Minnesota’s Accountable Communities for Health: Strengthening Clinical/Community Partnerships

Agenda

• How we got here
• What we are building on
• What we have learned so far
• Where we are now
• Key issues/questions
• Next steps
Driver 4 Activities

Select up to 15 Accountable Communities for Health (Year 2) and provide financial support to:

- Establish community advisory teams/partnerships
- Identify priority population health goals and improvement activities
- Ensure community leadership/ownership
- Provider technical assistance and development of payment model integration
- Develop sustainability plans

Cracks in Foundation

- Access to real-time clinical data across providers
- Care coordination skills
- Data analytic ability
- Provider-Community Partnerships
- Disparities
What are we testing?

Can we improve health and lower costs if more people are covered by Accountable Care Organizations (ACO) models?

If we invest in data analytics, health information technology, practice facilitation, and quality improvement, can we accelerate adoption of ACO models and remove barriers to integration of care (including behavioral health, social services, public health and long-term services and supports), especially among smaller, rural and safety net providers?

How are health outcomes and costs improved when ACOs adopt Community Care Team and Accountable Communities for Health models to support integration of health care with non-medical services, compared to those who do not adopt these models?

Early input

2012: Community meetings

• Move beyond medical model
• You may have to spend more now to save later
• Data, data, data – financial, claims, admin
• State: coordinate and facilitate, not dictate
• Create “communities for a lifetime”
• Don’t reinvent the wheel
• Think about employer role – 60% of coverage
Foundation: Community Care Teams

- Three existing CCT’s in Minnesota: ACH pilots
- Initially funded through HCH program
- Multi-disciplinary care teams: clinic/HCH, hospital, community & social services
- Focus on coordinating care for whole patient, engaging all sectors
- Developing new relationships, approaches
Foundation: Community Care Teams

• ~13-15 months funding
• $100 - $150K/community
• Open to nonprofits, gov’t entities, tribal gov’ts, clinics, hospitals, public health
• Locally-determined priorities/goals
• HCH at the center, providing coordination support
• Focus on building relationships

Community Care Teams

• Mayo: Wrap---around team approach, focusing on the development of the core team structure for seniors population.
• HCMC (Brooklyn Park/Brooklyn Center): Focus on diabetes and community/parish linkages
• Essentia Ely: Began with pediatric mental health, extended to broader population through community partnerships
CCT Lessons to Build On.....

- Engage trusted community leaders – and primary care providers - early on
- Start with small projects to get off the ground, establish roles & trust
- Build on existing relationships & work
- Need designated/supported time for work
- Build in LOTS of time to develop partnerships, agree on goals
- Sustainability/payment is key
- Culture change/paradigm shift
Similar Models: Other States

- VT, NC Community Care Teams
- Oregon: Coordinated Care Organizations
  - Unified local budgets
  - Governed by provider/community partnerships
- MD: Community Integrated Medical Home (SIM)
  - Regional community health hubs
  - Local health improvement coalitions
  - Hotspotting based on utilization data

Interviews: Other Minnesota Models

- Beacon Community, Mayo Clinic, Funding, HITECH grant from the U.S. Department of Health and Human Services
- Minnesota Department of Health SHIP/Community Transformation Grant, Funding, State of Minnesota and CDC
- Community Care Teams, Ely Clinic, Essentia Health, Funding MDH HCH
- Diabetes Collective Impact Initiative, MDH/DHS, Funding CDC
- ICSI Accountable Health Communities, Funding Bush Deliverable Planning Grant
- Stratis Health, Community Integration Projects
- ABCD III, MDH/DHS, Funding, Commonwealth Fund
- Preferred Integrated Network Project, Dakota County, Funding, DHS
- Hennepin Health, Hennepin County Health Department, Funding, DHS
National Quality Forum (NQF) project called “Population Health Framework”, led by the federal Department of Health & Human Services (HHS) – in year one of a three year project

Goal: Research and develop a Guide that explains the most effective approach to improving community health

Involves health care and public health groups, plus others to ensure that key determinants of health are addressed

- Behavioral – actions by individuals
- Environmental – impact of surroundings (clean air, safe neighborhoods, walkable communities)
- Social – high school graduation rates, income disparities, personal and spiritual connections

Throughout all:
- Health is a holistic concept, not just the absence of illness
- Equity and fairness – be sure to address disparities

Key elements (still in very rough draft form)

☑ A self-assessment about readiness to engage in this work
☑ Leadership – relationships and roles, skills in strategy, being a neutral convener to build bridges, adaptability
☑ An organizational planning and priority-setting process that includes
  • An identified method for identifying the right interventions and learning from experience (e.g., Plan, Do, Study, Act cycle)
  • How the success of the effort will be evaluated
NQF: Community Health Improvement Guide, Rough Draft
Key Elements (cont)

- A community health needs assessment and “asset mapping” process
- An agreed-upon, prioritized subset of health improvement activities with roles for participating organizations and individuals
- Responsibility for leading an area of health improvement
- Selection of measures or indicators and performance targets
- USE of those same prioritized measures
- Audience-specific strategic communication, speaking to social values and making the business case (e.g., value-proposition, return-on-investment)
- Joint reporting on progress toward achieving the intended results and sharing those results with the entire community
- A plan for sustainability
- Indications of scalability

More lessons to build on...

- Successful community partnership building may take up to 2 years
- Organic formation of community partnership and/or care coordination networks are observed in successful models
- Many models have care coordination function that connects healthcare providers, behavioral health and public health services
- Short-term achievements will be key for continued engagement of community partners
- A model that heavily relies on grant money may not sustain after the grant cycle ends
Factors that Facilitate Success

- Strong IT infrastructure that enables information exchange
- Existing community resources and networks, past experience of successful collaboration
- Early involvement of and strong buy-in from healthcare providers
- Shared focus on goals that can be reasonably achieved in the given timeframe
- Shared vision among community partners
- Target population is well defined so that community partners can bring their cause to the shared problem
- Strong community leaders who are committed to improving health of the population
- Strong governance structure and top leadership involvement
General ACH approach

• We describe what, you tell us how
• Focus on complex populations
• Common measurement where possible
• Process and outcome measures
• “Community” can be geographic, cultural, condition-based
• All partners at table
ACH Subgroup

Broad stakeholder group to:

— Provide guidance and advice in developing strategies to raise awareness of the ACH vision and create community readiness

— Provide advice on soliciting input from diverse stakeholders and communities regarding the ACH approach and applying that input to program planning as appropriate;

— Develop recommendations for selection criteria

ACH Funding to:

• Leadership/governance
  — Coordinate an ACH leadership team
  — recruit members including local citizens
  — facilitate and coordinate ACH meetings with community partners
  — manage ACH grant dollars.

• Implement community service delivery teams

• Develop health improvement plan

• Implement small grants to support community participation.

• Participate in evaluation of the model
General ACH criteria

- Not one-size-fits-all
- Proposals may be initiated by providers, community orgs, non-profits, tribes, etc.
- Include at least one ACO that provides primary care to a threshold % of population and has financial accountability for outcomes
- Community-led oversight body that represents population & needs: includes providers from across spectrum
**General ACH criteria, con’t**

- Collaborate with LPH to develop health improvement plan
- Build on local needs assessments
- Move towards integration of care across spectrum, including public health and social services
- Priority on areas with high disparities
- Sustainability plan

**Role of Public Health**

- Convener/Facilitator
- Partner in community needs assessments
- Partner in prevention/improvement plans
- Outreach
- Identify existing projects/initiatives
- Leadership development
- Bridge clinical/population health
Role of Public Health

- MPHA forums (Jan, March, June)
  - Use HiAP to identify barriers (housing, transportation)
  - Education on what creates health/best practices
  - Convener
  - Data sharing hub?
  - Developing shared language
  - Promote community participation

Resources

- SIM Continuum of Accountability Matrix
  - HIE, governance, collaboration, etc
- Partnership Self-Assessment Tool
  - Synergy
  - Decision-making
  - Resources
  - Admin/management
  - Leadership
  - Satisfaction
- People/orgs to connect to
Key Questions

• Role of ACOs – and what is an ACO, anyway?
• What is “accountability” for an ACH?
  – Developing plan to reduce costs, improve quality
  – Establishing community leadership body
  – Defining – and engaging – population(s)
  – Not achieving ROI in two years
• What does “shovel ready” look like?
  – Should everyone be at the same level?
  – Design vs testing?

HCHs in MN     ACO Hospitals in MN
Key Challenges

- Bridging clinical to population health
- Moving from TCOC to TCOH
- Sustainability
- Consistency vs local control/innovation
- Balancing ROI vs aspirational goals

Next Steps

- ACH Advisory Subgroup continues
- Learn from current partnership projects
- Work with community to refine ACH criteria
- Contract with existing CCTs
- Develop/release RFP
- TA/preparation for communities: tools, resources, best practices
- Community engagement
ACH Grant Timeline

• ACH Advisory Subgroup Meetings thru April, 2014
• Contract with Community Care Teams Summer 2014
• Community engagement/prep through June 2014
• Post competitive RFP July, 2014
• Award grants by ~October, 2014
• Implementation begins ~October/November, 2014

A healthy community is...

“... one that is continually creating and improving those physical and social environments and expanding those community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.”

~ World Health Organization
A healthy community is...

“A community is like a ship; everyone ought to be prepared to take the helm.”

-Henrik Ibsen

Questions?

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