three Allina Health IHPs.

Health Catalyst, an analytics vendor, helped load claims data into the Enterprise Data Warehouse. Unfortunately, Allina found that within claims data, an individual member can have multiple recipient IDs that may map to a single medical record number in the Allina Health system. Health Catalyst developed a new matching algorithm to create a better match between the member file and the medical record number and the team worked hard to match and validate data. As a result, duplicate claims flowing into the IHP data repository have been corrected and validated.

Findings and outcomes
The Allina Health IHP influenced how accountable care organizations are set up within the Allina Health system. This project also helped identify opportunities specific to Medicaid patients as well as broader opportunities that may have an impact on Medicaid patients. In addition, this project helped foster deeper and more sophisticated relationships between Allina's operations teams and the Health Catalyst team.

Contact
For more information, email Melissa Hutchison at Melissa.Hutchison@allina.com.

Children's Hospitals and Clinics of Minnesota

IHP

Minneapolis

Target population
Members of the Medicaid population receiving primary care services from the Children's Hospitals and Clinics of Minnesota IHP.

Program goals
To facilitate the transformation of data into information that will advance care coordination, clinic and provider-level reporting, data mining and population health research. To identify IHP patients in data systems and incorporate a risk stratification tool that is appropriate for a pediatric population.

Program summary
In order to improve the match rate of patients in the electronic health record, Children's contracted with Concord Consulting to implement the QualityStage software. This software helps match IHP population data with Children's data. It identifies IHP patients, flags them and pulls the flag as well as the IHP data into a data warehouse. Using this data, the project worked to develop reports and tools in Qlickview that could help reduce emergency department utilization, reduce patient no-show rates and generate Clinical Risk Group-based reporting for clinics, providers and care coordinators.

Findings and outcomes
With the QualityStage matching software, Children's achieved a 94 percent match rate between IHP population data and Children's data. The data and risk stratification tools help identify pediatric populations that can benefit from targeted support. Additionally, the dashboard data developed through this grant support and inform discussions with Children's Health Network. Children's also adjusted the grant to account for the staffing required to teach providers and electronic health record users how to use the dashboards and tools.

Contact
For more information, email Theresa Duffy-May at Theresa.Duffy-May@childrensmn.org.

Essentia Health

IHP

Duluth

Target population
Members of the Medicaid population receiving primary care services from the Essentia Health IHP.

Program goals
To hire a dedicated IHP data analyst, create the programming needed to match IHP enrollees to their patient record and create processes for use of tools, registries and reports for care managers and the IHP accountable care organization contract manager.

Program summary
Essentia hired a data analyst to download and manage the IHP care management data. Although matching patients in Epic (Essentia's electronic health record vendor) took longer than Essentia anticipated and required significant manual work, all IHP enrollees were eventually matched with their online Epic electronic medical record. Essentia hired a nurse care manager to organize and develop workflows within the Epic Healthy Planet registry. The nurse care manager also works on creating algorithms for identifying high-risk enrollees in order to offer them preventive care.

Findings and outcomes
Through this work, the nurse care manager identified many high-risk patients and made positive interventions in their care. Essentia also completed a dashboard to track the nurse care manager's work and impact, and hopes to continue enhancing the dashboard to include sociodemographic and other data.

Contact

For more information, email Catherine VonReuden at Catherine.VonRueden@EssentiaHealth.org.

Federally Qualified Health Center Urban Health Network (FUHN)

IHP

St. Paul

Target population

Members of the Medicaid population receiving primary care services from the FUHN IHP.

Program goals

To integrate electronic health records and other relevant clinical data into a population health data integration system; use software to develop data-driven care coordination algorithms, workflows and processes; and equip and support each of the 10-member federally qualified health centers in understanding and using the data.

Program summary

With the help of Optum, FUHN's administrative services partner, FUHN created an identification and stratification tool with interventions that focus on avoidable emergency department utilization, diabetes care management, asthma management, and pain management and opioid use. All care coordination staff were trained on how to use the tool and apply the standard FUHNwide interventions.

In fall 2016, FUHN hired a project manager who completed an assessment of the health information technology capacities at each FUHN clinic. FUHN then helped each clinic develop an individualized health information technology work plan. The project manager also provided consultative expertise in selecting a new data analytics vendor and organizing a FUHNwide Health Information

Technology Committee to steer the development of FUHN's health information technology efforts.

Findings and outcomes

From more than 33,000 patients, the identification and stratification tool isolated 2,278 patients for intensive care coordination services.

The difficulty in selecting data analytics and health information exchange vendors and the need to coordinate with other state and federal grants delayed FUHN's work plan and timeline. This resulted in shifting a portion of the resources toward the Optum work.

Implementation of the FUHNwide health information technology work will continue after the end of this grant program.

Contact

For more information, email Deanna Mills at mill1310@umn.edu.

Hennepin County Medical Center (HCMC)

IHP

Minneapolis

Target population

Members of the Medicaid population receiving primary care services from the HCMC IHP.

Program goals

To improve HCMC's ability to identify social determinants of health in its population, specifically housing insecurity; to use this data to focus resources and target appropriate interventions; to enable front-line caregivers to target appropriate interventions to those identified through analytics as needing them; and to evaluate the effectiveness of predictive models and resulting workflows through an IHP performance dashboard.

Program summary

HCMC hired a project manager who met with key stakeholders to understand the status of the project then drafted a work plan to ensure accountability for deliverables on a timely basis. With this plan in place, HCMC built and implemented provider dashboards in Epic (its electronic health record vendor) that included risk stratification tools. Using the Risk Adjusted Panel Platform, HCMC created a model for dashboards that includes an insecure housing indicator. HCMC also trained more than 300 providers on how to use the Epic dashboards and formed multidisciplinary, multi-setting work teams to share how each area uses the dashboards and scorecards.

Through this collaborative work, HCMC determined how to best fit the insecure housing indicator into the workflows, resulting in a new optimized model. This allowed HCMC to decide where the insecure housing indicator should be located in the data warehouse, form sub-tier attributes and establish a plan to ensure that the data warehouse is sharing the information with the provider-facing medical record.

Findings and outcomes

The work helped bring multidisciplinary work teams together on behalf of patients, in particular, the sometimes disparate in-patient and clinical teams. The training and peer-learning portions of this work resulted in useful tips about patient indicators and dashboards, which resulted in an immediate return by saving one to two hours per day. In addition, this project helped pull resources together to work toward longstanding opportunities, e.g., the dashboard development and the optimization of these tools.

Contact

For more information, email Marceil Luedtke at Marceil.Luedtke@hcmed.org.

Lakewood Health System

IHP

Staples

Target population

Members of the Medicaid population receiving primary care services from the Lakewood Health System IHP.

Program goals

To advance a mineable data warehouse by hiring staff to import IHP claims into Lightbeam Health Solutions, convert current electronic health record databases to Epic and use analytic findings to improve care coordination and health outcomes.

Program summary

Lakewood Health System worked with Lightbeam Health Solutions in order to proactively manage patient care and build out a functional data warehouse. Lakewood also held additional Epic training for IT staff members in order to improve knowledge of data structures and improve the analytic capabilities of report writers and informatics staff. Lakewood also validated patient rosters in Lightbeam (using Catalyst) and created a working appointment extract from Epic that feeds into Lightbeam for providers to have daily snapshots created of upcoming patients in Lightbeam.

Findings and outcomes

Through this grant, Lakewood Health System promoted a deeper understanding of the Epic database system among its staff members. This allows Lakewood to extract the data it needs, load it into the data warehouse and mine the data and analytics around patient subsets. The organization can now look at ways to roll out a care coordination model for patients with a high-risk score and impact that score through the data warehouse.

Contact

For more information, email Joe Reycraft at joereycraft@lakewoodhealthsystem.com.

Mankato Clinic

IHP

Mankato

Target population

Members of the Medicaid population receiving primary care services from the Mankato Clinic IHP.

Program goals

To better understand the population served through the IHP program, develop strategic partnerships, explore health information exchange integration and create an electronic feed to integrate multiple data sources into the electronic health record.

Program summary

Mankato Clinic created a database infrastructure to more efficiently store and query large amounts of claims data. The clinic also completed an extraction, transformation and loading process for all current IHP data files, establishing an initial link to the internal electronic health record database. With these reports in the database, Mankato can start performing data analysis. With this ability in mind, Mankato began planning potential use of IHP data and created outlines for potential reporting projects.

Mankato also started working on additional payer member file extraction, transformation and loading processes to get a more accurate representation of health care utilization.

Findings and outcomes

All IHP reports are now stored in the database and there is a 99.5 percent patient match. Next steps involve researching strategies to best use the warehouse for data analysis and patient intervention.

Contact

For more information, email debraa@mankato-clinic.com.

SIM dollars supported IHPs by funding the advancement of data analytics programs to drive insights on improving cost, care and quality.

North Memorial Health Care

IHP

Twin Cities Metro

Target population
Members of the Medicaid population receiving primary care services from the North Memorial Health Care IHP.

Program goals
To create functionality for the OptumOne tool to be used for the Medicaid IHP population and to fund internal efforts to identify care delivery costs and subsequent data analysis.

Program summary
Because each affiliate partner of North Memorial operates a different electronic medical record, North Memorial chose to use the OptumOne tool since it is able to aggregate data from disparate electronic medical records along with claims data secured from the Centers for Medicare and Medicaid Services. While waiting for the OptumOne installation, North Memorial began stratifying its population in the provider enterprise data warehouse. Once the OptumOne suite was installed, North Memorial began incorporating IHP claims data. A project team created between the Minnesota Department of Health, Optum and North Memorial, along with a claims analyst, helped keep the project focused and on task.

Through this system, North Memorial identified the highest-risk IHP Medicaid patients. From this data, North Memorial implemented a "rising risk" care conference process in order to engage IHP members who demonstrate as high-risk (based on utilization and diagnoses data). The rising risk care process includes cross-sector and multidisciplinary participants who can develop and deploy a comprehensive care plan. Additionally, this program helped North Memorial gain a deeper understanding of cost drivers for the IHP.

Findings and outcomes
The initial technical phase of the work was completed in spring 2017. Operational and clinical stakeholders continue to conduct claims analyses in order to evaluate current initiatives, programs and plans for future strategies to manage the IHP population. Analysis related to population utilization (including primary care, specialty care, hospital and emergency department) is contributing to the development of strategic initiatives across the organization.

As of April 2017, nearly 30 IHP members have engaged in the "rising risk" process. For more information about the rising risk process, see the "Vail Place and North Memorial Hospital (Total Collaborative Care ACH" program summary on page 21.

Contact
For more information, email Megan Banick at megan.banick@northmemorial.com.

Southern Prairie Community Care

IHP

Marshall

Target population
Members of the Medicaid population receiving primary care services from the Southern Prairie Community Care IHP.

Program goals
To implement admission, discharge and transfer alerts for the IHP population; create a population-specific algorithm for the alerts based on real IHP claims data; and train providers to use it. To develop quarterly and annual financial reporting for participating provider systems to measure performance and distribute shared savings.

Program summary

Southern Prairie implemented Nightingale Notes, an electronic health record software solution. This application allows Southern Prairie staff to share data with other members of the care teams. It also provides a framework and data structure that Southern Prairie can use to evaluate the integrated care services provided to IHP members, assess the impact of the work on patient outcomes, identify trends, and inform continuous refinement and improvement in processes and services delivered.

In order to track financial reporting, Southern Prairie worked with an actuary from Forma to develop quarterly reports. These reports have been helpful in understanding the progress of the network overall and highlighting ways to move the needle on cost and quality.

In the spring of 2016, Southern Prairie's primary IT vendor, Sandlot Solutions, announced that it was ceasing operations. Despite this challenge, Southern Prairie moved the project forward through a contract with RelayHealth. The first admission, discharge and transfer interface for public health went into production Nov. 7, 2016, and the first interface for a hospital went into production on November 29, 2016.

Findings and outcomes

The work completed to date has provided critical infrastructure to support long-term data sharing and analytics. The reports produced through the work of the actuary provide more information to inform targeted financial strategies across the network. The reports have also been effective in communicating community progress to a variety of audiences including Southern Prairie leadership, staff, provider network members and consumers. The prospect of the next phase of analytics work is providing an incentive among network members for health information exchange.

Contact

For more information, email William Muenchow at william.muenchow@southernprairie.org.

Wilderness Health

IHP

Two Harbors

Target population

Members of the Medicaid population receiving primary care services from the Wilderness Health IHP.

Program goals

To implement a clinical care medical record module from eClinicalWorks in order to provide analytics, patient engagement and care planning tools, care coordination between providers, risk stratification, and reporting.

Program summary

Wilderness Health worked with eClinicalWorks to pull IHP claims files into a clinical care medical record analytics tool. Wilderness Health staff was then able to review the data and identify diagnosis codes. To determine a validation strategy for the clinical care medical record, Wilderness Health hired a project manager. When Wilderness Health had issues working with the vendor, the project manager worked to track issues on a defect log and put together a vendor management strategy and corrective action plan. This plan outlined a list of expectations, deliverables and response time requirements for eClinicalWorks to follow. Wilderness eventually terminated the contract with eClinicalWorks and signed a new contract with another vendor.

Additionally, Wilderness Health created a Data and Reporting Subcommittee made up of Wilderness members and connected with several other providers throughout the country that are also using the clinical care medical record platform to share tips and experiences. Wilderness also created an emergency room pilot project, which includes ER and primary care provider collaboration for extended follow-up visits scheduled for frequent ER users. The ER pilot work started by connecting St Luke's ER to a primary care doctor.

Data Analytics projects are often long-term investments in infrastructure and processes that resonate throughout a health system's entire organization.

Findings and outcomes

Although the ER pilot project is still small with just a few patients, it has already achieved success with these patients. For instance, one of the patients identified by an ER doctor as needing primary care did show up for their follow-up extended visit with the primary care physician. At the end of the visit, the patient was surprised to learn that they could follow-up with the primary care physician and has now established primary care for their partner as well.

Contact

For more information, email Cassandra Beardsley at Cassandra.beardsley@wildernesshealthmn.org.

Winona Health

IHP

Winona

Target population

Members of the Medicaid population receiving primary care services from the Winona Health IHP.

Program goals

To improve the data analytic capabilities of selected clinical staff, develop repeatable processes for evaluating the attributed population data and implement population health management tools. To expand the scope and scale of community care network processes that use Cerner's data analytic tools (Smart Registries, Dynamic Work Lists, PowerInsight) and HealtheIntent software package.

Program summary

Winona Health signed a contract with Stratis Health for data analytics training and analysis. The Stratis Health team helped revise community care network client tracking methods and integrated this data back into the main IHP Care Management Report. The Stratis Health team also developed a report on recommendations for criteria to be used in community care network candidate selection. The community care network adopted these recommendations to guide their recruitment of new clients.

Through a partnership with Cerner, Winona Health's primary IT vendor, Winona Health implemented Population Health Smart Registries, which provide reports and visual scorecards on individual patients to help monitor utilization, quality and cost trends. In order to improve the data analytic capabilities of Winona Health staff, Cerner held training sessions on its data analytics tools, super-user group meetings and office hours as needed for troubleshooting.

Findings and outcomes

Using the Stratis Health criteria, the community care network admitted 16 new clients since February 2016, a significant increase in admission rate for this program. The first five Smart Registries are now live in the clinic and are helping Winona Health better identify the collective impact special interventions may have on closing gaps in care.

Winona Health also trained physicians and clinical staff, building program competency across many services lines and enhancing access to data and data sharing across the organization. Winona Health did not end up using Stratis as much as anticipated. As a result, DHS accommodated reallocating funds from consultant costs to additional software.

Contact

For more information, email Kelly Fluharty at kfluharty@winonahealth.org.

LEARNING COMMUNITIES GRANT PROGRAMS

ROUNDS 1 AND 2

These grants helped organizations plan, implement, facilitate and evaluate learning communities. For the purpose of this grant, learning communities were defined as teams with common goals or interests sharing best practices and actively engaged in making focused structure changes to advance patient-centered, coordinated and accountable care. Learning communities give care providers tools to improve quality, patient experience and health outcomes while actively engaging communities and reducing health care expenditures as part of the Minnesota Accountable Health Model Grant.

American Academy of Pediatrics, Minnesota Chapter

St. Paul

Target population
Primary care clinics and aligned behavioral health providers and clinics serving children or teens.

Program goals
To implement a pediatric learning community that engages pediatric providers in clinic-based services for integration of pediatric primary care with behavioral health screening, counseling, referral and follow up.

Program summary
This learning community involved six pediatric clinics. In order to learn how to effectively integrate behavioral and mental health issues into pediatric primary care, teams from each of these clinics attended one in-person training conference, watched educational videos and webinars, and participated in monthly learning collaborative and mental health work group conference calls. In addition, each team within the learning collaborative conducted at least two internal audits of their patients to determine how well children and teens with one or more behavioral health conditions are connected to the care they need.

Findings and outcomes
Three of the six participating clinics totally redesigned service access to improve mental health and primary care integration. The average of reported encounters that measured and documented a mental health screen within these six clinics (either Patient Health Questionnaire-2 or Patient Health Questionnaire-9) rose from 61 to 85 percent between the first and second audits. Additionally, three of the clinics saw improvements in the number of patients with a positive screen for a mental health issue or depression who received an on-site or off-site referral.

Contact
For more information, contact MNAAP Executive Director Katherine Cairns at cairns@mnaap.org or 651-402-2056.

Resources
MNAAP mental health website
American Academy of Pediatrics, Minnesota Chapter
www.mnaap.org/mentalhealth.htm

This website contains the training modules and webinars that were created during the grant period. It also hosts other training modules and webinars that may be helpful for those interested in serving children or teens.

Mental Health Tools
American Academy of Pediatrics, Minnesota Chapter
www.mnaap.org/mentalhealthtools.htm

This website hosts a list of helpful mental health tools and resources, including the mental health screening and assessment tools for primary care and the American Academy of Pediatrics' mental health toolkit.

ROUND 1

COMMON GOALS

Center for Victims of Torture

St. Cloud

Target population

War-traumatized refugee populations and Minnesota's newest citizens in St. Cloud, as well as the practitioners and providers who care for these populations.

Program goals

To improve the coordination and integration of behavioral health services for war-traumatized refugee populations in St. Cloud and surrounding areas.

Program summary

The Center for Victims of Torture led numerous focus groups and constituency-specific trainings in order to identify and address the diverse needs of this community. By engaging community feedback throughout the process, the center ensured that every learning topic and next step in the project was determined by engaging community members themselves, with the center acting as a facilitator and technical expert. The Center for Victims of Torture used the Art of Hosting and Harvesting Conversations That Matter methods of facilitation, which was found to be a particularly engaging and welcoming method for facilitating cross-cultural dialogue that includes refugees.

Findings and outcomes

Overall, evaluations indicated improvement among providers in their ability to discuss mental health with refugees, explain how to navigate U.S. systems and make effective referrals. Somali community members indicated improvements in adopting parenting skills in a new culture. Everyone learned more about making appropriate referrals in St. Cloud regarding refugees' multilayered psychosocial, health, legal, occupational, educational and immigration needs. This project also led to the establishment of an ongoing learning community in St. Cloud that includes significant refugee community representation.

Contact

For more information, email AAHassan@cvt.org.

Resources

Refugee Mental Health: Building Trust and a Working Relationship (training webinar)
Center for Victims of Torture and Minnesota Department of Health
www.health.state.mn.us/divs/idepc/refugee/guide/10mentalhealth.html

Project staff presented a statewide webinar Sept, 16, 2015, to pilot curriculum that teaches non-mental health professionals in a health care setting how to open and close brief conversations that touch on mental health with refugee patients. This webinar can be found under "Training Webinar 2: Building trust and a working relationship."

The Art of Hosting
Art of Hosting
www.artofhosting.org

The Art of Hosting is an approach to leadership that scales up from the personal to the systemic using personal practice, dialogue, facilitation and the cocreation of innovation to address complex challenges.

Rainbow Research Inc.

Minneapolis

Target population

Community health workers, community paramedics and other individuals representing health care systems, community clinics, health plans, nonprofit organizations, government organizations and educational institutions as well as community members.

Program goals

To advance patient-centered, coordinated and accountable care through the full integration of emerging professions into the primary care, behavioral health and Minnesota health care delivery systems. To strengthen understanding of community health workers and community paramedics by bringing together stakeholders to build on and contribute to existing work. To identify key issues, outline practical solutions to current challenges, and develop policy and system solutions needed to support the full integration of these professions.

Program summary

Rainbow Research held a kick-off event at the beginning of the grant period. At this event, participants had the option to join four different learning communities, each highlighting a specific area of emerging professions. Ongoing meetings included presentations by various organizations highlighting best practices in addition to interactive components to build cross-sector relationships and promote critical dialogue using Art of Hosting techniques.

After meeting in these teams, Rainbow Research staff conducted follow-up calls to assess what participants had gained by participating in the kick-off event and individual learning team events,

relationships they had built, plans for action and what had happened as a result. Members of the core project team as well as key representatives from each learning team then participated in a strategic summary meeting to review key themes brought up at each event and identify opportunities for continuation of collaborative work between community health workers and community paramedics to identify opportunities to promote continued action and address outstanding needs.

Findings and outcomes

Evaluative surveys given before and after events indicate that this learning community was successful in increasing knowledge, building relationships and moving individuals and agencies towards identifying and taking action. Over the course of the five months, participants identified key challenges facing the emerging professions of community health workers and community paramedics. Members from the Emerging Professions Learning Community helped identify key short- and long-term goals to address each of the five issue areas going forward. At the last event, participants further identified actions steps for each goal and assigned relevant responsible people where possible.

Contact

For more information, contact Research Associate Katie Fritz Fogel at kfogel@rainbowresearch.org or 612.824.0724 ext. 212.

Resources

The Art of Hosting
Art of Hosting
www.artofhosting.org

The Art of Hosting is an approach to leadership that scales up from the personal to the systemic using personal practice, dialogue, facilitation and the co-creation of innovation to address complex challenges.

Learning Community ACH Grant

Learning communities equip care providers to improve quality, patient experience and health outcomes, while actively engaging communities and reducing health care expenditures as part of the Minnesota Accountable Health Model. The Accountable Communities for Health (ACH) grant provided technical support and peer learning opportunities for ACH teams throughout the state.

National Rural Health Resource Center

Duluth

Target population
All 15 of ACH grantees.

Program goals
To train, collaborate with and connect ACH leaders in order to promote peer-to-peer sharing and exchange of tools and best practices.

Program summary
In July 2015, the National Rural Health Resource Center completed a technical needs assessment of the Accountable Communities for Health. From this assessment, the National Rural Health Center developed an 18-month learning plan for the ACHs that featured a series of in-person trainings, webinars, cohort calls and newsletters on topics of interest. ACH team members participated both as learners and contributors. The activities were designed to allow peer-to-peer sharing and exchange of tools and best practices.

Findings and outcomes
The ACH learning community affirmed the importance of peer-to-peer learning through monthly webinars, monthly participant discussions, in-person workshops and customized technical assistance. Each learning session or resource was based on a topic central to the ACH model, such as care coordination, leadership, population health, community engagement and partnership, and governance. The learning community responded to the needs of the ACHs by shifting resources and revising work plans to include an ACH project leader call to increase opportunities for sharing key learnings.

Contact
For more information, email info@ruralcenter.org.

Learning Communities Grant Round 2

Round 2 learning community grant funding focused on quality improvement projects that support the advancement of provider organizations and community partners along a continuum of practice transformation and community care integration efforts. There were three areas of focus: building the foundation for implementation of a health care home model of care delivery in primary care; sustaining and enhancing the health care home model of care delivery in primary care; and advancing community health.

The goal of the second round of learning community grant funding was to provide teams with education, assistance and support to implement a quality improvement project using rapid learning cycles. Rapid learning cycles include four steps: Plan, Do, Study, and Act.

ROUND 2

Institute for Clinical Systems Improvement

West Central Minnesota

Target population
Health care organizations from West Central Minnesota.

Program goals
To improve participating organizations' skills in team development, communication and quality improvement in order to increase their capacity to apply quality improvement skills to transformation efforts.

Program summary
The Institute for Clinical Systems Improvement planned collaborative learning activities so that teams could learn new skills, plan together how to apply them at their organizations, receive coaching and learn new content over time. Two face-to-face events for the learning community teams were held in the region, focusing on education, collaborative learning, networking and goal-setting.

Two webinars for the learning community teams were held between these face-to-face events to promote continued learning and provide coaching. Individualized training was offered to help each organization work toward a specific focus, with team leader advisory calls to give input into planning and ongoing evaluation of all activities. In addition, several organizations participated in on-site training that was offered to increase the flow of information and strategies across the organization.

Findings and outcomes
Participant evaluation responses were highly favorable and had positive outcomes. For example, one organization set a goal to increase completion of forms in the waiting room vs. exam rooms to 80 percent; they exceeded this goal and gained 5.6 minutes of patient-provider time. Another wanted to improve organizational knowledge of quality improvement; they went from 16 percent of their organization being aware of the Plan-Do-Study-Act model to nearly 100 percent. Another organization set a goal to create common scripting for care coordinator first-contact calls, and they met this goal and went on to define meaningful telephone contacts.

The team leaders expressed that this learning collaborative prepared them to take a deeper team approach to their improvement efforts, and it was highly effective. A key learning from this learning community is that people are eager to improve their ability to work as teams on change efforts and leaders are eager for support as they guide their organizations through times of transition. This training modeled how leadership can work with staff to create solutions rather than bearing the burden of having to come up with strategies and then hope for staff "buy-in" and modeled ways for staff to contribute. Having an external organization onsite helped normalize the leadership team's expectations of staff. The training created context and a common language for leaders and staff to practice better communication and improvement strategies and made it accessible for smaller rural organizations.

Contact
For more information, contact icsi@icsi.org.

Resources
Institute for Clinical Systems Team Quality Improvement Learning Community webinar
Janet Howard (Minnesota Department of Health), Tani Hemmila (Institute for Clinical Systems) and Sarah Horst Evans (Institute for Clinical Systems)
http://www.health.state.mn.us/healthreform/homes/collaborative/pastwebinars.html

This webinar presentation provides an overview of the Learning Community activities throughout the grant period. It shares a bit of the training that participating organizations received from the Institute for Clinical Systems, as well as organizations' progress and lessons learned.

Quality Improvement Basics: Simple Tools for Successful Projects
Sarah Horst Evans and Jeyn Monkman, Institute for Clinical Systems
Minnesota Learning Days, 2017
www.hchsimlearningdays.org/handouts/MDH%20Learning%20Days%20-%20ICSI%20QI%20Basics%20-%20FInal.pdf

This PDF presentation highlights how the Model for Improvement's three simple questions can be applied to any quality improvement need, big or small. This presentation also walks through how to use the Plan-Do-Study-Act cycle as a tool to thoughtfully acquire the knowledge and learning needed to create changes that stick. Learn how to empower and engage teams through process mapping, using data to tell your story and addressing the adaptive challenges that come with all improvement work.

Primary Care and Public Health Learning Community Grant

This project sought to advance the work of an existing partnership between local public health and primary care to address shared goals to improve the health and health outcomes of a community. Eligible applicants included community health boards, tribal governments and primary care practices. This grant funding supported local public health and primary care partners' participation in a learning community to share experiences and lessons learned. The strategy of the learning community was to study, apply and build upon best practices for public health and primary care partnership; work with community health and clinical data to identify one or more shared priorities for improving community health; and begin implementation of the plan with an eye on continued partnership and sustainability in meeting community needs.

Morrison-Todd-Wadena Community Health Board

Long Prairie in Todd County

Target population
Clients at Todd County Health and Human Services and CentraCare Health's Long Prairie Clinic.

Program goals
To support local public health and primary care partners' participation in a learning community, to share experiences and lessons learned and to advance current knowledge regarding primary care public health partnerships.

Program summary
Staff from both agencies worked with key community partners and a facilitator hired by the Minnesota Department of Health. Together, these teams worked on strengthening their relationship through expanding understanding of each agency's role, capacity and responsibilities. The teams then developed an implementation plan with all community partners. To develop this plan, the teams used a community health needs assessment and primary care clinic data. The plan focuses on addressing tobacco use within the Prepaid Medical Assistance Program population.

Learnings and outcomes
Through this process, CentraCare Health's Long Prairie Clinic and Todd County Health and Human Services learned how to better partner to advance health throughout the county. One of the biggest learnings that came out of this process was that CentraCare Health was not fully aware of many of the programs, services and workflows that were available through Todd County Health and Human Services. By participating in the learning community, these organizations were able to collaboratively create a referral form and staff workflow. They were also able to develop an integrated tobacco cessation referral process between the organizations. Both teams are looking forward to sustaining this partnership into the future.

Contact
For more information, email Katherine Mackedanz at Katherine.mackedanz@co.todd.mn.us.

ORAL HEALTH ACCESS GRANT
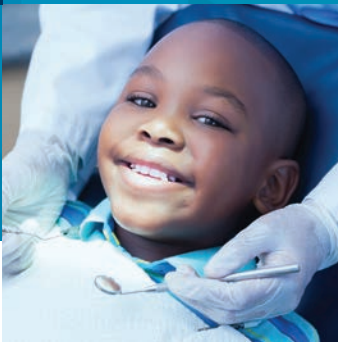
The oral health access grant aimed to support the development and implementation of strategies that increase access to dental preventive care and treatment for underserved populations. Evidence links poor oral health to poor outcomes for chronic conditions such as diabetes and heart disease.

This project focused on whole-person disease management for people with chronic disease with a goal of increasing the integration of oral health and primary care for underserved populations, making oral health care more accessible and achieving oral health equity and improved health outcomes.

Unity Family Healthcare

(doing business as CHI St. Gabriel's Health)
*Little Falls and the Unity Family Healthcare
service area*

Target population
All patients, with a particular focus on low-income patients with chronic conditions and children who need fluoride varnishes.

Program goals
To integrate oral health preventive care within the primary care setting and improve access to oral health care for underserved populations with chronic disease in Morrison County. To support the electronic transfer of records between Apple Tree Dental and Family Medical Center.

Program summary
With grant funding, Apple Tree Dental hired a care coordinator who plays an integral role in managing referrals, helping patients navigate the application process and scheduling care and follow-up services. The care coordinator, Family Medical Center's health navigators and other members of the patient-centered medical home team are developing a process for referrals and the transfer of dental and medical information with the goal of electronic record exchange. This will enable health care providers to better coordinate and exchange and track oral and medical health information.

Family Medical Center began fluoride varnishes as part of its pediatric and well-child visits and education about the connection between oral health and overall health. In addition, a survey gathered baseline information on oral health behaviors, attitudes and barriers patients face in accessing oral health care.

Apple Tree Dental moved into a permanent space on CHI St. Gabriel's Health campus, allowing for additional days of operation.

Findings and outcomes
Patients saw significant benefits from this grant within the first few months of operation. Between January 23, 2017, and March 31, 2017, the clinic was open 14 days, an increase from two days a month to two days each week that allowed 106 patients to be seen with 153 appointments.

Through the end of March 2017, 294 patients from three clinic locations and Apple Tree Dental participated in the survey. This information will be used to develop a program to meet patients' needs.

Additional providers and nurses will provide fluoride varnishes during pediatric visits as the project continues to roll out.

This project inspired collaboration with additional community partners including Morrison County Public Health and Social Services.

Contact
For more information, email Kathleen Lange at kathleenLange@catholichealth.net.

PRACTICE FACILITATION GRANT

Practice facilitation links people with managerial expertise to people in organizations desiring change. Here, two grantees worked with dozens of providers in urban and rural settings on an array of projects, including accelerating behavioral health and primary care integration; using data to improve interoperability; assessing service costs; and developing programs for whole health, chronic care management, health information technology, health care home certification, alternative models of care, quality improvement and total cost of care. Projects built on each organization's existing strengths through in-person meetings, coaching in-person and online with pairs of organizations, and by bimonthly webinars.

Institute for Clinical Systems Improvement

Statewide

Target population
Primary and specialty care providers.

Program goals
To provide practice facilitation with 10-15 primary care and specialty clinics and expand the number of patients served by team-based integrated and coordinated care in Minnesota.

Program summary
The Institute for Clinical Systems Improvement began with one cohort of clinics located across Minnesota. These clinics focused on improving total cost of care, chronic disease management, health care home certification, health information technology, behavioral health integration, alternative care models or general quality improvement.

To identify a second cohort for the practice facilitation, the Institute for Clinical Systems Improvement recruited organizations that were also participating in the SIM Learning Community – another grant project managed by the Institute for Clinical Systems Improvement. Each participating organization completed an initial assessment, a leadership discovery interview with Institute for Clinical Systems Improvement staff and an analysis of strengths, weaknesses and opportunities. Institute for Clinical Systems Improvement then identified some of the "practice facilitation basics" and created webinars in order to educate participants. For instance, webinars included promoting the significance of data in quality improvement projects and educating participants about privacy and security in data sharing. Each webinar concluded with a presentation by a participant who described their project and then answered questions and networked with others.

Findings and outcomes
Practice facilitation contributed to the integration of care in each participant organization as they formed change teams to integrate and improve workflows in their care delivery models. Each of the organizations had very different goals and the impact on patient outcomes varied from organization to organization, however having an opportunity to connect with other teams and share learnings was valued across projects and programs.

One of the key takeaways for all participants was that real improvement takes time. The work is adaptive and requires culture change, as well as technical change.

Contact
For more information, contact The Institute for Clinical Systems Improvement at www.icsi.org/contact_us/ or 952-814-7060

Resources
ICSI Practice Facilitation Resources
Institute for Clinical Systems Improvement and Stratis Health
www.icsi.org/learning__events/learning_center/practice_facilitation/

This webpage contains a series of resources developed throughout the grant period including a video tutorials and related tools to help guide health care organizations through the steps of facilitating and sustaining improvement.

Filling Your Improvement Toolbox: The Shift from Volume to Value
Candy Hanson, Stratis Health; Jeyn Monkman, Institute for Clinical Systems Improvement
Minnesota Learning Days, 2017
www.hchsimlearningdays.org/handouts/Filling%20Your%20Improvement%20ToolboxHCH%20Learning%20Days2017.pdf

This PDF presentation shares practical tools created during the State Innovation Model - Practice

Facilitator program. Health care is constantly changing and the shift to value-based care has been long anticipated as organizations move to better understand value-based payment, including Medicare's Quality Payment Program and how this impacts care delivery. Ensuring that quality improvement is incorporated into patient care and affordability is essential. This presentation focuses on important elements needed to enhance internal capacities for quality improvement activities.

National Council on Behavioral Health

Statewide

Target population

Members of the Minnesota Association for Community Health Centers and members of the Minnesota Association for Community Mental Health Providers.

Program goals

To provide intensive coaching and facilitation for practice change that amplifies existing state integrated health, e-health and accountable care efforts.

Program summary

The National Council on Behavioral Health provided customized coaching, organization-specific consultation and access to resources to 16 organizations for a year. Approximately half of the participating organizations were located in rural or areas, 13 were Community Mental Health Centers and three were Federally Qualified Health Centers.

All 16 organizations completed initial consultation calls with National Council on Behavioral Health coaches to identify strengths, weaknesses and areas they most want to improve. Each organization developed a statement of priority needs and goals for practice facilitation. All participating organizations outlined transformation plans, which were used as the basis for small group coaching calls. Every organization identified at least one practice transformation goal to work toward over the course of the grant period.

Findings and outcomes

Participating agencies focused on defining achievable change and structuring realistic planning and assessment to ensure sustainable progress. Participating organizations demonstrated progress on their goals.

This project also demonstrated the value of a learning community approach for the participating providers, including the opportunity to share experiences and practical strategies for defining change messages, troubleshooting partnership development, and defining health information technology readiness and patient registry needs. Participating providers felt that the knowledge transfer elements of in-person meetings, webinars and coaching met their needs for advancing their understanding of care integration and practice change. Further, participating providers learned to create synergy between developing core messages for various stakeholders and maintaining momentum of goal setting with multiple overlapping initiatives in which they are asked to establish change strategies.

Contact

For more information, contact Pam Pietruszewski at pamp@thenationalcouncil.org or 202-684-7466.

Resources

Practice Facilitation Resource Webpage

National Council on Behavioral Health

www.nationalcouncildocs.net/minnesota-practice-facilitation

This website hosts an archive of the resources, tools and articles shared throughout the grant period. (For instance, the Partnership Assessment Tool, Missouri Registry Measures and Communications Plan Template.)

Substance Abuse and Mental Health Services Administration Resource Hub

Substance Abuse and Mental Health Services Administration

www.integration.samhsa.gov/

The National Council also maintains the Substance Abuse and Mental Health Services Administration Resource Hub. Many of the resources shared on this hub were shared with partner organizations throughout the grant period. This website covers a wide range of topics, including motivational interviewing, partnership building and mental health news.

Consistent feedback from practice facilitation participants was that communication and collaboration between clients, staff, and community partners involves significant time to create change.

PRACTICE TRANSFORMATION GRANTS

ROUNDS 1 AND 2

Minnesota has made significant progress improving health, providing better patient experience and lowering costs through practice transformations such as accountable care organizations (ACOs), health care homes and community care teams. However, millions of Minnesotans continue to experience fragmented, uncoordinated care. This lack of coordination between services can result in poorer health and higher costs.

This is predominantly the case when individuals have complex health issues and a need for mental health, substance abuse or other long-term supports and services.

The Practice Transformation SIM Grant Program sought to expand team-based, integrated and coordinated care. The grants supported the formation and maintenance of team-based care models, such as health care homes and behavioral health homes, integration and coordination across the continuum of care, supports and services, peer-to-peer learning to share best practices, and integration of new emerging professions into the care team. Four rounds of practice transformation grants were distributed throughout the SIM grant period.

Dakota Child and Family Clinic

Twin Cities South Metro and Dakota County

Target population
All pediatric and adult patients primarily within Dakota County and surrounding communities regardless of ability to pay.

Program goals
To upgrade health information technology within the organization by moving all operations to cloud-based applications, including business operations, electronic health records, patient communication, reporting and data analytics.

Program summary
Early on in the process, the Dakota Child and Family Clinic realized that its current infrastructure was unable to support cloud services. During the first half of the project, a lot of time was dedicated to improving internet access, assessing technology needs and ensuring that all aspects of the project complied with Health Information Technology for Economic and Clinical Health (HITECH) and Health Insurance Portability and Accountability Act (HIPAA) laws.

Through engaging a Patient Advisory Council, the clinic developed its online patient portal based on patient needs and concerns about health information technology. To encourage patients to enroll in the portal, the clinic started a monthly drawing for a Target gift card among patients who enrolled and staff with the most number of enrolled patients.

Findings and outcomes
Although the internet-based delays were frustrating at times, navigating this process improved the internet speed and infrastructure within the clinic. This allowed Dakota Child and Family Clinic to handle the increase in online traffic. As a result, documents are now stored in Google Cloud with Elastica security.

After the grant period ended, the clinic began using small, handheld tablets to record patient vitals and review medications. This is possible due to the e-health improvements made during the grant period.

Overall, the clinic increased the privacy and security of data, utilized cloud-based systems to provide 24-hour access and technical assistance, and improved timeliness with communication and information exchanges among patients and community partners. This project demonstrates how small charity clinics can meet the requirements of HIPAA and HITECH without spending thousands of dollars for systems that do not meet the needs of the clinic.

Contact
For more information, call Executive Director Gretchen Moen at 651-209-8640.

Guild Incorporated

Twin Cities metro

Target population
People 16 and older with mental illness of a serious or persistent nature.

Program goals
To prepare and implement a behavioral health home.

Program summary
Before applying for this grant, Guild Incorporated joined the Behavioral Health Home First Implementers Group. With funding, Guild Incorporated established a behavioral health home implementation team. The team met at least once a month to determine ways to adapt the behavioral health home model to fit the organization, form a work plan, and review necessary standards and staffing requirements. Additionally, the project manager, quality and informatics specialist, and IT manager collaborated to build a client registry. This registry helps Guild Incorporated facilitate integrated care, expand information exchange activities with other community partners, and increase the collection and

ROUND 1

reporting of physical health data stored in electronic health records. Clients were invited to provide input into the primary care integration plan, which will help to inform future processes.

Findings and outcomes

Although behavioral health home implementation was delayed at the state level, Guild Incorporated's changes to the electronic health record, creation of a client registry and increased contact among staff and primary care providers enhanced the ability to manage the patient population and formed a useful foundation for future care integration moving forward. Guild Incorporated is now a certified behavioral health home.

Contact

For more information, email Beth Allen at ballen@guildincorporated.org.

Murray County Medical Center

Southwest Minnesota

Target population

Diabetic patients with primary care physicians at Murray County Clinic.

Program goals

To enroll the diabetic population in Southwest Minnesota in care coordination services while redesigning the workflow for all care coordination patients.

Program summary

For this project, Murray County Medical Center in Slayton hired two licensed practical nurses in order to focus on enrolling and coordinating care for the diabetic population. The medical center also developed a diabetic education plan to be incorporated into all diabetic focused visits. To ensure that diabetic patients are up to date on lab tests, education and preventive care, the medical center created a diabetic order set. To efficiently

and effectively connect diabetic patients to these services, the clinic established a standardized workflow for referrals to diabetic education, charting of data and information exchange.

After this grant, workflows were designed so that important patient information is located in one central area. As a result, staff know where to locate the information and providers do not need to search through the chart in order to locate the desired patient information.

Findings and outcomes

As a result of this grant program, communication and coordination improved between the clinic providers, nurses, care coordinator and diabetic educator at the Murray County Medical Center. At the end of the grant period, 164 diabetic patients had a current diabetic flow sheet on file in their chart. Of the total diabetic clinic population, 10 percent enrolled in care coordination through the grant. At the end of the grant period, 22 percent of the diabetic population was receiving care coordination services. Additionally, people with diabetes who are served by the clinic have been provided with tools and contact information to help them self-manage their diabetes effectively.

Contact

For more information, call Naomi Samuelson at 507-836-1359.

Native American Community Clinic

Twin Cities metro

Target population

Urban Native American people.

Program goals

To increase capacity to identify patients for health care homes care coordination, enhance integrated services for patients, and ensure coordination and improved service delivery in all health services.

Program summary

One of the team leads at Native American Community Clinic met with 10 staff members involved in the health care home at the clinic. From the insights and feedback found in these interviews, Native American Community Clinic created a work plan and established a new workflow for clinic processes. Native American Community Clinic also implemented weekly care coordination meetings that include providers, care coordinators, behavioral health staff, patient advocates and quality improvement staff to discuss health care home process changes.

In order to work toward continued improvement, Native American Community Clinic formed two committees. A quality care committee met every month to discuss quality improvement. A patient advisory committee met quarterly and provided feedback on clinic policies, processes and education materials through email in between meetings.

Findings and outcomes

In the new integrated care workflow, all patients who visit the clinic are eligible for care coordination. The integrated care staff sits in an accessible location, proactively screens the patient schedule and tells providers if they identify someone who may benefit from behavioral health services. This revised intake process is a more proactive method for integrating care. Because of the inclusion of staff representatives from all departments in the care coordination meetings, several new procedures have been implemented to improve patient care, such as an improved transition process for pediatric patients to transition to adult providers and the implementation of a drug screening with every pregnancy test to address substance abuse issues if needed.

Contact

For more information, email Shannon Fahey at sfahey@nacc-healthcare.org.

Sanford Luverne Medical Center

Rock County

Target population

Patients diagnosed with diabetes and depression in the Rock County area.

Program goals

To improve outcomes and compliance for patients diagnosed with diabetes and depression by implementing advanced medical home principles to add a striated model of care coordination, promoting the use of staff at the top of their license, improving depression screening and disease management, and improving routine and preventive diabetes surveillance.

Program summary

Sanford Luverne Medical Center moved a medical assistant into the role of a care coordinator assistant, responsible for managing some of the clerical paperwork from the nurse health coach. The care coordinator assistant was also trained to update and pull information from patient registries to identify potential at-risk patients using Epic HealthyPlanet, Sanford Health's electronic medical record. The care coordinator assistant could then refer these patients to the nurse health coach for additional review and risk stratification, using the standard Minnesota tiering.

Additionally, during the first half of the grant period, key staff members were trained in the concept of motivational interviewing and clinical interpretation of the Patient Health Questionnaire-9, a tool for screening, diagnosing, monitoring and measuring the severity of depression.

Findings and outcomes

Even after the grant period ended, the care coordinator assistant continued to work in this area. The care coordinator assistant's activities were even expanded to identify and coordinate care for patients with other chronic diseases. Because much of the clerical work is now done by the care

coordinator assistant, the nurse health coach sees more patients, allowing staff to work to the top of their license. Additionally, the staff education funded by this grant reinforced each team member's role and responsibility in ensuring the internal process for implementation of the Patient Health Questionnaire-9, notation of it in charts and proper communication of results.

Over the grant period, Sanford Luverne Medical Center increased health coach visits by an average of 9.5 per month, or 0.81 per day. The care coordinator assistant made an average of 115 calls and 27 appointments each month - resulting in the nurse health coach averaging seven appointments per day. In addition, the number of patients with a depression diagnosis on the registry increased from 67 in February to 81 by the end of the grant period in July. The clinic's average Optimal Diabetes score also increased from 38.1 percent in February to 48.1 percent in July.

Contact

For more information, email Clinic Director Laurie Jensen at Laurie.jensen@sanfordhealth.org.

Program summary

In order to plan and test the VisForms software, South Lake Pediatrics formed a workgroup with the director of business systems, the director of quality improvement and two care coordinators. This group met weekly to review progress on VisForms, workflows and protocols. Unfortunately, South Lake Pediatrics never reached a point where it could efficiently manage a population of patients with the VisForms program. For this reason, the clinic decided to discontinue its relationship with Visualutions.

Through working with the VisForms workgroup, South Lake Pediatrics determined that it could use Excel spreadsheets to create better reporting and develop stronger workflows to ensure better patient care. Care coordinators were trained to use pivot tables in Excel in order to create reports, track referrals and ensure data integrity. South Lake Pediatrics worked with an outside consultant to develop registries and reports in order to measure quality.

EFFICIENT
TRACKING AND RECORDING

South Lake Pediatrics

Minnetonka

Hennepin, Wright, Scott and Carver counties

Target population

Individuals from birth to their 23rd birthday and their families in Western Hennepin, Wright, Scott and Carver counties.

Program goals

To create a more efficient method of tracking and reporting data and improve the overall quality of the referral process and care coordination services. To test and implement the VisForms software from Visualutions Inc., a product that enables workflow tracking for care coordination.

Findings and outcomes

Despite facing challenges with its original vendor, South Lake Pediatrics improved its registry and increased efficiency among care coordinators. Through improving its Excel spreadsheets, staff updated workflows, protocols and reports for the depression and anxiety registry. Additionally, the improved spreadsheets are now capable of measuring quality. South Lake Pediatrics is now able to track how many patients have had referrals to counseling and have also had a mental health emergency room visit or inpatient stay.

Contact

For more information, call Director of Quality Maria McGannon, APRN, CNP, IBCLC, at 952-401-8300.

Assembling a quality improvement team with representatives from all departments is recommended to ensure comprehensive practices are designed for staff and patients to improve health outcomes.

South Metro Human Services

(now Radias Health)

Twin Cities metro

Target population

Adults with serious mental illness, the majority of whom struggle with a co-occurring substance use disorder.

Program goals

To lay the foundation for future work as a behavioral health home. This includes hiring a consultant to help convene consumers and other stakeholders, redesigning clinical systems work and developing new data-collection or management tools.

Program summary

South Metro Human Services, now Radias Health, worked with staff members to understand their data collection needs for behavioral health home certification. South Metro Human Services then created a work plan and a communications plan that focused on improving the patient registry and sharing information with United Family Health.

South Metro Human Services worked to bring medical, pharmaceutical and dental services on site. Through reaching out to different providers in the community, South Metro Human Services identified United Family Health as a primary care partner and Genoa as a pharmacy partner. They also worked to increase knowledge about health information exchange, patient registries and effectively migrating to a new electronic health record.

Findings and outcomes

Since receiving the grant, South Metro Human Services successfully negotiated partnerships with co-located primary care and pharmacy services and has made progress on integrating dental care. By attempting to locate primary care, a pharmacy and dental services in the same location as behavioral health services, staff made significant progress toward their vision of becoming a more integrated provider that can offer holistic, person-centered care to clients through partnerships with other providers.

South Metro Human Services also monitored and participated in the behavioral health homes process to understand the pros and cons of moving ahead as a behavioral health homes provider. The increased knowledge about health information exchange and patient registries will help South Metro Human Services effectively share information with partners as they come online.

Contact

For more information, email Terry Schneider at Terry.Schneider@radiashealth.org.

University of Minnesota Community University Health Care Center

Twin Cities metro

Target population

Low-income residents of the Phillips Community in South Minneapolis, including immigrants; refugees; non-English speaking residents; people and families who lack insurance or access to primary care; individuals and families experiencing racial, cultural, language or socioeconomic barriers to care; and other vulnerable individuals.

Program goals

To ensure that patients with complex and comorbid medical or mental health conditions receive expert, team-based, integrated and coordinated care via a care coordination team; become recertified as a health care home; and align health care home recertification efforts with behavioral health home efforts.

Program summary

The University of Minnesota Community University Health Care Center hired a consultant who met with nurse care coordinators and psychosocial care

managers. The consultant helped these staff members build and refine their skills in transitions of care, individual care coordination and panel management.

To ensure that the health care center met all needs for health care home recertification, an administrative team met on a regular basis to ensure that all procedures were up-to-date. In addition, every staff member received training on care coordination efforts and any changes to the team.

In order to streamline care, a care coordination team worked closely with the information services director to explore revisions in the electronic health record. Together, they developed a registry and panel management log. This allows care coordinators to use a "clinical event manager," an electronic tool to manage their panel and stay current in outreach. This tool allows care coordinators to track data on reducing unnecessary emergency room use, increasing clinic visits, increasing patient satisfaction and increasing clinical outcomes consistent with Minnesota Community Measurements. This also helps the care coordinators follow up with every patient.

Findings and outcomes

Near the end of the grant period, the health care center signed an agreement to become a certified behavioral health home first implementer. This funding allowed the health care center to make significant improvements to its care coordination processes. The health care center now reaches 100 percent of patients with follow up if they have been in the emergency room or hospitalized. Additionally, the health care center received a lot of positive feedback from patients who use care coordination services.

Contact

For more information, email Grants and Program Manager Sara Bolnick at boln0002@umn.edu.

Well Being Development

Northeast Minnesota

Target population

The adult population of about 12,000 residents in rural Iron Range communities (the population served by the Essentia Health-Ely Clinic and Ely-Bloomenson Community Hospital), focusing specifically on people with behavioral health issues.

Program goals

To develop an actively involved and engaged community care team behavioral health network to address unmet behavioral health needs in rural Iron Range communities and increase the integration of medical and behavioral health in the region.

Program summary

Well Being Development focused on developing a behavioral health network and strengthening collaborative relationships among member agencies, originally including Well Being Development, Essentia Health-Ely Clinic, Range Mental Health Center, Ely Bloomenson Community Hospital and Vermillion Community College. After working with a legal consultant, Well Being Development decided to organize the behavioral health network as a health care network (as opposed to a HIPAA Organized Health Care Arrangement or a legal entity).

Each month, a behavioral health network governance group met to develop, review and accept procedures and policies. The group kept minutes from these meetings and sent regular progress reports to all behavioral health network members. Well Being Development also conducted interviews with board members, an organizational network analysis and a survey for governance group members to gain feedback from all key stakeholders.

Well Being Development engaged local consumers in planning discussions to assess needs and concerns about care coordination and crisis treatment. From this research and feedback, the behavioral health network planned and implemented a pilot.

In order to better integrate care, adult rehabilitative mental health services workers attended primary care appointments with their clients.

Findings and outcomes

Although pilot participation numbers were lower than planned, participating consumers and staff reported positive outcomes, including better communication between patient and provider as well as higher satisfaction with appointments in post-pilot interviews.

As a result of these practice transformation activities, the behavioral health network built a strong governance group with regular attendance by group members. These activities also increased communication among administrators from member agencies, identified gaps in continuity of care and led to the development of policies and protocols to enable coordinated care.

Contact

For more information, email Well Being Development Executive Director Jenny Uhrich at jennyu@ elynlc.org.

Resources

Expanding Missions of Rural Community Care Teams: Accomplishments and Challenges
Minnesota Learning Days 2017
Pat Conway, Essentia Institute of Rural Health; Heidi Favet, Essentia Health-Ely Clinic; Jenny Uhrich, Well Being Development
www.hchsimlearningdays.org/handouts/ Expanding%20Missions%20of%20Rural%20 Community%20Care%20Teams.pdf

This PDF presentation focuses on strategies to successfully establish, grow and sustain behavioral health networks. Topics include building value for network members from various disciplines, making evaluation an asset, and overcoming challenges and barriers to networks.

Zumbro Valley Health Center

Southeast Minnesota

Target population

Underinsured and uninsured people in Southeast Minnesota.

Program goals

To complete health care home certification and implement an integrative staffing structure that transforms the culture of care and treatment for clients with complex needs.

Program summary

Zumbro Valley Health Center developed a patient registry tool to collect clinical and other uniform data. This tool allows providers to identify clients with comorbid conditions and evaluate specified outcomes.

In May 2015, Zumbro Valley Health Center successfully became a certified health care home. In order to assess client understanding and needs for an integrated health model, the health center conducted focus groups. They also developed a centralized document called One Care Plan that pulls together all of the health care services a patient receives at Zumbro Valley Health Center and stores it in one place. Through this new process, Zumbro Valley Health Center ensures that all providers on a client's care team have access to treatment results.

To increase understanding of team-based care principles for staff, Zumbro Valley Health Center held mandatory training sessions for all staff on the key features of an integrated care model.

Findings and outcomes

Through this grant, Zumbro Valley Health Center staff now seamlessly view treatment information from other programs, enhancing the team-based approach to care and providing visibility to other care received. In addition, the primary care clinic staff uses the patient registry tool for all patient appointments, ensuring key preventive care needs get met through the monitoring of this tool.

TEAM
APPROACH

The grant provided funding for the tools and health care home certification that helps bring together staff into care teams critical to treating the myriad health, behavioral, social and other needs of clients.

Finally, the organization learned key lessons from the two focus groups conducted, including the importance of care received within a single setting, satisfaction that clinicians speak with one another and the types of services clients want to receive at Zumbro Valley Health Center, including nutrition, chiropractic care and vision services.

Contact
For more information, call Sean Rice at 507-289-2089.

FirstLight Health System

Pine and Kanabec counties

Target population
Residents of the Pine and Kanabec counties, which are communities with high levels of poverty and unemployment.

Program goals
To develop a care coordination leadership team, become a certified health care home, support work flow redesign within each of the care coordination programs and improve Medicare billing.

Program summary
FirstLight Health System formed a leadership team that met regularly to help guide the grant process and create policies and procedures. To learn more about how to design an effective care coordination program, this team completed a study of specific care coordination team tasks, reviewed literature and models, and communicated with a Critical Access Hospital who successfully implemented a similar program.

As a result of this research, FirstLight Health System created a 24-hour phone line with access to the care team. When a new patient is enrolled in care coordination, they receive a magnet with the 24-hour phone number. FirstLight Health System also educated charge nurses and health unit coordinators on this process. Additionally, First Light formed a Patient and Family Counsel. This group of 10 community members meets once a month to share feedback on health care home quality goals, marketing materials and program growth.

Findings and outcomes
FirstLight Health System became a certified health care home in June 2016. By the end of the grant period, staff was coordinating care for more than 107 patients. Additionally, the 24-hour phone line was fully implemented and worked well when used. Through this line, the team developed effective communication with patients with frequent phone contact and education about the use of MyChart.

Care team patients shared positive feedback about the quality of care and felt that coordination had improved. In a study of care team patients, FirstLight Health System found that more than 48 percent had health care directives completed at the end of the grant period.

Contact
For more information, email Diane Bankers at dbankers@fl-hs.org.

Practice Transformation results include improvements in work flow, access and quality of care, information exchange with patients and community partners, and clinic capacity.

Fraser

Anoka, Hennepin and Ramsey counties

Target population
Children of all ages with mental health disorders.

Program goals
To support Fraser's work to become a behavioral health home that will help remove barriers to the integration of care.

Program summary
Fraser was an active participant in the Behavioral Health Home First Implementers Group. To learn more about the information systems available for creating a successful behavioral health home, Fraser hired a consultant from Advocate Consulting LLC. This consultant completed an information systems evaluation, which identifies opportunities and gaps in the current information systems platform and suggests opportunities for improvement in the management of information.

Fraser formed a behavioral health home leadership team. This team met weekly to develop and discuss a project management plan. Fraser also provided staff training about behavioral health home goals and processes, how to identify eligible clients and the process to make referrals through the electronic medical record.

Fraser also developed a marketing plan for parents, staff and primary care providers. Potential eligible clients received letters introducing behavioral health homes and a handout of frequently asked questions.

Findings and outcomes
This process improved documentation in the client electronic medical record. The additional staff training and focus on expanding e-health helped team members understand that the electronic medical record is a whole-health record. Staff have gained a new appreciation on the importance of capturing a client's medical health information in a coordinated system, so that information may be viewed and shared with key staff members. This learning has integrated medical health with mental health and helps team members provide comprehensive, coordinated, family-centered care.

Contact
For more information, email Fraser Integrated Health at integrated.health@fraser.org.

Lac qui Parle Clinic

La qui Parle and Big Stone counties

Target population
The clinic serves Lac qui Parle and Big Stone counties, including the rural communities of Madison, Marietta, Louisburg, Bellingham, Dawson, Nassau, Ortonville and Boyd.

Program goals
To transform the practice into a patient-centered medical home by pursuing certification as a health care home.

Program summary
Lac qui Parle Clinic is a family practice, rural health clinic attached to a 12-bed Critical Access Hospital. Lac qui Parle Clinic formed a project management team that held weekly leadership meetings and monthly medical staff meetings. These teams worked to develop policies and processes for patient screening, communication and triage. Lac qui Parle Clinic educated its Madison hospital staff members and patients on the processes for after-hours care and next-day appointments at the clinic.

During this grant period, Lac qui Parle Clinic began using the Epic electronic medical record to identify patients who may benefit from coordinated care. The care coordinator then works one-on-one with these patients. Each care coordination patient received educational materials in a binder that explain in detail how they can access their health care home 24 hours a day, seven days a week.

Lac qui Parle Clinic also formed a health care home community connection team, made up of community organizations, patients, community resources and members from the organization.

In addition to an active patient registry, Lac qui Parle Clinic developed registries specifically related to its diabetic patients and those currently prescribed opioids. This helps the clinic monitor patient care and aids in future quality of care projects. Because the clinic and hospital are physically attached and share the same electronic medical record, all members of the care team have access to patient care plans and medical records.

Findings and outcomes
At the end of the grant period, the care coordinator was coordinating care for six patients. As a result of the staff training and education efforts, everyone understands patient-centered care. This has allowed the clinic to look closer at areas where it could continue to improve and expand its care coordination efforts. It also encouraged providers and nurse teams to take ownership of their panels, even if not coordinated care patients, to work on better outcomes for all.

Before this grant, the clinic had somewhat siloed care. Now greater collaboration exists between hospital and clinic staff including better communication, referrals of potential clients and emergency room follow up. The development of the health care home community connection team created a broader sharing of ideas, helping to generate plans for future projects.

Contact
For more information, email Nurse Clinic Manager Kris Monson at kmonson@mlhmn.org.

Lutheran Social Service of Minnesota

(Altair ACO)

Anoka, Dakota, Hennepin, Ramsey and Washington counties

Target population
People with intellectual or developmental disabilities who live in rural and metropolitan Minnesota and their parents, guardians and case managers.

Program goals
To implement a project management team with team development and planning to ensure that clients' behavioral health needs are met by offering a full range of "disability competent" behavioral health services. To include behavioral health services in Altair ACO primary care and incorporate quality improvement activities into its behavioral health practice.

Program summary
Altair held biweekly meetings for all of its ongoing SIM projects, monthly and bimonthly in-person meetings with the Altair executive director and practice facilitator, ongoing meetings of a behavioral health advisory team, and monthly check-in meetings with the Minnesota Department of Health. To promote care coordination across the community, the project team became familiar with practices in place for coordinating care through Altair. The team then researched additional practices that would benefit Altair's behavioral health care coordination.

A survey gathered data from clients who have an intellectual or developmental disability and have interacted with the behavioral health system and their guardians and family members.

Findings and outcomes
The survey recorded 17 responses and the results were used to form recommendations for the next steps involved in this initiative. It also allowed client voices to be represented in Altair's work.

This collaboration helped initiate increased cross referrals so clients receive more holistic services. It has also enabled clients to access several service elements that are important to their mental health, such as case management, psychosocial skills (adult rehabilitative mental health services), individual psychotherapy, family psychotherapy, skills group (dialectical behavioral therapy or other), medication management and reconciliation.

The grant brought together clinicians from many diverse organizations to discuss best practices and different methods that have been successful in their clinical practice. Through working to meet the objectives of this grant, Altair discovered that only a few mental health providers in the Twin Cities community (and beyond) felt both confident and competent in providing behavioral health services to this population. This gap was addressed early on through a training guide discovered and endorsed by the group.

Contact
For more information, call George Klauser at 612-805-6910.

Mankato Clinic, Ltd.

Blue Earth and Nicollet counties

Target population
Patients who are medically ill with comorbid psychiatric illness and patients who are primarily psychiatrically ill with high costs of care due to utilization patterns.

Program goals
To design a model of care delivery that focuses on integrating and coordinating care, increasing access to care for patients with primarily psychiatric needs, and developing a care plan that is transferable across organizational settings.

Program summary
At the beginning of the grant period, Mankato Clinic developed a project charter to clearly identify different strategies that the clinic intended to use. This included many steps, such as assessing the feasibility of becoming a behavioral health home, expanding access to behavioral health care and participating in the Lake Superior Quality Innovation Network's Institute for Clinical Systems Improvement project.

A project team worked to draft a strategy for increasing patient access to services. This led to the development of a new model of care that includes access to urgent evaluation and triage by a psychiatric nurse or behavioral health therapist. This model also includes integration of a psychologist as part of the primary care team.

To better coordinate care, Mankato conducted needs assessments for both internal and community providers. Mankato also identified community partners (Blue Earth County) to explore options for electronic transfer of patient information.

Findings and outcomes
Based on the needs assessment, the clinic was able to form new strategies for increasing patient access internally. It also began to actively work with Blue Earth County Behavioral Health team members to develop a care coordination model that will improve communication and coordination processes with the ultimate goal to decrease unnecessary utilization, improve patient satisfaction and improve clinical quality outcome measures for their shared population. Mankato Clinic then began looking at data to define the population and identify gaps and trends.

Although having different electronic health record systems was a barrier for effective health information exchange, the relationship that Mankato developed with Blue Earth County Behavioral Health personnel will allow for continued conversations and evolutions in this area.

Contact
For more information, contact Care Management Manager Emily Goetzke, MSN RN, at emilyg@mankatoclinic.com or 507-385-4118.

Preventing Hospital Readmissions through Effective Transitions of Care (PDF)
Population Health and Care Management Manager Emily Goetzke, MSN, RN, Mankato Clinic, Ltd.
Minnesota Learning Days 2017
www.hchsimlearningdays.org/handouts/
Preventing%20Hospital%20Readmissions%20
through%20Effective%20Transitions%20of%20
Care.pdf

Hospital readmissions can be prevented when transitions of care are well managed. This presentation describes how a partnership among Mankato Clinic, an area hospital and skilled nursing facilities worked to address this challenge. The presentation highlights the development of the partnership and steps taken to promote seamless transitions.

North Metro Pediatrics

Anoka County and the North Metro

Target population
800 underserved children in Anoka County and the North Metro.

Program goals
To provide seamless, comprehensive mental health and medical care to patients with behavioral health needs in a primary care setting.

Program summary
North Metro Pediatrics used the CASIII tool to determine the recommended level of care for mental health patients and efficiently communicate among providers and care coordinators within the electronic health records system. Creating new forms and templates in the electronic health record helped North Metro better align the electronic health records for primary care and behavioral health, allowing nurse practitioners, care coordinators and mental health providers to all access coordinated patient information. In order to assess barriers that patients may face in accessing mental health

services, North Metro issued a survey among the parents of potential patients.

Findings and outcomes
The implementation of additional forms in the electronic medical record allowed North Metro Pediatrics to better coordinate care for clients. It also helped the marriage and family therapist get her work done faster by entering data into the forms instead of freehand typing the information. Survey results about perceived barriers will form strategies for better coordinating care for patients in the future.

Contact
For more information, contact Executive Director Jeff Lundgren at jlundgren@northmetropeds.org or 763-783-3722.

BARRIER
ASSESSMENT

Open Door Health Center

26 counties across Southern Minnesota

Target population
Patients in Southern Minnesota who use Open Door Health Center services.

Program goals
To improve access to care and integration of services by assessing medical and behavioral clinical workflow, evaluating existing integrative processes and procedures between medical and behavioral health services, and building on existing quality improvement initiatives.

Program summary
Open Door Health Center started this project by hiring a consultant from Peterson Habicht. The consultant spent time at Open Door to observe existing workflows, ask questions, interview staff, delve into unclear areas and bring a new perspective to the work that Open Door does. Through this in-depth

observation by the Open Door team and the consultant, Open Door saw a need to better prepare the team to work together toward integrated care. In response, Open Door started an all-staff initiative to improve understanding of the roles of each team member and each department. Each staff member reviewed their job descriptions, clearly described how their role worked within each department for optimum patient care and shared their responses with the rest of the team. Open Door then developed an intranet site for staff to share information, including kudos, success stories, role information, staff pictures with title and biographical information, resources, and commonly used forms.

The administration formed a Process Improvement Committee. This committee reviewed current workflows and opportunities to improve a patient's experience at Open Door Health Center. A Quality Improvement Small Group formed specifically to work on determining quality improvement goals and measurements, strategies, benchmarks to achieve these, and the type and level of involvement or support needed.

Findings and outcomes

This evaluation and modification showed Open Door Health Center that it's headed in the right direction. Though the organization always makes decisions with patients and clients in mind, staff discovered they need to focus some energy on evaluating internal needs. Through this process, Open Door Health Center learned it needed to make significant changes internally to improve staff communication and understanding. Work has begun to communicate with staff about delineated staff roles and departmental and organizational changes, to encourage more collaboration between departments, and to create more awareness and support from leadership and the board of directors.

Contact

For more information, contact Lisa Hoffman Wojcik at hoffmanwojcik.lisa@odhc.org or 507-344-5506.

South Lake Pediatrics

Hennepin, Wright, Scott and Carver counties

Target population

Individuals from birth to their 23rd birthday and families from Western Hennepin, Wright, Scott, and Carver counties.

Program goals

To prepare for behavioral health home certification by designing a workflow process that aligns care coordination activities, getting ready to transition select health care home patients to behavioral health home services and creating an annual budget for the management of behavioral health home patients at South Lake Pediatrics.

Program summary

South Lake Pediatrics formed a behavioral health home oversight committee to help guide and prepare for behavioral health home certification. The oversight committee met every two months over the course of this grant. Multiple monthly meetings also took place among a smaller internal workgroup that included the medical director, director of quality and project lead.

Originally, South Lake Pediatrics intended to use existing staff members in the behavioral health home. It held weekly meetings with the care coordinators to keep them informed and educate them about their behavioral health home roles and responsibilities. Following a behavioral health home site visit, South Lake Pediatrics determined that it would not move forward with the certification process. The current staff did not have the capacity to take on this program, and South Lake did not feel that it could justify adding new staff for a pilot program.

Findings and outcomes

Although South Lake Pediatrics did not decide to move forward with behavioral health home certification, it still developed the workflows and policies

for the behavioral health home program. By going through the initial steps of the certification process, South Lake Pediatrics evaluated its health care home processes and made changes to these policies and procedures.

Contact

For more information, call Director of Quality Maria McGannon, APRN, CNP, IBCLC, at 952-401-8300.

Southdale Pediatric Associates

South Metro, Edina, Eden Prairie and Burnsville clinics

Target population

The entire Southdale Pediatric Associates clinic population, especially focusing on patients dealing with chronic and complex conditions.

Program goals

To work toward health care home certification.

Program summary

Southdale Pediatric Associates created a health care home work group, which held monthly meetings to plan and discuss the grant project.

To work toward greater communication between patients and providers, Southdale Pediatric Associates created a patient access plan. This plan includes a template for patients to write in different phone numbers for their preferred care, including their preferred urgent care, hospital and after-hours care. Care coordinators also worked to track patients by exporting work lists onto a shared drive.

Southdale Pediatric Associates changed the workflows for care planning. By creating a care plan template, care coordinators can pull up-to-date information about their patient's care from within the electronic medical record. To improve the quality of care, staff started encouraging patients to schedule an appointment before leaving the clinic rather than calling the future appointment phone line.

Findings and outcomes

After taking many preparatory steps toward health care home certification, Southdale Pediatric Associates received positive feedback from both patients and providers. With patient work lists now available on a shared drive, providers can make comparisons of workflow processes and see all completed work in one place. The care plan template improved the amount of time previously taken to complete the condition management tool. And since patients opt to schedule their appointments as much as four months in advance, they do not have to worry about forgetting to schedule their next appointment.

At the end of the grant period, Southdale Pediatric Associates continued preparations for health care home certification.

Contact

For more information, call Erin Kortekaas at 952-278-6966.

INTEGRATED
APPROACH

Touchstone Mental Health

Hennepin County

Target population

Underserved, low-income adults with a serious mental illness.

Program goals

To plan and prepare for behavioral health home certification by creating a quality improvement team, developing a plan for design and development of a comprehensive care plan and planning for the development of a health registry.

Program summary

Touchstone Mental Health created a Practice Transformation Team that met eight times over the course of the grant period to discuss program planning and project management. This team worked to define client criteria for participation in the behavioral health home and decided to limit the client size to 100

participants for the first year. This decision helped inform the rest of the implementation planning.

The Practice Transformation Team reviewed all Touchstone Mental Health care plans and looked for similarities and differences to the behavioral health home care plan as defined by the State. Based on this information, the group then developed a care plan assessment and report, process flows for client assessment and follow-up reports.

To develop a health registry, Touchstone Mental Health decided to use its existing electronic health record vendor, Credible. Touchstone Mental Health built the registry to include all items that the Department of Human Services requires for behavioral health homes, as well as specific measures related to blood pressure, tobacco and substance abuse screening.

BEHAVIORAL
HEALTH HOME SERVICES

Findings and outcomes
Touchstone Mental Health made steady, measured progress throughout the nine-month period to reach the point of planning to apply for behavioral health home status. A number of essential questions needed to be worked through in order to prepare for the application, and funding from this grant allowed Touchstone staff to explore these questions.

At the end of the grant period, Touchstone Mental Health continued preparations for health care home certification.

Contact
For more information, call Kathie Prieve at 612-843-2201.

University of Minnesota Community University Health Care Center

Twin Cities metro

Target population
Patients of the Children's Health Team, an initial cohort of 106 children with mental health and medical needs.

Program goals
To implement a project team, improve quality of care, monitor patient health, refine tracking and enhance coordinated care.

Program summary
At the beginning of the grant period, a Children's Mental Health Team comprised of a multidisciplinary group of medical, dental and mental health providers formed out of the broader Children's Health Team. The group collected feedback from the community to learn about strengths, needed improvements and intervention ideas. This group then met to discuss interventions for use with children and goals for moving integrated care forward.

Staff members identified and received training in Yoga Calm, an intervention used with children and adolescents to regulate extreme emotion and advance coping skills. Staff also received training in the evidence-based model TeamSTEPPS, a collection of strategies and tools to enhance team performance and patient safety, and the SOAR method, a visioning and assessment of team strengths, opportunities, aspirations and results. This process, as well as other strategies, helped staff brainstorm how to improve access to services for children engaged in both medical and mental health services and how to increase team-based communication.

Findings and outcomes
This grant allowed the community university health center to solidify the Children's Mental Health team and learn a new intervention, Yoga Calm, to work with children and adolescent patients. Team members have limited time to work on team building, attend retreats and meet regularly - though

these are important aspects of what leads to meaningful practice transformation. Staff members indicated that the trainings and workshops will have a positive impact on how to work better as a team and structure communication.

Contact
For more information, email Grants and Program Manager Sara Bolnick at boln0002@umn.edu.

Zumbro Valley Health Center
Southeast Minnesota

Target population
Underinsured and uninsured populations in Southeast Minnesota with comorbid or co-occurring disorders.

Program goals
To develop electronic medical record-based tools to define populations to be served, create methods to better gauge accurate total costs of care delivery and expand the existing continuous quality improvement program.

Program summary
Over the nine-month grant period, Zumbro Valley Health Center worked closely with its electronic medical record vendor, Qualifacts, to develop a series of new reports and dashboards. Key tools included: population health reports by staff, program and agency reports, and visual graphs of data for quick review by providers.

Zumbro Valley Health Center also developed a multidisciplinary integration team to discuss which existing clients would benefit from an integrated approach. This team, which is led by the organization's care coordination manager, meets multiple times per week to review key cases and identify improvements to the treatment plan. The integration team began piloting a new screening tool designed to assess behavioral health, physical health and key social determinants (i.e., housing, transportation and employment) during the initial meeting with a client. This screening tool will be implemented organizationwide following the pilot and the integration and continuous quality improvements teams will assess and identify improvements to it and the intake process.

Findings and outcomes
This grant, along with Zumbro Valley Health Center's commitment to its integrated care model, has transformed the care delivery process for clients. Through the use of the new electronic medical record-based tools, the associated training and a variety of other initiatives, clinicians have begun using a 360-degree approach to care. Care providers effectively incorporate mental, chemical, physical and dental services as well as programs focused on the social determinants impacting clients.

Zumbro Valley Health Center conducted a study with Wilder Research examining the health and financial outcomes of an integrated care model. This study demonstrated how integrating services resulted in significant improvements in both areas.

Contact
For more information, call Sean Rice at 507-289-2089.

Resources
Outcome Evaluation of Zumbro Valley Health Center Primary Care Service (PDF)
Zumbro Valley Health Center, Wilder Research and the Minnesota Department of Human Services
www.wilder.org/Wilder-Research/Publications/Studies/Zumbro%20Valley%20Health%20Center/Outcome%20Evaluation%20of%20Zumbro%20Valley%20Health%20Center%20Primary%20Care%20Service.pdf

During this grant period, Zumbro Valley Health Center completed a two-year study with the Department of Human Services and Wilder Research to establish cost savings (using actual claims data) to the state for Zumbro Valley Health Center clients using its integrated care model. The study showed a return on investment of $2.63 per $1 spent.

PRACTICE TRANSFORMATION GRANTS

ROUNDS 3 AND 4

Round 3 Practice Transformation Grants were used to support organizations in the Behavioral Health Home First Implementers Group, a learning community of organizations interested in becoming certified behavioral health homes. The behavioral health home model expands upon the concept of person-centered medical homes (health care homes in Minnesota) and makes a more concerted effort through design, policies and outcome measures to serve the whole person across primary care, mental health, substance use disorder treatment, long-term services and supports, and social service components of our health care delivery system. Organizations received grant funds to prepare and apply for behavioral health home certification.

Amherst H. Wilder Foundation

St. Paul East Metro

Target population

Adults and children who access Amherst H. Wilder Foundation's mental health services and who qualify for participation in a behavioral health home.

Program goals

To participate in the Behavioral Health Home First Implementers Group. To bolster the ability to function within a multidisciplinary team by providing training and staff development opportunities that support successful implementation of a behavioral health home. To align staffing, policies and procedures with the behavioral health home model to enhance integration practices and processes. To integrate care teams to include people from multiple domains that have historically worked in silos.

Program summary

In order to plan and prepare for behavioral health homes certification, Amherst H. Wilder Foundation formed an implementation team and cross-program subgroups. These groups worked together to develop workflows, trainings, processes and procedures necessary for implementing a behavioral health home. In order to strengthen the multidisciplinary team, the organization applied the AIMS Center Team Building Process for Integrated Behavioral Health Care. This tool helped staff understand the unique but interconnected roles of team members and create an effective shared workflow that best meets the needs of behavioral health home members. (For more information about this tool, go to the "Additional Practice Transformation Resources" section of this document.)

Amherst H. Wilder Foundation successfully hired a behavioral health home staff team, including an integration specialist and systems navigators.

Findings and outcomes

This process allowed the organization to successfully train the existing staff team on behavioral health home implementation, hire new team members necessary for implementation and apply for behavioral health home certification. The Amherst H. Wilder Foundation was one of the first 13 organizations to be certified as a behavioral health home in Minnesota.

Contact

For more information, email Amy Ward at amy.ward@wilder.org.

Fairview University of Minnesota Medical Center

Fairview Counseling Centers and Fairview Clinics - Integrated Primary Care

Andover, Burnsville, Hiawatha, Riverside Integrated Primary Care, Princeton, Wyoming

Target population

Adults and children who access mental health services at Fairview Clinics Integrated Primary Care and who qualify for participation in a behavioral health home.

Program goals

To participate in the Behavioral Health Home First Implementers Group, create a fully developed and high functioning behavioral health home team, engage key stakeholders, and inform staff about the initiative.

Program summary

Fairview hired a project manager to oversee the planning and preparation for implementing a behavioral health home. The organization also formed a behavioral health home Steering Committee to support behavioral health home hiring, workflows, building electronic medical records, billing, policy development and certification processes among the

ROUND 3

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participating Fairview clinics. This team met every other week and had six small work groups that addressed these different action items.

With grant funding, at least one member of Fairview's staff attended all of the Behavioral Health Home First Implementers Group meetings, Learning Days sessions and other workshops.

Findings and outcomes
Behavioral Health Home First Implementers Group meetings and workshops provided useful training and resources that helped Fairview plan and prepare for behavioral health home certification and implementation. At the end of the grant period, two of Fairview's clinics were certified and three more were in the process of becoming certified, pending the hiring of care coordinators and behavioral health home staff.

Contact
For more information, email Chris Beamish at Cbeamis1@fairview.org.

Fraser

Twin Cities Metro

Target population
Children of all ages with mental health disorders.

Program goals
To participate in the Behavioral Health Home First Implementers Group and prepare for behavioral health home Implementation. To design and implement the electronic medical record infrastructure and clinical workflows to support a behavioral health home.

Program summary
In addition to attending Behavioral Health Home First Implementers Group meetings and workshops, Fraser sent its electronic medical records

manager and trainer to the national Cerner Health Conference. This conference provided valuable information about electronic medical records, new capabilities and relevant updates that needed to occur for Fraser to support and implement a behavioral health home. Fraser built useful assessments into its electronic medical record (Anasazi), including a brief needs assessment and health wellness review. Using the treatment plan template, Fraser also developed a health action plan. Once clients were enrolled, their data became available in the behavioral health home registry. By integrating mental and medical health services, Fraser created new electronic medical record work processes and documentation revisions.

Findings and outcomes
Fraser was one of the first 13 organizations to be certified as a behavioral health home in Minnesota. At the end of the grant period, the program had been positively received by members of the community and the first 40 clients were enrolled. Fraser found that the ability to share relevant information about clients and their families among all team members exceptionally useful.

Fraser has a pediatric focus in population served, which has not fit well with some data tracking for outcomes (e.g. diagnosis related to medications). This prompted the organization to find additional data for outcome tracking that better meets the population served.

Contact
For more information, email Fraser Integrated Health at integrated.health@fraser.org.

Guild Incorporated

Twin Cities Metro

Target population
People 16 and older who have a mental illness of a serious or serious and persistent nature, who access Guild services and who qualify for participation in a behavioral health home.

Program goals
To participate in the Behavioral Health Home First Implementers Group and implement a fully developed, high functioning behavioral health home team. To accurately assess the impact of the behavioral health home rate on the organization, manage the change process for implementing a behavioral health home and develop formal partnerships with primary care providers.

Program summary
Guild Incorporated formed an Integrated Care Steering Committee, which held monthly meetings throughout the grant period. To improve integration efforts across the agency, the Integrated Care Steering Committee developed a communication plan to share information related to integration agencywide on a biweekly basis.

During this grant period, Guild met with multiple primary care providers, though by the end of the grant period, the organization had not formally partnered with a provider. Because many primary care providers did not fully understand behavioral health homes, Guild also developed communication materials to educate and engage potential partners.

Guild spent a large amount of time and energy developing a patient registry and found that this registry significantly improved its ability to manage care by population agencywide.

Findings and outcomes
Guild was one of the first 13 organizations to be certified as a behavioral health home in Minnesota. Now, patients who do not meet the eligibility requirements for targeted case management can be referred to the behavioral health home team. Interest in this team continues to grow as word continues to spread.

The information learned through building and using the patient registry is being used to structure other service lines across the agency.

Contact
For more information, email Beth Allen at ballen@guildincorporated.org.

Lakeland Mental Health Center
West Central Minnesota

Target population
People who access Lakeland Mental Health Center's mental health services and who qualify for participation in a behavioral health home.

Program goals
To participate in the Behavioral Health Home First Implementers Group, develop the policies and procedures needed to become a behavioral health home, and identify and train care coordination teams.

Program summary
Lakeland Mental Health Center participated in all Behavioral Health Home First Implementers Group learning summits, workshops and webinars. Staff participated in monthly calls among provider organizations to hear others share their experiences, questions, issues, concerns and lessons as everyone worked toward certification. In addition, Lakeland Mental Health Center implemented a change management communication strategy to keep everyone at the organization informed about behavioral health home planning and implementation.

By the end of the grant period, Lakeland had hired a nurse integration specialist and was in the process of hiring a systems navigator.

Findings and outcomes
Lakeland Mental Health Center achieved behavioral health home certification. The organization found it valuable to collaborate with other agency staff in order to develop the behavioral health home. This created mutual support, sharing of resources and more diverse ideas for planning and implementation.

Lakeland found it especially helpful to collaborate with other providers located in rural areas of the state.

Contact
For more information, email Donna Baker at dbaker@lmhc.org.

Mental Health Resources Inc.

Hennepin, Ramsey and Dakota counties

Target population
People who access services through Mental Health Resources and who qualify for participation in a behavioral health home, specifically focusing on culturally diverse populations.

Program goals
To participate in the Behavioral Health Home First Implementers Group and ensure all staff members are prepared to provide culturally competent, integrated health care to clients enrolled in the behavioral health home. To increase health literacy throughout the agency and achieve health care integration for clients, specifically those to be served by the behavioral health home team.

Program summary
In order to work toward more integrated care, Mental Health Resources partnered with many organizations. With help from Abbott Northwestern Hospital and four community-based mental health organizations, Mental Health Resources developed a written process and protocol for patients discharged from psychiatric hospitals to the community. Mental Health Resources also developed and implemented a tobacco- and nicotine-use screening tool to use with persons with a serious mental illness. This new workflow assesses client tobacco use on a regular basis rather than just at intake and includes motivational interviewing components to better support clients.

Mental Health Resources held substantial staff trainings to increase health literacy and educate staff about the patient population. Many of these trainings focused on health disparities among the populations the organization serves and the social determinants of health.

Findings and outcomes
Mental Health Resources decided not to become a behavioral health home. After working with consultants and other agencies in the Behavioral Health Home First Implementers Group, Mental Health Resources realized it was very unlikely that the organization would be able to support this program financially at this time. Additionally, Mental Health Resources realized that adding a behavioral health home would be duplicative of the services the organization already offers.

Although Mental Health Resources did not become a certified behavioral health home, this grant allowed staff trainings in a variety of areas and sparked important conversations about addressing health inequities in the community. As a result of the partnership with Abbott Northwestern Hospital, 60 patients connected to medical, psychiatric and community resources after hospital discharge. Since implementation of the new tobacco and nicotine workflow, 16,000 screenings were completed with 2,294 clients by the end of the grant period.

Contact
For more information, call Vice President of Clinical Services Ann Henderson at 651-365-3588.

COUNSELING
RESOURCES

Mental Health Systems PC

Twin Cities Metro

Target population
Persons with mental illness in the Twin Cities Metro.

Program goals
To participate in the Behavioral Health Home First Implementers Group. To hire staff, budget for the program and explore ways to make a behavioral health home financially viable.

Program summary
To prepare for behavioral health home certification, Mental Health Systems PC held trainings on billing, building relationships with other providers and models of care. The Implementation Team held frequent meetings with staff and conducted an internal review of organizational workflows, process and documentation plans.

Over the course of the grant period, Mental Health Systems PC created job descriptions and a preliminary budget. At the end of the grant period, the organization was ready to hire behavioral health home staff.

Findings and outcomes
At the end of the grant period, Mental Health Systems PC had submitted its application for becoming a behavioral health home and was waiting to complete a site visit. This grant allowed the organization to devote time to prepare for all of the needed changes for the new service delivery model of a behavioral health home. Without this added funding and time, Mental Health Systems PC would not have been able to make this kind of progress at this time.

Contact
For more information, email Steven Girardeau at sgirardeau@mhs-dbt.com.

Natalis Counseling and Psychology Solutions

Twin Cities Metro

Target population
Hmong clients and families of Natalis Counseling & Psychology Solutions, which later became Natalis Outcomes.

Program goals
To participate in the Behavioral Health Home First Implementers Group. To train and prepare a Hmong-speaking professional to serve as a cross-cultural behavioral health home systems navigator and improve the quality of connection between Hmong clients and the Natalis clinical team.

Program summary
By participating in the Behavioral Health Homes First Implementers group, Natalis Counseling & Psychology Solutions was able to build relationships with other agencies working toward behavioral health home certification. To connect with the Hmong community, the organization began training some of its experienced multicultural care coordinators to fill the systems navigator positions required in a behavioral health home.

Natalis Counseling & Psychology Solutions also used a "facilitated referral partnership model" in structuring its behavioral health home. In this model, primary care and health home clinic partners play a crucial role in referring existing behavioral health home clients to physical health screenings; alcohol, tobacco and drug use screenings; or cessation services.

Partway through the grant period, Natalis Counseling & Psychology Solutions opted to transfer its first implementer's status to Natalis Outcomes, a co-located comprehensive care management provider and Minnesota Health Care Plan enrolled mental health provider. This change helped to achieve behavioral health home certification and program implementation in a timely manner.

Findings and outcomes

After the first implementer's status was extended to Natalis Outcomes, leadership at Natalis Counseling & Psychology Solutions educated Natalis Outcomes' providers and clients and consulted eligible Minnesota Health Care Plan panelists about the behavioral health home benefits available to them. Natalis Outcomes achieved behavioral health home certification before the end of the grant period. From initial patient feedback, Natalis Outcomes found that the vast majority of its large Hmong panel eligible for and happy about receiving behavioral health home services and support.

Contact

For more information, contact Jeffrey Wigren, MPH, MHA, at Jeffrey.wigren@natalisoutcomes.org or 612-800-6503.

ELECTRONIC
MEDICAL RECORDS

Northland Counseling Center Inc.

Itasca and Koochiching counties

Target population

Adults experiencing barriers to wellness due to mental illness and addiction symptoms.

Program goals

To participate in the Behavioral Health Home First Implementers Group. To educate staff, collaborate with community partners, update the electronic medical record to support behavioral health home implementation, secure staff support for the program, hire the necessary behavioral health home staff and train all team members on their role in the behavioral health home.

Program summary

To learn more about behavioral health home integration, Northland Counseling Center attended the annual Community Health Worker Conference and participated in some of the weekly Behavioral Health Home First Implementers Group webinars.

Northland Counseling Center created clear definitions for each role of the integrated behavioral health home team and trained all staff on the behavioral health home referral process.

Although making changes to the electronic health record took longer than anticipated, Northland Counseling Center got all forms and assessments working effectively in the system. Staff continue to make minor tweaks to make the electronic health record as useful as possible. For instance, many providers were reluctant to refer patients to the behavioral health home because they thought it would create more paperwork on their end. In response, Northland Counseling Center started working on a way to build that information into the electronic health record.

Northland Counseling Center reached out to outside organizations in the community to provide information about the counseling center program. This allowed the organization to build a larger referral network and continue to build awareness and buy-in for what behavioral health homes can do for clients in the community.

Findings and outcomes

Northland was one of the first 13 organizations to be certified as a behavioral health home in Minnesota. Before the end of the grant period, Northland already had a few clients enrolled in the behavioral health home.

Contact

For more information, email Jennifer Thiel at jthiel@ northlandcounseling.org.

Northwestern Mental Health Center

Kittson, Mahnomen, Marshall, Norman, Polk and Red Lake counties

Target population

Individuals with a serious mental illness, particularly depression, who also have a chronic health condition with complex needs.

Program goals

To participate in the Behavioral Health Home First Implementers Group, become a certified behavioral health home and positively impact the health of clients.

Program summary

Northwestern Mental Health Center used a macro, mezzo and micro level approach to shape an action plan for this grant. This approach helped ensure all levels of the organization were included and engaged in the behavioral health home implementation process.

On the macro level, Northwestern Mental Health Center's chief executive officer engaged with the Board of Directors on the behavioral health home, helping guide and approve agency policies. Northwestern Mental Health Center also worked on furthering existing relationships with community partners, including various primary care entities.

On the mezzo level, a team lead and integration specialist participated in many of the Behavioral Health Home First Implementers Group's workshops, webinars, meetings and conferences to build skills in team development, implementation of procedures and process flows.

On the micro level, Northwestern Mental Health Center used "boots on the ground" efforts to focus on team development, individual staff service delivery and behavioral health home implementation. Near the end of the grant period, Northwestern Mental Health Center began implementing team building exercises to strengthen coordination and collaboration among staff members. The organization also decided to purchase online care management and care coordination training modules for all behavioral health home staff to complete.

Findings and outcomes

Northwestern Mental Health Center achieved behavioral health home certification by the end of the grant period and planned to start seeing patients as soon as possible. It was one of the first 13 organizations to be certified as a behavioral health home in Minnesota.

Contact

For more information, contact Shauna Reitmeier, MSW, LGSW, at sreitmeier@nwmhc.org or 218-281-3940.

Range Mental Health Center

Greater Ely area

Target population

People in need of mental health and chemical health services in the Ely community.

Program goals

To participate in the Behavioral Health Home First Implementers Group. To identify partnerships with primary care physicians, integrate activities with these partners, develop a patient registry, create a culture of integration and identify potential clients.

Program summary

Range Mental Health Center found participating in the Behavioral Health Home First Implementers Group to be a useful way to plan for behavioral health home application and implementation. The opportunity to hear what other teams were doing and how they were meeting certification standards helped Range Mental Health Center plan for service development.

Proposed applicants for behavioral health home services certification expressed benefit in participating in the webinars, learning day, and conference calls with other agencies as the opportunities to share ideas, challenges and different tactics were very valuable.

Range Mental Health Center worked collaboratively with the Ely clinic and community care team. These organizations committed to collaborate and helped develop programs and streamline the process for referral and exchange of information. Near the end of the grant period, Range Mental Health was negotiating to house one clinician within the Ely clinic in order to more completely integrate mental health services with primary care.

Findings and outcomes

By the end of the grant period, Range Mental Health Services had completed a policy manual, hired behavioral health home team members and was waiting for confirmation of certification from the Department of Human Services. The team planned to begin September 2017.

Contact

For more information, email Mary Carpenter at mcarpenter@rangementalhealth.org.

Range Regional Health Services

Iron Range and Northeast Minnesota

Target population

People living on the Iron Range and in Northeast Minnesota who are in need of primary care and behavioral health services.

Program goals

To participate in the Behavioral Health Home First Implementers Group in order to build a more robust and connected infrastructure designed to meet the behavioral health needs of the community and surrounding area.

Program summary

From the beginning of the grant period, Range Regional Health Services worked to integrate behavioral health home work into its broader organizational structure. The organization created an integrated behavioral health monthly meeting to engage primary stakeholders and promote coordinated staff partnerships across the organization. Additionally, Range Regional Health Services delivered a preliminary presentation to senior leadership and gained approval to pursue a business analysis.

Range Regional Health used the AIMS assessment and the change assessment. (These tools are linked in the "Additional Practice Transformation Resources" section of this document.) These tools helped the team identify its current abilities, gaps that needed to be filled and stakeholders that should be included.

Range Regional Health Services found input from other first implementers helpful in proposing the behavioral health home to senior leadership.

Findings and outcomes

Through participating in this grant, Range Regional Health Services evaluated its standard practice of care provided to patients. Key leaders researched and received training on how to implement a change in practice model, and using grant funding enabled staff to push toward making these changes. Senior leadership gained interest and many staff members were motivated to learn more about integrated behavioral health.

At the end of the grant program, Range Regional Health Services was on track for behavioral health home certification.

Contact

For more information, email Paula Pennington at ppennin1@range.fairview.org.

Sanford Medical Center, Thief River Falls

Pennington County and surrounding counties

Target population

Patients who have a mental illness.

Program goals

To participate in the Behavioral Health Home First Implementers Group, develop a behavioral health home team and manage the change process for implementing a behavioral health home to create the best possible atmosphere for success.

Program summary

Sanford Medical Center in Thief River Falls created a local, multidisciplinary behavioral health home implementation team that included staff from primary care, finance, administration and behavioral health. The team met bimonthly and as needed in order to identify needs and strategies that one area alone would not have been as successful in doing. Staff also met with local county social service directors to begin building external relationships that could benefit the behavioral health home.

Unfortunately, competing priorities shifted focus away from behavioral health home implementation across the organization. As Sanford Medical Center worked toward certification as an inpatient behavioral health hospital, staff capacity was limited to work on this grant project. However, the team continued to move forward and created many of the necessary workflows and processes within its electronic health record.

Findings and outcomes

The time and energy Sanford Medical Center spent working toward the goals of this program started to shift the care culture within staff. Members of the multidisciplinary team broadened their knowledge of the care that Sanford Medical Center can provide and can now speak to that with their teams. This experience also helped Sanford plan for future projects.

Sanford Medical Center achieved behavioral health home certification Feb. 2, 2017.

Contact

For more information, contact Heather Waldal, RN, BSN, at Heather.Waldal@sanfordhealth.org or 218-683-2735.

South Central Human Relations Center

Steele and Waseca counties

Target population

Adults with a serious mental illness who would benefit from comprehensive care coordination for their health-related concerns.

Program goals

To participate in the Behavioral Health Home First Implementers Group and create a fully developed, high functioning behavioral health home team.

Program summary

Near the beginning of the grant period, South Central Human Relations Center decided to organize a grant action plan around the behavioral health home certification standards. The team also used Kotter's 8-Step Change Model and the Plan-Do-Study-Act model to guide planning and engagement efforts with staff, clients and key stakeholders. (These resources are linked in the "Additional Practice Transformation Resources" section of this document.)

South Central Human Relations Center planned engagement activities for staff and community members, including a Friday forum. More than 45 people attended, including agency staff, health plan representatives and county human services staff. The forum presentation featured a panel of behavioral health home team members and a PowerPoint on South Central Human Relations Center's planned implementation of the behavioral health home. The

organization also looked across programs within the agency to identify areas of duplication and gaps that could be filled by behavioral health home services.

Findings and outcomes

At the end of the grant period, South Central Human Relations Center had applied for behavioral health home certification and was waiting to host a site visit. It was on track for certification.

South Central Human Relations Center found its Friday forum well received, sparking interest among key stakeholders and promoting more internal dialogue about the behavioral health home.

After understanding their role on the team and the significance of implementing a behavioral health home, team members took responsibility for assignments and presenting their progress to the group.

Contact

For more information, contact Carolyn Wheeler at carolynw@schrc.com or 507-455-8101.

South Lake Pediatrics

Hennepin, Wright, Scott and Carver counties

Target population

Individuals from birth to their 23rd birthday and their families in Western Hennepin, Wright, Scott and Carver counties.

Program goals

To participate in the Behavioral Health Home First Implementers Group. To strengthen external partnerships and advance technical capabilities by implementing direct secure messaging.

Program summary

South Lake Pediatrics developed an internal committee to provide oversight during its behavioral health home implementation. In addition, the organization developed a steering committee with external behavioral health home partners and held regular meetings with Relate Counseling Center, Fraser and Prairie Care Institute.

Originally, South Lake Pediatrics intended to implement direct secure messaging with its grant funding. However, after working through the implementation process for this tool, the organization determined direct secure messaging entailed too many financial and operational barriers at the time.

South Lake Pediatrics shifted its goal to developing templates in the electronic health record to support behavioral health home implementation. The team hoped templates would provide South Lake Pediatrics with better reporting capabilities to track needed patient follow-up and ultimately reduce gaps in care. However, as the team continued to work toward behavioral health home certification, they determined behavioral health home implementation to be financially unfeasible at this time. As a result, South Lake Pediatrics used the remaining grant funding to develop templates for care coordination.

Findings and outcomes

Although South Lake Pediatrics decided not to apply for behavioral health home certification, this funding allowed the team to explore this care option and make a fully informed decision. In addition, South Lake Pediatrics successfully created templates for care coordination: a template for postpartum depression follow-up calls and a template for care coordination projects by South Lake Pediatrics' Somali care coordinator. At the end of the grant period, the organization regularly used the templates and found them to be helpful for documenting structured data to run reports. The reports help maintain the patient registry and identify gaps in care.

Contact

For more information, call Director of Quality Maria McGannon, APRN, CNP, IBCLC, at 952-401-8300.

South Metro Human Services

Twin Cities Metro

Target population

Adults with serious mental illness, the majority of whom struggle with a co-occurring substance use disorder.

Program goals

To participate in the Behavioral Health Home First Implementers Group; integrate with primary care, pharmacy and dental care providers; use electronic health record data analytics to improve care and track outcomes; increase engagement and communication with clients; and implement a billing structure for behavioral health services and care coordination.

Program summary

South Metro Human Services (now Radias Health) successfully opened a co-located clinic with United Family Medicine and started seeing clients early in the grant period. The organization also partnered with Genoa Pharmacy to build an on-site pharmacy during this period. Through this partnership process, South Metro Human Services determined that it was not feasible to integrate dental services due to building space limitations, although it continues to have an interest in this partnership in the future.

To work toward behavioral health home certification, South Metro Human Services spent considerable time and energy selecting a new electronic health record. Unfortunately, there were delays in making this switch and South Metro Human Services was unable build the intended reports and data sharing technology with United Family Medicine.

South Metro Human Services chose not to pursue behavioral health home certification in 2016 as intended. After making this decision, the organization devoted remaining grant funding on integrating its services.

Findings and outcomes

The grant funding allowed for progress in service integration, and clients and staff gave positive initial feedback on the co-location of the primary care and pharmacy.

Contact

For more information, email Terry Schneider at Terry.Schneider@radiashealth.org.

Southwestern Mental Health Center, Inc.

Southwest Minnesota

Target population

Adults diagnosed with mental illness or children diagnosed with emotional disturbance within Cottonwood, Jackson, Nobles, Pipestone and Rock counties in Southwest Minnesota, regardless of ability to pay, age, race, creed, ethnicity or background.

Program goals

To participate in the Behavioral Health Home First Implementers Group and meet with other providers in the area to develop a clear understanding of the population needs and develop a plan on how to best achieve expected outcomes and quality health care.

Program summary

Southwestern Mental Health Center participated in many of the Behavioral Health Home First Implementers Group meetings, webinars and events. The team found these meetings helpful and informative.

To work toward behavioral health home certification, Southwestern Mental Health Center created an internal behavioral health home implementation group. This group worked to draft behavioral health home policies and procedures, position descriptions and workflow documents.

Southwestern Mental Health Center partnered with Avera Health to develop a patient registry. The organization also partnered with area hospital, clinic systems and the local Integrated Health Partnership to establish written pathways to greater care coordination enrollment.

Findings and outcomes

At the end of the grant period, Southwestern Mental Health Center achieved behavioral health home certification, pending the submission of a staff plan. Throughout the grant period, the organization met all of its intended objectives, activities and outcomes.

The Practice Transformation Grant allowed Southwestern Mental Health Center to participate in the Behavioral Health Home First Implementers Group training, where staff learned a wealth of lessons about MN behavioral health home implementation. Without this funding, organization would likely have been unable to participate in this group or complete the certification process.

Contact

For more information, call Scott Johnson, MSW, LICSW, at 507-283-9511 or Amy Meyeraan, RN, MSN, at 507-376-4141.

Stellher Human Services Inc.

Becker County

Target population

Clients that access Willow Tree, a crisis stabilization unit, and the county's crisis response services. Willow Tree focuses on serving clients experiencing significant difficulty with daily functioning as a result of mental health crisis or documented need of stabilization to prevent a mental health crisis.

Program goals

To participate in the Behavioral Health Home First Implementers Group and establish a behavioral health home with clients in the Becker County area.

Program summary

Stellher Human Services met with its existing partners to educate them about behavioral health home implementation, create collaborative referrals and transition into this new care model. This conversation evolved into co-locating Stellher Human Services employees in partnering primary health care facilities. Stellher Human Services began using direct secure messaging to efficiently exchange information with key partners.

Stellher Human Services hired a financial consultant to develop a sustainable budget and staffing patterns for the behavioral health home. Although the organization originally intended to hire a site manager, that plan did not work out. However, other dedicated staff members stepped up throughout the grant period to help make the changes needed to meet behavioral health home standards. This ended up being beneficial for behavioral health home planning. Instead of having only a few staff members involved in the process, involving a bigger portion of the team allowed Stellher Human Services to include many voices in the change conversation.

HEALTH
PARTNERSHIP

Findings and outcomes

At the end of this grant period, Stellher Human Services was on track to applying for behavioral health home certification. Through meeting with key partners and involving a large portion of the staff team, Stellher Human Services identified a long list of consumers that may be eligible for behavioral health home participation. Additionally, the organization and its partners began working toward embedding a mental health professional in the hospital emergency room to triage mental health crises and connect eligible clients to the behavioral health home.

Contact

For more information, email Bill Sargent at bill@stellher.com.

Touchstone Mental Health

Hennepin County

Target population
Low-income adults who are underserved and who have a serious mental illness. The majority of people served by the agency live in Hennepin County.

Program goals
To participate in the Behavioral Health Home First Implementers Group to plan and prepare for behavioral health home certification.

Program summary
Touchstone Mental Health received a Round 2 Practice Transformation Grant to begin work on a behavioral health home plan. With Round 3 funding, Touchstone focused on the internal changes needed to implement a behavioral health home.

Touchstone Mental Health stayed up to date with behavioral health home requirements and learned strategies for implementation through participating in the Behavioral Health Home Summit and Behavioral Health Home First Implementers Group activities. Team members also contacted other providers who had already submitted their behavioral health home certification to learn more about the process and ask questions. These agencies provided helpful information for Touchstone Mental Health's project.

Within the Touchstone staff, a behavioral health home team was formed. This team worked to maintain agency communication and educated staff about the behavioral health home model, service description and eligibility.

Findings and outcomes
Working through this grant process helped Touchstone Mental Health think more strategically to determine if a behavioral health home fit the organization and to take a close look at the financial viability of this program. At the end of the grant period, Touchstone Mental Health was on track for apply for behavioral health home certification. After walking through a financial analysis of the program, the Touchstone Mental Health team decided it was best to implement a new behavioral health home in the first quarter of 2017.

Contact
For more information, email Kathie Prieve at 612-843-2201.

University of Minnesota Community University Health Care Center

Phillips Neighborhood in South Minneapolis

Target population
People who are low-income, immigrants, refugees, non-English speaking; people and families who lack insurance or access to primary care; individuals and families experiencing racial, cultural, language or socioeconomic barriers to care; and other vulnerable individuals.

Program goals
To participate in the Behavioral Health Home First Implementers Group and achieve behavioral health home certification.

Program summary
As a participant in the Behavioral Health Home First Implementers Group, the health center attended many webinars and learning conferences. To meet the attendance requirements, the health center developed a cohesive calendar and set of expectations for staff to attend and report back findings to the group. The health center held a total of 14 department meetings to educate the entire staff about the behavioral health home certification and implementation process. In addition, all staff received ongoing communication about behavioral health home goals and progress through the staff newsletter.

The health center provides panel management to its top emergency department users and top total cost

of care patients and could pull eligible patient lists from this data. Each care coordinator manages a list of a specific panel of patients.

In preparation for behavioral health home certification, the health center completed many documents, including a patient registry; behavioral health home procedures, talking points, resource lists and a training checklist; a needs assessment, wellness assessment and health action plan in the electronic medical record; and updated procedures that pertained to behavioral health home workflow.

Findings and outcomes

At the end of the grant period, the health center had achieved behavioral health home certification and was working to implement behavioral health home services. The health center was one of the first 13 organizations to be certified as a behavioral health home in Minnesota.

As a result of this work, the health center was asked to participate in an interview about building and sustaining community partnerships. Staff shared their experience with partner clinics in the neighborhood, including the Native American Community Clinic and Indian Health Board. The health center also established working relationships with partners such as Minneapolis Public Schools, Community Outreach for Psychiatric Emergencies, and detox and housing facilities.

Contact

For more information, email Grants and Program Manager Sara Bolnick at boln0002@umn.edu.

Vail Place

Hennepin County

Target population

Adults 18 and older with serious and persistent mental illness who are in need of ongoing help to obtain or maintain self-sufficiency in the community.

Program goals

To participate in the Behavioral Health Home First Implementers Group, manage the change process for implementing a behavioral health home, create the best possible atmosphere for success and assess the impact of the Minnesota behavioral health home rate on the organization.

Program summary

Vail Place started the grant process by creating a team to lead the development and integration of the behavioral health home. The team worked to establish relationships with health care partners and agencies, educate others about the behavioral health home, and introduce the referral process. The team also presented the vision for the care and referral model to Vail Place's senior management, Board of Directors, agency staff and individuals involved in current programs.

Vail Place worked with its communication consultant to develop an agency communication plan. This plan helped establish ongoing communication about the behavioral health home to all directors, managers, direct line staff and select external stakeholders. Following these conversations, Vail Place decided to add a behavioral health home service line.

Vail Place also secured funding from a foundation to focus on deepening relationships with Accountable Communities for Health partners, test processes similar to those that will be used with the behavioral health home and prepare for a smooth transition to providing behavioral health home services.

Findings and outcomes

The eligibility guidelines for behavioral health home participation are broader than most Vail Place programs, allowing the organization to expand its reach to individuals with serious mental illnesses. Vail Place was certified as a behavioral health home in 2017.

Contact

For more information, contact Shelly Zuzek, LICSW, at szuzek@vailplace.org or 952-945-4250.

Western Mental Health Center

Lincoln, Lyon, Murray, Redwood and Yellow Medicine counties

Target population
People with mental health or related needs in Lincoln, Lyon, Murray, Redwood and Yellow Medicine Counties.

Program goals
To participate in the Behavioral Health Home First Implementers Group in order to educate and train staff in behavioral health home implementation and develop a patient registry.

Program summary
Between two to four staff members from Western Mental Health Center attended each of the webinars and learning days hosted by the Behavioral Health Home First Implementers Group. After each webinar or event, a larger behavioral health home work group met and talked about next steps and lessons to inform the behavioral health home action plan. This kept all team members up to date and ensured that Western Mental Health Center incorporated learnings into each planning step.

In order to create the patient registry that worked best for the behavioral health home, Western Mental Health Center learned about two different models: one with its primary care partner, Avera Marshall, and the other with another community mental health center, Zumbro Valley Health Center. Both registries had some similar elements but were very different in delivery and style. One was based and driven off of an excel spreadsheet and the other was built into the electronic medical record system. Through meeting with both of these partners, Western Mental Health Center was able to narrow its focus and explore what it really needed from its patient registry. In the end, the organization combined the two models to develop a system that would capture data in a meaningful way for its staff and clients. This new system involves gathering patient information in the electronic health record and then transferring it onto an Excel spreadsheet for tracking purposes. From there, Western Mental Health Center began working with its electronic health record software company to create a report that can pull out data to measure outcomes.

Findings and outcomes
Western Mental Health Center was one of the first four agencies to become a certified behavioral health home. Through this process, the health center learned a lot about organizational change, messaging, consistency and standardizing practices across all aspects of the organization. By creating and sticking to a work plan, Western Mental Health Center stayed focused on its work and goals throughout the grant period. The organization plans to continue using a work plan as a tool to implement other programs and initiatives throughout the center.

Contact
For more information, contact Western Mental Health Center Executive Director Sarah Ackerman at sackerman@wmhcinc.org or 507-337-4926.

Woodland Centers

Chippewa, Kandiyohi, Lac qui Parle, Meeker, Renville and Swift counties

Target population
People with mental health needs in West Central Minnesota. Approximately 80 percent of Woodland Centers' clients live below the federal poverty level and receive a 100 percent sliding fee scale reduction.

Program goals
To participate in the Behavioral Health Home First Implementers Group, educate staff, prepare for behavioral health home certification and create external messaging to drive recruitment and enrollment in the behavioral health home.

Program summary

Woodland Centers formed a team to oversee behavioral health home implementation and participation in the Behavioral Health Home First Implementers Group. The implementation team held a weekly two-hour meeting to discuss goals and progress and assign action steps to each team member throughout the grant period. The team also held meetings with external stakeholders to discuss behavioral health homes, how this service will affect their practice and the benefits they may see as a result of the behavioral health home.

Woodland Centers participated in every workshop, webinar and conference hosted by the Behavioral Health Home First Implementers Group. To share the information learned from these meetings and educate staff about the behavioral health home plan, Woodland staff created an informative Power-Point presentation to be presented at internal and external stakeholder meetings. Over the course of the grant period, the Woodland team presented this PowerPoint to every Woodland Centers employee. The BHH Implementation team also held meetings with external stakeholders to discuss BHHs, how this service will affect their practice and the benefits they may see as a result of BHH.

To prepare for recruitment and enrollment, Woodland used its electronic health record to determine how many eligible patients currently receive services at Woodland Centers. Staff then created brochures and handouts for clients and referrals sources as marketing tools.

Findings and outcomes

By the end of the grant period, Woodland Centers achieved behavioral health home certification and had a number of enrolled clients. Woodland Centers was one of the first 13 organizations to be certified as a behavioral health home in Minnesota.

Working through this grant program, Woodland Centers realized how much significant work can be accomplished when everyone works as a collaborative team across the center. This grant also pushed the organization to form and strengthen

relationships within the staff team and among external partners. Woodland Centers anticipates that these relationships will continue to grow along with the behavioral health home.

Contact

For more information, contact Woodland Centers Executive Director Ashley Kjos at ashley.kjos@wcenters.org or 320-235-4613.

LEADERSHIP
EDUCATION

Zumbro Valley Health Center

Southeast Minnesota

Target population

People with addiction disorders, mental illnesses and medical issues in Southeast Minnesota.

Program goals

To participate in the Behavioral Health Homes First Implementers Group and prepare for behavioral health home integration in order to become a certified behavioral health home. To partner with other state, local and regional organizations and work toward improved patient outcomes.

Program summary

Zumbro Valley Health Center found participating in the Behavioral Health Homes First Implementers Group extremely helpful to exchange information with other mental health center staff, learn about their processes and clarify certification guidelines.

To work toward behavioral health home certification, Zumbro Valley Health Center developed and implemented a number of new initiatives, including behavioral health home-based workflows. These

workflows helped the organization streamline referrals among programs and develop multidisciplinary teams to enhance client treatment.

The organization also focused on educating its management and leadership staff about behavioral health homes and other integrated care models. The Zumbro BHH Leadership Team held multiple meetings with management and leadership staff to educate these groups about different care models and their impact on the organization.

Zumbro Valley Health Center used some of its grant funding to enhance patient registries, population health-based reports and other tools in its electronic medical record.

Findings and outcomes

By the end of the grant period, Zumbro Valley Health Center had achieved behavioral health home certification. It was one of the first 13 organizations to be certified as a behavioral health home in Minnesota. Zumbro Valley Health Center prepared its team for successfully improving the care of people served under the behavioral health home model through providing extensive training to staff about integrated care models, the benefits to clients and the use of multidisciplinary treatment teams.

Contact

For more information, call Sean Rice at 507-289-2089.

ROUND 4

Amherst H. Wilder Foundation

Twin Cities East Metro

Target population

Underserved and uninsured or underinsured populations in urban and suburban East Metro communities.

Program goals

To advance the next phase of behavioral health home implementation, which includes training staff to reinforce changes in policies, procedures, staffing patterns and service delivery models; fostering a team-based approach that eliminates silos among service lines and provider types; and increasing enrollment and participation in the behavioral health home among eligible and interested clients.

Program summary

Amherst H. Wilder Foundation's behavioral health home project management team used once-weekly clinical and administrative project meetings to identify barriers and opportunities in implementation of this new service delivery model. The team identified a need for deeper education and hosted staff training sessions and team exercises to educate and integrate the use of the behavioral health home service among mental health program staff. This included a training on how to make referrals to the behavioral health home, an exercise between behavioral health home navigators and clinical therapists to review caseloads for eligibility, and many other activities.

As the organization continued to work through behavioral health home implementation, it created a more successful staffing pattern for its behavioral health home team. Before the grant, Amherst H. Wilder Foundation used multiple systems navigators at lower FTE allocations. However, in order to allow for concerted focus on community-based work, the organization lowered the number of navigators and increased their FTE allocations. The team found that

Aquí Para Ti has already identified approximately 40 patients who meet the criteria for enrollment with a behavioral health home services provider, and who would benefit from participation.

this allows for more dedicated focus on enrollment and participation, including the flexibility to go and visit clients in their homes to keep them engaged and participatory.

Amherst H. Wilder Foundation also used the practice transformation opportunity to experiment with the use of interpreters and bilingual staff within the behavioral health home service model, serving Hmong, Vietnamese, Cambodian and Karen clients.

Findings and outcomes

By investing in high-frequency meetings in the beginning of implementation, Amherst H. Wilder Foundation solved logistical, technical and operational aspects of the service model and had the program running smoothly in a short period of time. After a few months, the team could shift to biweekly meetings and focus on service delivery.

Amherst H. Wilder Foundation found that in-person staff trainings and outreach - as opposed to written communications regarding the new service model - were critical in obtaining education, understanding and buy-in from fellow staff who now make referrals regularly to the program.

Through the experience, the organization found that participation in the program depends upon the behavioral health home staff's diligence in outreach and engagement of enrolled clients. Often times, short-term life crises cause participants to deprioritize their mental health needs. However, once the crisis stabilizes, a warm outreach from behavioral health home staff often allows clients to re-engage.

Contact

For more information, call Amherst H. Wilder Foundation's Community Mental Health and Wellness program at 651-280-2310 and request to speak with the behavioral health home manager.

Hennepin County Medical Center's Aquí Para Ti program

Minneapolis

Target population

Urban and underserved Latino adolescents, young adults and their families. Patients often face complex issues that include immigration, acculturation, scarcity of economic resources, language barriers and mental health issues. Aquí Para Ti's clients require family-centered, team-based, comprehensive and integrated clinical services.

Program goals

To support Aquí Para Ti in becoming certified as a behavioral health home, modify clinic workflow and documentation systems, integrate Hennepin County Medical Center and community partners in patient-centered care, and support the expansion of integrated medical services.

Program summary

Aquí Para Ti created a project management team to oversee grant activities and work toward meeting the program's goals. The project management team met eight times during the first quarter to plan and implement activities, and members of the team held several other meetings with personnel from the billing and electronic health records departments. These additional meetings were geared toward preparing to become a behavioral health home. Staff also dedicated time to developing protocols and procedures to meet behavioral health home standards, training staff and planning a redesign of the referral process.

Aquí Para Ti identified key partner providers and reached out to them to initiate conversations and enhance existing partnerships as well as the secure exchange of clinical information. Staff also completed a staff training on strengthening patient resiliency and centering parenting.

Findings and outcomes

Aquí Para Ti has already identified approximately 40 patients who meet the criteria for enrollment in a behavioral health home and who would benefit from participation. The organization is still in the process of formalizing its care team with culturally and linguistically appropriate providers, but meets all other requirements to be certified as a behavioral health home.

Contact

For more information, contact Ursula Reynoso at Ursula.reynoso@hcmed.org or 612-873-8043.

Lutheran Social Service of Minnesota

(Altair ACO)

Anoka, Dakota, Hennepin, Ramsey and Washington counties

Target population

People in rural and metropolitan Minnesota with intellectual or developmental disabilities and their parents, guardians and case managers.

Program goals

To help health care providers, county case managers and other providers working with Altair ACO be more equipped and confident in providing services to people with functional limitations and enable people receiving services to play an active role in their care planning

Program summary

Altair ACO created an educational campaign directed at county case managers, care coordinators, disability service providers, other health care providers, clients and patients served, and clients' trusted advisors. Altair ACO hired a consultant to oversee and advise the campaign. The consultant and the project management team held phone calls every two weeks to receive updates, identify barriers and work toward solutions. The consultant also scheduled one-on-one meetings with each implementation team member and respective leadership partner. These one-on-one meetings helped the consultant better understand the unique needs of individual Altair ACO partners.

Findings and outcomes

By the end of the second quarter of this grant program, the campaign curriculum was finalized and approved by the Steering Committee. The population for the pilot group received training on assessing and practicing disability-competent care.

Contact

For more information, call George Klauser at 612-805-6910.

ACTIVE
CARE PLANNING

Natalis Outcomes

St. Paul

Target population

Persons receiving Medicaid who could benefit from integrated behavioral health home services.

Program goals

To train and support nontraditional primary and urgent care teams for behavioral health integration, mental health diagnostic assessment and referral to behavioral health home services; improve patient access to crisis stabilization counseling provided by these newly trained and clinically supported teams; and provide clinical supervision for diagnostic assessment services to hasten behavioral health home eligibility.

Program summary

The behavioral health home program at Natalis Outcomes works under a "facilitated referral partnership model." This model relies on other medical and social service providers or organizations to refer consumers to the behavioral health home program. In the first five months of implementation, Natalis Outcomes experienced referral obstacles due to length of visit constraints, clinical workflow demands and other system-level bottlenecks among its two community based grant partners. Although individual providers from the partnering clinics were enthusiastic about the behavioral health home program at first, individual and organizational behavior dependent on top-down communication did not happen to the extent needed to launch the project successfully.

Natalis Outcomes suspended the grant project for one month in order to re-operationalize the work with a third partner agency. Natalis Outcomes eventually identified and recruited a third multispecialty mental health agency for adults and children. Rank-and- file adult rehabilitative mental health services workers and children's therapeutic services and supports workers received training on the virtues, service benefits and eligibility conditions for behavioral health home services. Natalis Outcomes also conducted a 90-minute behavioral health home orientation for 15 individual professionals with a lengthy question-and-answer session and ongoing informational support. The practice facilitator also trained 30 bachelor's level mental health practitioners on crisis management, counseling and intervention skills.

Findings and outcomes

By the end of the grant period, one of Natalis Outcomes' grant partners will have made between 12-20 behavioral health home referrals to the project. The behavioral health home team is expected to effectively engage half of those referred in comprehensive care management services.

From this experience, Natalis Outcomes learned three key takeaways:

1. Recruit multiple like-minded partner organizations to work with on health care delivery reform and practice transformation initiatives.

2. Stay in close contact with the partner agency to ensure continuity of care and referral making continues.

3. Ask key questions of referring health care professionals to ensure that behavioral health home services are a good fit.

Overall, this grant allowed Natalis Outcomes to bridge some of the gaps that prevented people from accessing behavioral health home services. It also strengthened the facilitated partnership model for educating and introducing the behavioral health home program to community providers.

Contact

For more information, contact Jeffrey Wigren, MPH, MHA, at Jeffrey.wigren@natalisoutcomes.org or 612-800-6503.

North Metro Pediatrics

Twin Cities North Metro

Target population

Children and young adults from birth to 21 years old in the Twin Cities North Metro, primarily serving uninsured families (30 percent) and families enrolled in Minnesota Health Care Programs.

Program goals

To partner with Lutheran Social Service to provide physical and behavioral health services to clients in a primary care setting and continue progressing toward serving patients as a behavioral health home.

Program summary

With additional funding committed from Medica, North Metro Pediatrics and Lutheran Social Service are piloting a partnership to serve low-income and uninsured patients with mental health needs and their families in the North Metro. Together, one licensed associate marriage and family therapist from North Metro and one licensed marriage and family therapist from Lutheran Social Service began offering trauma-focused diagnostic assessments, therapeutic services and treatment planning. With SIM funding, North Metro could support the licensed associate marriage and family therapist and help the employee work toward full licensure. North Metro also used funding to implement and plan for the future of the project.

Although North Metro wants to integrate its electronic health record with Lutheran Social Services' electronic health record, it was too costly to make such a change at this time. Instead, North Metro developed an Excel spreadsheet to track patient outcomes, scores from initial testing, follow-ups and referrals. North Metro also began accessing records from Lutheran Social Service, copying them on a thumb drive and then scanning the records into the North Metro electronic health record.

Findings and outcomes

As of June 2016, North Metro had 204 mental health visits since the beginning of the grant. Through partnering with Lutheran Social Service, North Metro could offer more appointments for behavioral health services, increasing the number of clients that can be seen and decreasing wait times.

Contact

For more information, contact Executive Director Jeff Lundgren at jlundgren@northmetropeds.org or 763-783-3722.

Stellher Human Services, Inc.

North Central Minnesota

Target population

Patients in need of mental health services on a regular basis, specifically services related to crisis management.

Program goals

To partner with Essentia Health, St. Mary's regional health team to share processes, improve access to mental health services and decrease mental health crises while enhancing communication among all agencies and providing better outcomes for patients through the use of a behavioral health home model.

Program summary

At the beginning of the grant period, the grant team began meeting with current crisis team members to assess the current state of information exchange, define barriers and identify areas to improve this flow. From these meetings, the grant team proposed a new workflow process to better integrate care.

CRISIS
SERVICES

Stellher Human Services also conducted and completed group sessions with regional community collaborative partners to determine the criteria and needs for obtaining behavioral health home certification. Although Stellher Human Services originally intended to implement direct secure messaging and develop a health information exchange, the cost was too high to implement. Findings and outcomes. This "Proposed Crisis Services Workflow" developed through this program outlines a better flow of information across organizations and among patients and providers.

The team used this workflow to spark discussions with potential health information trading partners about the flow of information across agencies. The workflow identifies areas throughout the various levels of care scenarios where providers can communicate and coordinate care for the patient to facilitate a positive outcome and enhanced communications.

Contact
For more information, email Bill Sargent at bill@stellher.com.

United Family Medicine

St. Paul

Target population
Residents of St. Paul who are uninsured or underinsured and underserved.

Program goals
To assemble a task force to identify, compare and evaluate two patient care models in order to improve patient centered care and staff and provider workflow.

Program summary
United Family Medicine formed a redesign committee early in the process to meet weekly throughout the first few months of the grant period and evaluate different care models for testing. The committee consisted of staff members from each area of the clinic. It was then divided into smaller work groups to deal with specific areas of the redesign.

Two pilot teams tested two different models of care. The first pilot focused on changing how United Family Medicine triages patients. By moving to a centralized triage system with one nurse, the clinic created an opportunity to enhance the other positions that previously performed triage and hire one nurse manager. The remaining positions were revamped and given a new place in the workflow to provide more assistance with patient care and provider support. To track the success of this pilot, the smaller redesign task force implemented a staff and provider survey, debriefing at bimonthly meetings and reviewing work-life balance.

The second pilot team focused on incorporating a medical home approach for all patients with one provider working with the same two clinical staff members. This process involved training clinical staff to provide documentation in the exam room while the provider provided direct patient care. This change gave the clinical staff more ownership with coordinating care and following the entire patient experience as opposed to just getting the patient ready in the exam room. A survey was conducted with patients, staff and team members to evaluate this pilot.

Findings and outcomes
Results from the pilot surveys are being recorded and analyzed. Near the end of the grant period, the triage pilot team requested to continue the trial.

Throughout the grant period, United had challenges communicating among those involved in the pilot and redesign teams and the rest of the staff as a whole. This led to a strong effort to improve the communication throughout the clinic.

Contact
For more information, email Melissa Parker at mparker@unitedfamilymedicine.org.

Vail Place

Hennepin County

Target population
People with serious and persistent mental illness residing in Hennepin County, primarily individuals in urban settings.

Program goals

To work toward becoming a certified behavioral health home by creating systems and processes to support a patient registry and reporting efforts in order to better coordinate care across a team and manage the health of the population.

Program summary

Vail Place used the Plan-Do-Study-Act approach to structure work for this grant project. (For more information on this method, visit the "Additional Practice Transformation Resources" section of this document.) As part of the planning phase, a project management team met regularly throughout the grant period to review needs, brainstorm ideas and make initial plans. In the doing phase, the organization completed a gap assessment, added missing data fields to the electronic medical record, and identified required elements for a behavioral health home and entered them into the electronic medical record. In addition, Vail Place researched and identified a business intelligence platform that will get the most functionality from the electronic medical record and developed new policies, procedures and workflows for the behavioral health home. In the studying phase, Vail Place intends to run baseline reports and determine any additions and revisions that need to be made. In the acting phase, the tools and strategies developed throughout the process will be used to manage gaps in care, identify health needs and manage population health.

Findings and outcomes

Vail Place decided to secure Microsoft Power BI to lay over its current electronic medical record, allowing for efficient exporting of data so reports and analytics can be generated. This approach to data management and analytics will help create a flexible registry solution, allowing Vail Place to respond to changes and developments in program needs and ensure continuous quality improvement. The aim of the platform is to create a tool that is easily accessible to clinicians. This will empower them to use data

to inform their work on a daily basis using real-time information. It will also serve as an engagement strategy to motivate and encourage individuals receiving services.

Vail Place plans to hire two consultants to help with the technical aspects of the project. The consultants will work with the internal IT staff to implement use of the Power BI platform, giving staff hands-on experience with building reports and using the application.

Contact

For more information, contact Shelly Zuzek, LICSW, at szuzek@vailplace.org or 952-945-4250.

Woodland Centers

(Willmar)

West Central Minnesota

Target population

People with mental health needs in West Central Minnesota. Approximately 80 percent of Woodland Centers clients live below the federal poverty level and 100 percent receive a sliding fee scale reduction.

Program goals

To assess and improve the workflow of Woodland Centers' behavioral health home team. To continue to engage clients and stakeholders and encourage feedback and guidance on possible changes to the processes. To improve the skills and knowledge of the behavioral health home staff in order to enhance their ability to engage and activate clients in their care.

Program summary

Woodland Centers' behavioral health home team met weekly to assess and improve the behavioral health home workflow including completion of paperwork, meeting with clients, ways to identify potential clients in sources of data and the various roles of team members. Through this process, the behavioral health home team refined many processes and helped clients get better care.

The behavioral health home team met with almost every social service agency in the area, the Rice Memorial Hospital behavioral health staff and the Southern Prairie Community Care staff.

In order to improve knowledge and skills among members of the behavioral health home team, Woodland Centers' staff attended DISCUS training to learn to identify the signs and symptoms of clients having side effects from antipsychotic medications. Staff also attended the SIM Learning Days conference in St. Cloud.

Findings and outcomes

Midway through the grant period, Woodland had 40 clients enrolled in behavioral health home services, double what it started with when it began this project. Through updating workflows, processes and consulting with key stakeholders, the organization improved its ability to get clients started in behavioral health home services from the date of referral and improved its ability to track what occurs with a client after the referral is made. Staff improved documentation processes in the electronic health record for internal referrals so it is clear when clients have been contacted for intake into the behavioral health home program. The new tracking also clearly indicates if a client is unable to receive the service due to not having the proper insurance or electing to maintain another service that is duplicative of behavioral health home.

Contact

For more information, contact Woodland Centers Executive Director Ashley Kjos at 320-235-4613 or ashley.kjos@wcenters.org.

Zumbro Valley Health Center

Southeast Minnesota

Target population

People with addiction disorders, mental illnesses and medical issues in Southeast Minnesota.

Program goals

To expand the skill set of all Zumbro Valley Health Center treatment staff by providing training on motivational interviewing and other evidence-based best practices and incorporating these into treatment planning. To develop a group of trauma-informed cognitive behavioral therapy experts and incorporate these principles into day-to-day treatment practices.

Program summary

The project management team successfully coordinated a range of staff trainings to expand the skill set of treatment staff and incorporate these lessons into day-to-day treatment practices. Zumbro Valley Health Center contracted with Ambit to support a range of trauma-informed cognitive behavioral therapy trainings. All staff members were trained on motivational interviewing principles, an evidence-based practice key to working with people diagnosed with a mental illness. In addition, dozens of staff received training on Mental Health First Aid, a critical skill in properly responding to the signs of mental illness and substance use. Non-clinical staff also received the motivational interviewing and Mental Health First Aid trainings to enhance their understanding of client needs and train them on how to respond to these needs if required. Two therapists participated in trainings for eye movement desensitization and reprocessing to enhance the organization's ability to deliver trauma-based services.

Findings and outcomes

Zumbro Valley Health Center focused its grant money on providing critical training to staff to both enhance their knowledge of best practices and prepare the organization for requirements as a

Certified Community Behavioral Health Clinic. The evidence-based practices learned via the trainings have been incorporated into staff's day-to-day processes and clients already benefit from this knowledge. The scope of these trainings would have been impossible without the grant funding.

As the organization continues its transition to a care team-based structure, it is essential for these teams to have expertise in these modalities. As a result of this program, Zumbro staff gained knowledge about key practices, therapies and treatments and the signs of mental illness and substance use disorder.

Contact

For more information, call Sean Rice at 507-289-2089.

Additional Practice Transformation Resources

(These resources were used by Behavioral Health Home First Implementers Group participants.)

The AIMS Center Team Building Process for Integrated Behavioral Health Care
Advancing Integrated Mental Health Solutions (AIMS)
www.integration.samhsa.gov/workforce/UW_Integrated_BH_Care_Team_Building_Process.pdf

This team-building tool is based on experience helping more than 500 organizations adapt, implement and sustain evidence-based collaborative care for common mental disorders. In order for integrated care programs to succeed, clinics need to clearly define the roles of all team members and create an effective shared workflow that makes optimal use of existing staff resources and meets the behavioral health needs of the unique patient population served by each clinic. This document helps organizations walk through these important steps to better integrate mental health services.

Kotter's 8-Step Change Model
Dr. John Kotter
www.kotterinternational.com/8-steps-process-for-leading-change/

Over four decades, Dr. Kotter observed countless leaders and organizations tried to transform or execute their strategies. He identified and extracted the success factors and combined them into a methodology, the award-winning 8-Step Process for Leading Change. This short, free, online e-book walks through the eight steps for effective change communication. It shares tools to lead change, statistics on successful change and an assessment to help you identify your organization's barriers to change. In order to access the e-book, it is necessary to enter an email address and organizational information, although the content is free.

Plan-Do-Study-Act Model
Institute for Healthcare Improvement
www.ihi.org/resources/Pages/HowtoImprove/default.aspx

The Plan-Do-Study-Act cycle is shorthand for testing a change in the work setting by planning it, trying it, observing the results and acting on what is learned. This is the scientific method adapted for action-oriented learning.

PRIVACY, SECURITY AND CONSENT MANAGEMENT GRANTS FOR ELECTRONIC HEALTH INFORMATION EXCHANGE

(PART A AND PART B)

Although electronic health information exchange is a growing and useful tool for health care and other health-related organizations, exchanging patient information in Minnesota can be challenging from an operational perspective and a legal perspective, with laws such as the Health Insurance Portability and Accountability Act (HIPAA) and the Minnesota Health Records Act. These grants aimed to provide guidance to health care providers and other organizations interested in exchanging health information electronically and help address some of the privacy, security and consent management challenges.

Gray Plant Mooty

Statewide
Funding: Part A: Legal analysis

Target population

Health care organizations and providers in Minnesota.

Project goals

To analyze legal barriers and develop tools to support the electronic exchange of health information in Minnesota.

Project summary

Gray Plant Mooty completed a legal analysis on 11 identified use cases. This analysis included a legal review of relevant materials as well as information gathered during a public open mic event with stakeholders in November 2015. More than 140 people participated and provided more than 70 comments, raising concerns about privacy, security and consent in Minnesota. This comprehensive legal analysis and review of leading practices was used as the basis for the Foundations in Privacy Toolkit.

Lessons and outcomes

The Foundations in Privacy Toolkit contains template policies and procedures, flowcharts, template agreements and checklists to help providers electronically exchange health information in Minnesota while meeting federal and state requirements. These documents can be used by providers in many ways. The policy and procedure documents can be customized and implemented as part of an organization's HIPAA privacy compliance efforts. The flowcharts and checklists can be used to analyze business relationships and unique disclosure situations, and the template agreements can be used to guide negotiations and simplify execution. All of the documents can be used to educate and train a workforce.

Contact

For more information, contact the Minnesota Department of Health's Office of Health Information Technology at mn.ehealth@state.mn.us or 651-201-5979.

Resources

Foundations in Privacy Toolkit
Gray Plant Mooty
www.gpmlaw.com/Practices/Health-Law/Foundations-in-Privacy-Toolkit

Land of 10,000 Barriers: Tips and Tools for Exchanging Health Information in Minnesota (PDF)
Jesse Berg, Tim Johnson and Julia Reiland, Gray Plant Mooty
Minnesota e-Health Summit 2017 (June 15, 2017)
www.health.state.mn.us/e-health/summit/2017/docs/s15.pdf

Learn about the Minnesota Department of Health grant-funded work to help ensure that health care providers have the access to the knowledge and tools required to use, disclose and share electronic health information in a safe and secure manner. This PDF presentation provides information on implementing leading practices that enable safe and secure electronic health information exchange across settings for care coordination and other activities.

Hielix

Statewide

Funding: Part B: Education and technical assistance

Target population

Individuals in health care organizations (hospitals, providers, long-term care, public health, behavioral health, social service agencies and other related organizations) tasked with the responsibility for ensuring their organization is compliant with HIPAA and the Minnesota Health Records Act requirements. Staff members charged with developing, implementing and enforcing privacy, security, and consent policies and procedures.

Project goals

To develop and disseminate toolkits, tips, guides and materials that can be used to provide education and technical assistance to Minnesota health care providers and organizations on the topics of privacy, security and consent management of electronic health information exchange.

Project summary

In order to understand the privacy and security landscape in Minnesota, Hielix conducted an environmental scan, which included meetings with Gray Plant Mooty (the Part A recipient of the grant), a review of documents, interviews with health care stakeholders and a consultation with Stratis Health. The environmental scan helped Hielix identify available education and technical assistance materials and resources that could be used or easily adapted to address identified gaps in privacy, security and consent management of electronic health information exchange. It created the "as-is" picture of the current environment and served as a foundation for the development of Hielix's educational modules and materials.

Lessons and outcomes

Over the course of this project, Hielix created educational documents and complimentary presentation templates.

1. An Introductory Guide to Privacy, Security and Consent: This guide presents an over view of HIPAA and the Minnesota Health Records Act. It is meant to help providers and organizations understand the key attributes of privacy, security and consent and includes a process that organizations can use to assess how well they meet legal requirements.

2. A Policy Development Guide: This guide offers a step-by-step process for developing policies and procedures that meet HIPAA and Minnesota Health Records Act standards of privacy and security. It also presents a process for   identifying, designing and implementing the appropriate policies and procedures to help a covered entity or business associate achieve compliance with the published requirements of the Office of Civil Rights.

These documents will be available at www.health. state.mn.us/e-health/privacy/index.html when final.

Contact

For more information, contact the Minnesota Department of Health's Office of Health Information Technology at mn.ehealth@state.mn.us or 651-201-5979.

Additional Privacy, Security and Consent Resources

For more information about privacy, security and consent, visit the Minnesota Department of Health's e-health privacy and security website. The website provides useful local and national resources, activities, reports and other documents related to privacy, security and consent in Minnesota.
http://www.health.state.mn.us/e-health/privacy/index.html"www.health.state.mn.us/e-health/privacy/index.html

You may also find helpful information related to privacy, security and consent in the "Additional e-Health Resources" and "Additional HIE Resources" sections in this directory.

STORYTELLING ENGAGEMENT PROJECT

ROUNDS 1 AND 2

MINNESOTA

Storytelling Engagement Project

This project provided vendors with funding to create and implement a facilitated process to collect, produce and share stories of health integration and innovation. The stories aim to build awareness and support broad community interest in integrated care models. Final produced stories may have varying audiences such as care providers, communities, policymakers and health care administrators. Likely participants in project activities may include SIM contractors, awardees and partners; community partners implementing innovative strategies toward health integration; and SIM Task Force members and advisors.

Project activities may require a 12-16 month plan in three anticipated phases:

1. Planning
2. Story development and technical assistance
3. Story production and dissemination

Community Blueprint

Statewide
Funding: Storytelling project Round 1

Target population

Health and human services providers, related administrators, elected officials, the general public and mainstream media.

Program goals

To engage consumers and providers to share their stories and personal experiences with health care innovation in their community.

Program summary

Community Blueprint interviewed SIM grantees and similar community health partnerships and initiatives. Through these interviews, Community Blueprint sought to identify examples of partnerships for health, efforts to address health equity, and successful linkages or integration among communities and clinics. Community Blueprint also created materials to help SIM grantees share their own stories, including the document and video "How to Tell a Social Impact Story."

SOCIAL
IMPACT STORIES

Findings and outcomes

Community Blueprint developed web videos and wrote narrative nonfiction pieces published on SIM websites and partner websites.

Resources

Clippers and Curls video
Community Blueprint
www.youtube.com/
watch?v=wTp5KUfscRA&feature=youtu.be

Community Blueprint introduces viewers to the staff of Wilson's Image Barbers and Stylists and shares how one local barbershop is working to improve health in the African American community.

How to Tell a Social Impact Story document
Community Blueprint, Minnesota Department of Health and Minnesota Department of Human Services
http://communityblueprint.com/wp-content/
uploads/2015/01/How-To-Tell-A-Social-Impact-
Story-%E2%80%93-SIM-Storytelling.pdf

This document provides a step-by-step guide for telling an effective social impact story. It includes a workflow for developing an impactful story, as well as prompts to help writers get started.

How to Tell a Social Impact Story video
Community Blueprint, Minnesota Department of Health and Minnesota Department of Human Services
www.youtube.com/
watch?v=7S8ssVF0EI4&feature=youtu.be

This 3-1/2 minute video walks through strategies for telling an effective social impact story. Andy Berndt, founder of Community Blueprint, talks viewers through the process for developing an impactful story and shares useful storytelling insights.

DIAL

Statewide
Funding: Storytelling project Round 1

Target population

Health and human service providers, related professionals, administrators and the general public.

Program goals

To provide technical assistance to SIM stakeholders via events, site visits and workshops to help them document their successes.

Program summary

DIAL provided technical assistance to key stakeholders in the art of storytelling and communication methods. DIAL hosted training and capacity building sessions at health fairs and conferences in Greater Minnesota and in the Twin Cities metro area in order to reach a wide range of stakeholders and audiences across the state. DIAL also created a series of stories in a variety of formats for diverse audiences that highlight and support innovative SIM practices, programs and partnerships.

Findings and outcomes

DIAL interviewed SIM grantees and created training videos for the Minnesota Department of Health's Health Care Homes program on themes such as patient-centered care, community health workers and health equity.

Resources

Minnesota Health Care Homes YouTube Video Page DIAL and the Minnesota Department of Health

www.youtube.com/playlist?list=PLnv1INVkmxm-v9S1I8e4oOWeEZ8ybopOqL

These YouTube videos feature SIM grantees talking about their experiences with the Health Care Homes Program. The storytelling format of these videos is engaging, and the wide variety of topics covered make them a useful resource for anyone interested in learning more about Minnesota Health Care Homes.

Asian Media Access

Statewide
Funding: Storytelling project Round 2

Target population

Limited English Proficient populations in MN, local public health, social services and health and human service providers - particularly those serving populations with low English proficiency,

Program goals

To develop and share stories related to patient engagement in health and health care choices and culturally relevant care integration, particularly with local public health and social services.

Program summary

Asian Media Access worked with four ethnic group partners (African Immigrant Community Services, Hispanic Advocacy & Community Empowerment through Research, Project Sweetie Pie and Zintkala Lutato) to target Limited English Proficient communities and create culturally appropriate messages that integrate health and community.

Findings and outcomes

Asian Media Access published stories in its monthly e-newsletter and online to a wide audience. Asian Media Access staff also trained staff at the Minnesota Department of Health, Minnesota Department of Human Services and community partners on findings and best practices on strategies to reach limited English Proficient communities.

Resources

Community views on the Minnesota health care system videos
Asian Media Access

Asian Media Access created three story-sharing videos about health within the Somali, Hmong and Native American communities in Minnesota:

Somali Community Views on the Minnesota Health Care System
www.youtube.com/watch?v=TPBHJyTVncQ

Hmong Community Views on the Minnesota Health Care System
www.youtube.com/watch?v=M88-hMcsZVg

Native American Community Views on the Minnesota Health Care System
www.youtube.com/watch?v=PM2J4nzYlq4

Pillsbury United Communities - Waite House

Statewide
Funding: Storytelling project Round 2

Target population
Latinos, Spanish-speakers, elected officials, the general public and mainstream media.

Program goals
To develop and share stories about community health priorities for health equity and address population health in Latino communities.

Program summary
Pillsbury United Communities - Waite House launched the "Salud Como un Derecho Humano" ("Health as a Human Right") storytelling project to address gaps in health by cultivating awareness about Latino experiences of health and expanding community knowledge about social determinants of health. Through this project, Waite House hoped to shift the common definition of health from simply an absence of illness toward a more holistic understanding of individual and communal well-being.

The organization led listening sessions within the community to identify story leaders and featured stories on radio shows, at community events and online. Waite House created posters with short stories about Latino health care experiences for a local campaign and led information sessions for health and human service providers. In these sessions, Waite House staff shared stories from the community to help health and human service providers better understand access to health care and the Latino community's health experiences in Minnesota.

Findings and outcomes
Waite House presented research and stories in a number of trainings across the metro, including a training for staff at the Minnesota Department of Health and Minnesota Department of Human Services.

Resources
Latino Experiences in Accessing Healthcare in Minnesota
Pillsbury United Communities - Waite House and Hispanic Advocacy and Community Empowerment through Research
www.puc-mn.org/sites/default/files/files/pdf/405-339-hr.pdf

This research report helped educate Minnesota Department of Health and Minnesota Department of Human Services staff about Latino health care experiences in Minnesota. To create this report, Hispanic Advocacy and Community Empowerment through Research facilitated nine discussion sessions with Latino residents in six cities within the metro area and surrounding rural communities. The discussions focused on what it means to be healthy, obstacles in accessing health care and recommendations for resolving these issues. A total of 105 people participated in this study.

Pollen Midwest

Statewide
Funding: Storytelling project Round 2

Target population

Health and human service providers and related administrators, the general public, providers, community groups and policymakers.

Program goals
To develop and share stories related to:

- Health equity and the social determinants of health
- Engaging underserved patients and populations
- Innovative SIM-funded models used by nonprofit safety net providers
- Cross-sector integrated care partnerships

Program summary

For this SIM Storytelling Engagement Project, Pollen partnered and consulted with MS Strategies, the Minnesota Department of Health, the Department of Human Services, SIM-funded providers, patients and communities. Through this collaboration, Pollen sought to create profile-driven stories that bring to life the impact and innovation of community partners' work. Pollen focused on telling stories related to health equity, from both the patient and provider perspective. Once potential stories were identified, Pollen contacted racially and culturally diverse freelance writers, illustrators, photographers and videographers to co-create stories with patients and providers. This way, the populations whose stories were being told are well-reflected in the creative talent capturing those experiences. To promote stories, Pollen used social media and marketing strategies. Pollen pulled bold graphics and compelling design into every story to propel interest and shareability.

Findings and outcomes

As of July 2017, Pollen has created four stories, along with accompanying illustration, photography, gif, video, etc. Pollen hosted these stories on its website. Pollen has one of the most networked and engaged audiences of civic-connectors and community-builders in the region.

Resources
Pollen SIM Stories
Pollen Midwest

Improving Healthcare in a Changing Community
https://www.pollenmidwest.org/stories/meet-norris-anderson/

Meet Southern Prairie Community Care Medical Director Norris Anderson and learn how this rural care provider is building a network and critical support system of providers across Minnesota.

Portraits of Health
www.pollenmidwest.org/stories/portraits-of-health-at-community-university-health-care-center/

These three mini stories from a doctor, an educator and a psychiatric care coordinator at the Community University Health Care Center show the power of meeting patients where they are.

A New Type of Leadership for a New Type of Care
www.pollenmidwest.org/stories/meet-colleen-mcdonald-diouf/

Meet Community University Healthcare Center Chief Executive Officer Colleen McDonald Diouf and learn what it takes to be a leader in a changing health care field.

Providing Dental Care to our Most Vulnerable Young People
www.pollenmidwest.org/stories/meet-elizabeth-branca/

Meet Advanced Dental Therapist Elizabeth Branca and learn how her job lets her serve more patients and expand treatment to communities with limited options for care.

Additional Resources

ACH

Aim for Impact and Sustainability Resource Page - National Rural Health Resource Center
https://www.ruralcenter.org/rhi/network-ta/aim-for-sustainability

Community-Based Care Coordination Toolkit - Stratis Health
https://www.stratishealth.org/expertise/healthit/carecoord/

Culture Care Connection - Stratis Health
http://www.stratishealth.org/pubs/cccnews.html

Assessment

Partnership Self-Assessment Tool - The Center for the Advancement of Collaborative Strategies in Health
https://depts.washington.edu/ccph/pdf_files/project site final.pdf

The Minnesota Accountable Health Model: Continuum of Accountability Matrix - Minnesota Department of Human Services and Minnesota Department of Health
http://www.dhs.state.mn.us/SIM_Docs_Reps_Pres

e-Health Resources

2017 e-Health Summit Breakout Presentation Materials - Minnesota Department of Health and Minnesota e-Health
http://www.health.state.mn.us/e-health/summit/2017/index.html
Health IT - Tools and Resources - Stratis Health
http://www.stratishealth.org/expertise/healthit/

Minnesota e-MN e-Health Website - Minnesota Department of Health and Minnesota e-Health
http://www.health.state.mn.us/e-health/index.html

HIE Resources

HIE Resources Website - Minnesota Department of Health
http://www.health.state.mn.us/e-health/hie/#resources

Getting the Information Needed for Better Health: Using Electronic Health Information Exchange in Minnesota (PDF) - Minnesota Department of Health and Minnesota e-Health Initiative
http://www.health.state.mn.us/e-health/hie/docs/factsheet.pdf

Minnesota HIE Framework and Guidance to Support Accountable Health (PDF) - Minnesota Department of Health and Minnesota e-Health Initiative
www.health.state.mn.us/e-health/hie/docs/hieframework.pdf

Connecting to Statewide Health Information Exchange (HIE) in Minnesota (PDF Presentation) - Minnesota Department of Health
www.health.state.mn.us/e-health/hie/docs/013117presentation.pdf

Learning Days

Health Care Homes and SIM Minnesota Learning Days 2017 Program (PDF)
Minnesota Department of Human Services and Minnesota Department of Health
http://www.hchsimlearningdays.org/documents/2017_AnnualLearningDays_0307-2.pdf

In April 2017, the Minnesota Department of Health's Health Care Homes program and the Minnesota Department of Human Services' Minnesota Accountable Health Model - SIM Minnesota hosted "SIM Learning Days." This conference provided an opportunity for Minnesota health care home

providers and community partners from behavioral health, public health, social services, long term care and post-acute care to gain and share knowledge, form relationships, and exchange information about integrating care for people we all care for and work with in our day-to-day practice. To access many of the presentations that providers and partners shared at this conference, visit http://www.hchsimlearningdays.org/sessions.php

Practice Transformation

The AIMS Center Team Building Process for Integrated Behavioral Health Care - Advancing Integrated Mental Health Solutions (AIMS) http://www.safetynetmedicalhome.org/change-concepts/organized-evidence-based-care/behavioral-health

Kotter's 8-Step Change Model - Dr. John Kotter https://www.mindtools.com/pages/article/newPPM_82.htm

Plan-Do-Study-Act Model - Institute for Healthcare Improvement http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx

Connecting to Statewide Health Information Exchange (HIE) in Minnesota (PDF Presentation) - Minnesota Department of Health www.health.state.mn.us/e-health/hie/docs/013117presentation.pdf

Index A: Funded opportunities by SIM driver

Driver 1:

e-health uses the power of information to promote better health by giving providers and patients the right information at the right time, while also safeguarding privacy.

Driver 2:

Integrated data approaches harness the power of data to identify health problems and solutions for individual patients, groups of patients and communities.

Driver 3:

Patient-centered, coordinated care puts patients at the center of a team of health care and health care service professionals. This team helps patients meet their health goals by connecting the dots to services in and outside the clinic.

Driver 4:

Community-driven solutions allow local public health, rural and urban counties, providers, health advocates, school districts, correctional facilities, and other partners to identify and implement opportunities for better health, especially for those in the community who are falling through the cracks.

Driver 5:

Payment and accountability are brought together so the state of Minnesota pays for value – best outcome at the best price – rather than volume in health care.

Through the Minnesota Accountable Health Model, the Minnesota Department of Health commissioned a baseline assessment to guide the development of tools and resources for providers and communities, and inform future monitoring efforts.

A comprehensive report, Baseline Assessment of ACO Payment and Performance Methodologies in Minnesota for the State Innovation Model (SIM) and appendices are available online at http://www.dhs.state.mn.us/SIM_ACO.html.

Driver 5's goal to increase the number and type of provider systems participating in the IHP program was supported through a survey to assess the baseline of ACO alignment.

More information on the survey and to learn how the IHP program expanded to include 21 participating organizations and enhanced alternative payment arrangements can be found in the Evaluation of the Minnesota Accountable Health Model Executive Summary prepared by the State Health Access Data Assistance Center (SHADAC).

Evaluation findings are available online at http://www.dhs.state.mn.us/SIM_Eval.html.

Index B: Funded programs by topic

Behavioral health homes

Awardee	Funding Opportunity	Page
South Metro Human Services (Now Radias Health)	Practice Transformation Round 1	105
Stellher Human Services, Inc.	Practice Transformation Round 4	141
Touchstone Mental Health	Practice Transformation Round 2	115
University of Minnesota Community University Health Care Center (CUHCC)	Practice Transformation Round 1	105
Vail Place	Practice Transformation Round 4	133
Woodland Centers (Willmar)	Practice Transformation Round 4	143

Chemical dependency

Awardee	Funding Opportunity	
FQHC Urban Health Network (FUHN)	e-Health Grant Round 1	31
FUHN (Federally Qualified Health Center Urban Health Network)	IHP Provider Grants Data Analytics	77
HealthEast Care System	Emerging Professions Integration Grant Round 1	51
Lac qui Parle Clinic	Practice Transformation Round 2	110
Minnesota Community Health Network (MCHN)	Health Information Exchange (HIE) and Data Analytics Grant Program	70
Northland Counseling Center Inc.	Practice Transformation Round 3	124
Otter Tail County Public Health (Greater Fergus Falls ACH)	Accountable Communities for Health (ACH) Rounds 1 and 2	18
South Metro Human Services (Now Radias Health)	Practice Transformation Round 1	105
South Metro Human Services (Now Radias Health)	Practice Transformation Round 3	130
Southern Prairie Community Care	e-Health Grant Round 1	39
Unity Family Healthcare d.b.a. CHI St. Gabriel's Health (Morrison County Community Based Care Coordination ACH)	Accountable Communities for Health (ACH)	20
Zumbro Valley Health Center	Practice Transformation Round 4	144

Children

Awardee	Funding Opportunity	
Children's Dental Service	Emerging Professions Integration Grant Round 1	51
Community Dental Care	Emerging Professions Integration Grant Round 3	57
Fraser	Practice Transformation Round 3	120
Generations Health Care Initiatives (Together for Health at Myers Wilkins ACH)	Accountable Communities for Health (ACH) Rounds 1 and 2	12

Index B: Funded programs by topic

Community care teams

Community engagement

Community health workers

Index B: Funded programs by topic

Community paramedics

Culturally appropriate health care

Dental therapists

Diabetes

Direct secure messaging

Disability services

Drug use

Index B: Funded programs by topic

Drug use

e-Health

Emergency Department utilization

Emergency Department utilization

Employment and health

Families

Food security

Index B: Funded programs by topic

Health care homes

Health information exchange

Health information Organization

Hmong population health

Homelessness

Incarceration

Integrated Health Partnerships

Latino population health

Index B: Funded programs by topic

Long-term care

Low-income

Medicaid/Medical Assistance population

Medicaid/Medical Assistance population

Awardee	Funding Opportunity	Page
Otter Tail County Public Health (Greater Fergus Falls ACH)	Accountable Communities for Health (ACH) Rounds 1 and 2	18
Southern Prairie Community Care	Accountable Communities for Health (ACH)	19
UCare Minnesota (UCare FUHN ACH)	Accountable Communities for Health (ACH)	19
Unity Family Healthcare d.b.a. CHI St. Gabriel's Health (Morrison County Community Based Care Coordination ACH)	Accountable Communities for Health (ACH)	20
Vail Place/North Memorial (Total Care Collaborative)	Accountable Communities for Health (ACH)	21

Medically underserved

Awardee	Funding Opportunity	
Community Dental Care	Emerging Professions Integration Grant Round 3	57
Essentia Health Ada	Emerging Professions Integration Grant Round 2	54
Essentia Health Ely Clinic (Ely Community Care Team)	Accountable Communities for Health (ACH)	11
Generations Health Care Initiatives (Together for Health at Myers Wilkins ACH)	Accountable Communities for Health (ACH) Rounds 1 and 2	12
New Ulm Medical Center (New Ulm Care Coordination ACH)	Accountable Communities for Health (ACH)	17
North Metro Pediatrics	Practice Transformation Round 4	140
Open Door Health Center	Emerging Professions Integration Grant Round 3	60
Otter Tail County Public Health (Greater Fergus Falls ACH)	Accountable Communities for Health (ACH) Rounds 1 and 2	18
Ringdahl Ambulances	Emerging Professions Integration Grant Round 2	57
United Family Medicine, St. Paul	Practice Transformation Round 4	142
Unity Family Healthcare (d.b.a. St. Gabriel's Health)	Oral Health Access Grant	93
West Side Community	Emerging Professions Integration Grant Round 1	53
Zumbro Valley Health Center	Practice Transformation Round 1	107
Zumbro Valley Health Center	Practice Transformation Round 2	117

Mental health

Awardee	Funding Opportunity	
All 24 Round 3 Practice Transformation grantees	All Round 3 Practice Transformation projects involved the formation of a behavioral health home, and all behavioral health home populations include people with mental health issues.	119
American Academy of Pediatrics Minnesota Chapter	Learning Communities Round 1	85
Essentia Health Ely Clinic (Ely Community Care Team)	Accountable Communities for Health (ACH)	11
Guild Incorporated	Practice Transformation Round 1	100
HealthEast Care System	Emerging Professions Integration Grant Round 1	51

Index B: Funded programs by topic

Mental health

Mothers

Native American health

Opioids

Oral health

Index B: Funded programs by topic

Patient registries (using or creating)

Patient matching (to electronic health records)

Practice facilitation

Awardee	Funding Opportunity	Page
ICSI (Institute for Clinical Systems Improvement)	Practice Facilitation	95
National Council on Behavioral Health	Practice Facilitation	96

Population research

Awardee	Funding Opportunity	
Allina Health Systems (Northwest Metro Healthy Student Partnership ACH)	Accountable Communities for Health (ACH)	9
Center for Victims of Torture	Learning Communities Round 1	86
CentraCare (CentraCare Health Foundation ACH)	Accountable Communities for Health (ACH)	10
First Light Health System	Practice Transformation Round 2	108
Gray Plant Mooty	Privacy, Security, Consent Part A: Legal Analysis	147
Hielix	Privacy, Security, Consent Part B: Education and Technical Assistance	148
ICSI (Institute for Clinical Systems Improvement)	Practice Facilitation	95
Lutheran Social Service of Minnesota (Altair Accountable Care Organization)	Health Information Exchange (HIE) and Data Analytics Grant Program	70
Lutheran Social Service of Minnesota (Altair)	Practice Transformation Round 2	111
Lutheran Social Service of Minnesota (Altair)	Practice Transformation Round 4	139
Medica Health Plans	e-Health Grant Round 1	37
Minnesota Community Health Network ()	Health Information Exchange (HIE) and Data Analytics Grant Program	70
National Council on Behavioral Health	Practice Facilitation	96
National Rural Health Resource Center	ACH Learning Community Grant	88
Native American Community Clinic	Practice Transformation Round 1	101
North Metro Pediatrics, PA	Practice Transformation Round 2	113
Open Door Health Center	Practice Transformation Round 2	113
Otter Tail County Public Health (Greater Fergus Falls ACH)	Accountable Communities for Health (ACH) Rounds 1 and 2	18
Pillsbury United Communities, Waite House	Storytelling Project Round 2	154
Rainbow Research, Inc.	Learning Communities Round 1	87
Second Harvest Heartland	Food Security Services	67
South Metro Human Services (Now Radias Health)	Practice Transformation Round 1	105
United Family Medicine, St. Paul	Practice Transformation Round 4	142
Unity Family Healthcare (d.b.a. CHI St. Gabriel's Health)	Oral Health Access Grant	93
Well Being Development	Practice Transformation Round 1	106
White Earth Nation	e-Health Grant Round 1	41
Zumbro Valley Health Center	Practice Transformation Round 1	107
Zumbro Valley Health Center	Practice Transformation Round 2	117

Index B: Funded programs by topic

Patient matching (to electronic health records)

Somali/East African population health

Staff training and development

Index B: Funded programs by topic

Staff training and development

Student health

Substance use

Awardee	Funding Opportunity	Page
FQHC Urban Health Network (FUHN)	e-Health Grant Round 1, Implementation	31
FUHN (Federally Qualified Health Center Urban Health Network)	IHP Provider Grants Data Analytics	77
HealthEast Care System	Emerging Professions Integration Grant Round 1	51
Lac qui Parle Clinic	Practice Transformation Round 2	110
Minnesota Community Health Network (MCHN)	Health Information Exchange (HIE) and Data Analytics Grant Program	70
Northland Counseling Center Inc.	Practice Transformation Round 3	124
Otter Tail County Public Health (Greater Fergus Falls ACH)	Accountable Communities for Health (ACH) Rounds 1 and 2	18
South Metro Human Services (Now Radias Health)	Practice Transformation Round 1	105
South Metro Human Services (Now Radias Health)	Practice Transformation Round 3	130
Southern Prairie Community Care	e-Health Grant Round 1, Implementation	39
Unity Family Healthcare d.b.a. CHI St. Gabriel's Health (Morrison County Community Based Care Coordination ACH)	Accountable Communities for Health (ACH)	20
Zumbro Valley Health Center	Practice Transformation Round 4	144

Tools, modules, trainings (statewide)

Awardee	Funding Opportunity	
Gray Plant Mooty	Privacy, Security, Consent Part A: Legal Analysis Foundations in Privacy Toolkit	147
Halleland Habicht Consulting, University of Minnesota School of Dentistry & Normandale Community College	Emerging Professions Dental Therapy Toolkit	65
ICSI (Institute for Clinical Systems Improvement)	Practice Facilitation Grant	95
LearningLens	e-Learning Modules Contract	49
National Council on Behavioral Health	Practice Facilitation Grant	96
Stratis Health	e-Health roadmap Contract	47
The Paramedic Foundation	Emerging Professions Community Paramedic Toolkit	64
WellShare International with CHW Alliance	Emerging Professions Community Health Worker Toolkit	63

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Transitions in care

Underinsured

Acknowledgements

MINNESOTA
ACCOUNTABLE HEALTH MODEL

www.mn.gov/sim