The Minnesota Accountable Health Model
Objectives

- Learn why the Health Care Home model of team based care is used as a foundation of the Minnesota Accountable Health Model.
- Understand the value of Practice Transformation to improve care.
- Learn about the importance of the integration of primary care and behavioral health.
- Hear from providers on various models of integrated care and the use of emerging professions to support team members in working at the top of their license.
Agenda

• Overview of the Minnesota Accountable Health Model and Health Care Homes (HCH)

• Introduction to Integrated Care

• Models of Integration of Behavioral Health and Primary Care in Practice
State Innovation Model Initiative (SIM)

- SIM is a Center for Medicare and Medicaid Innovation initiative to test and implement health care payment and delivery reform ideas
- Goal: Better quality in health care, improved experience, and lower costs
MN SIM Shared Vision

- The majority of patients receive patient-centered and coordinated care across settings
- The majority of providers are participating in Accountable Care Organizations (ACO) or similar models that hold them accountable for costs and quality of care - Financial incentives for providers are aligned across payers and promote the Triple Aim goals
- Communities, providers and payers have begun to implement new collaborative approaches to setting and achieving clinical and population health improvement
Practice Transformation

- Serve more patients through patient-centered care teams that effectively coordinate care.

- Develop sustainable infrastructure for a broad range of providers as they transform their work.

- Integrate care teams to include clinicians and staff from medical, behavioral health, social services and public health settings.
Health Care Homes: Background

• Centerpiece of Minnesota’s 2008 health reform initiative.
• Focus is on redesign of care delivery and meaningful engagement of patients in their care.
• The name “Health Care Home” acknowledges a shift from a purely medical model of health care to a focus on linking primary care with wellness, prevention, self-management and community services.
The Health Care Home Model: a patient centered delivery model driven by quality improvement to meet the triple aim.
Health Care Homes: 2016 Goals

• Continue building a strong primary care foundation to ensure all Minnesotans have the opportunity to receive team-based, coordinated, patient-centered care.

• Increase care coordination and collaboration between primary care providers and community resources to facilitate the broader goals of improving population health and health equity.

• Improve the quality and the individual experience of care, while lowering health care costs.
What is integrated care?

“Integrated care is a team-based model of care, based on the blending of numerous provider disciplines’ expertise to treat a shared population through a collaborative treatment plan with clearly defined outcomes. The client and their family play a vital role as members of the team, providing input on personalized health outcomes and preferences in treatment approach.”

http://www.integration.samhsa.gov/workforce/team-members
Health Care Homes: Foundational for Integrated Care

- The HCH model builds a strong primary care foundation for integrated care models through certification standards that aid in transforming systems.

Person-centered approach:
- encourages patients to take an active role in managing their health care
- based on the principles of shared decision making and patient/family engagement

Team based care:
- uses a team to engage with patients in providing ‘whole person’ care delivery
- establishes relationships between the patient and the care team for effective goal setting, care coordination, care planning, and follow up support
Integration of Behavioral Health Impacts
Overall Health

• “Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.” (http://www.integration.samhsa.gov/resource/what-is-integrated-care)

• Integrated Care “can improve mental and physical outcomes for individuals with mental disorders across a wide variety of care settings, and they provide a robust clinical and policy framework for care integration.”

• Over 30 RCT’s showing Integrated Care improves health outcomes. (http://moo.pcpcc.net/files/organizing_the_evidence.pdf)
The PROBLEM

People with mental illness die earlier than the general population and have more co-occurring health conditions.

68% of adults with a mental illness have one or more chronic physical conditions.

more than 1 in 5 adults with mental illness have a co-occurring substance use disorder.
The solution lies in integrated care – the coordination of mental health, substance abuse, and primary care services. Integrated care produces the best outcomes and is the most effective approach to caring for people with complex healthcare needs.
Models of Integrated Care
Questions?

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SIM Overview: Integration of Primary and Behavioral Health

Essentia Health – Ely’s Experience
Thanks
Overview

- Community partners in Ely and Duluth, in collaboration with Essentia Health, have launched two separate Accountable Communities for Health (ACH) models to improve health and address the social determinants of health.
- Funding for ACH projects comes from the state of MN through a State Innovation Model (SIM) grant.
- The Ely ACH is based in a rural community and strengthens the existing Community Care Team (CCT) and Community Health Worker (CHW) role which were initially funded by an MDH grant.
- The development of a Behavioral Health Network is a result of the collaboration and successes of the CCT.
Essentia Health

- Headquartered in Duluth, MN
- Nonprofit, Integrated Health System
- Accountable Care Organization
- Aligned facilities with secular and Catholic roots
## Death Rate Comparison (per 100,000)

**MN vs. 4 Northeastern Counties**

<table>
<thead>
<tr>
<th>Leading Causes of Death Rates</th>
<th>MN</th>
<th>CHB</th>
<th>Carlton</th>
<th>Cook</th>
<th>Lake</th>
<th>St. Louis</th>
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<tbody>
<tr>
<td><strong>2006-2010</strong> Cancer</td>
<td>169.6</td>
<td>194.1</td>
<td>207.5</td>
<td>178.7</td>
<td>182.3</td>
<td>190.6</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>126.6</td>
<td>167.8</td>
<td>180.6</td>
<td>152.1</td>
<td>135.2</td>
<td>168.1</td>
</tr>
<tr>
<td>Stroke</td>
<td>36.2</td>
<td>37.2</td>
<td>43.9</td>
<td>*</td>
<td>38.7</td>
<td>36.1</td>
</tr>
<tr>
<td>Unintentional Injury</td>
<td>36.2</td>
<td>43.9</td>
<td>46.6</td>
<td>*</td>
<td>38.2</td>
<td>44.2</td>
</tr>
</tbody>
</table>

*Source: MN Center for Health Statistics
Factors Contributing to Health
(relative contributions)

- Social and Economic Factors, 40%
- Health Behaviors, 30%
- Clinical Care, 10%
- Physical Environment, 10%
- Biology, 10%

Advancing Health Equity in Minnesota: Report to the Legislature
MDH, February 2014
Interesting Dynamics
How We Started

• RN Care Coordination & Chronic Disease Management
  – Diabetes, HTN, IVD, Depression, Asthma, etc
• Patient Engagement Strategies
  – Online Access
  – Group Visits
  – Support Groups and Education
  – Patient Advisory Group
What We Learned

• RN Care Coordination helps reduce complexity of system for patients
• Coordination and Education provides patients with tools to improve their health
• Our patient engagement strategies created efficiencies and support for patients to connect with their care team
• Care Coordination amplifies the biggest barriers to health and wellness
• Care Coordination made us curious about another path
RN Care Coordination is Important but…

- Medicine is the architect that lays out the plans
- Healthcare includes the craftsmen bricklayers, stonemasons, landscapers, electricians, and plumbers – (nursing, dentistry, PT, pharmacy, radiology, nutrition, mental health providers, educators, public health, etc)
- The payers and healthcare administration are the bankers and the inspectors that tells how much money can be spent and, by the way we changed the standard for what is classified as quality
- Homeowner consults friends / family (and the internet of course) for experiential or anecdotal advice
Two Pieces of the Puzzle

• CHW (the project manager) is maximized with functioning CCT
• CCT grows and strengthens through the collaborative work of the CHW
Community Health Worker (CHW)

- Coordinate non-medical issues that affect health and wellness of our patients.
- Care management for individuals whose primary needs are not medical.
- Provides support to RN care coordinator for psychosocial needs of CDM patients.
- Provides information and warm handoffs / referrals for patients who need connections to additional resources, but do not need care coordination.
- Provides resource for ALL staff.
Individuals Barriers

• A-Basic needs (shelter, food, clothing)
• B-Transportation
• C-Communication
• D-Systems navigation/understanding the systems
Community Care Team Members

19 Agency Partners

- Health Care
- Mental Health
- Social Services
- Education
- Non-profit
- Consumers and Families
What Can a Team Do?

• Address processes leading to fragmented care
  – Managing referrals
  – Improve / Establish Communication
    • Meds
    • Treatment plans
• Shared Understanding of Privacy Laws
• Adopt methods that facilitate the communication of pertinent information to members of the patients care team
• Commit to “No Wrong Door” Philosophy

One Agency Cannot Do it All
Consent to Release and Exchange Personal Information
Between Your Care Team Agencies

1. Purpose of the exchange of information: Coordination of your care
   This release will permit the individuals and agencies you choose to work together in a confidential, professional manner to meet your wellness needs.

2. Your basic information:
   
<table>
<thead>
<tr>
<th>Name / Helena MA</th>
<th>Date of Birth</th>
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   Address

3. Type of information to be exchanged as it pertains to helping the team assist in your wellness:
   Cross out and initial any item if you do not give this permission:
   • History and Physical
   • Diagnoses
   • Medications
   • Progress Notes
   • Care Plan or Treatment Plan
   • Mental and Chemical Health Diagnoses, Treatment Plan, Treatment Summary, Diagnostic Assessment and Medications
   • School IEP & Assessments
   • Immunizations
   • HIV/AIDS testing
   • Emergency and Urgent Care Reports
   • Discharge/Treatment Summary

4. Identify which of the following agencies and/or individuals are important in coordinating your care and give them permission to collaborate on your care by sharing information as noted above (Check the members to whom you'd like to give permission):

<table>
<thead>
<tr>
<th>Boundary Waters Care Center</th>
<th>Northwoods Hospice Respite Partners</th>
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<tbody>
<tr>
<td>Center for Rural Mental Health Studies</td>
<td>Project Care Free Clinic</td>
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<tr>
<td>Ely Bloomenson Community Hospital</td>
<td>Range Mental Health Center</td>
</tr>
<tr>
<td>Ely Community Resource</td>
<td>St. Louis County Public Health &amp; Human Services</td>
</tr>
<tr>
<td>Essenta Health-Ely Clinic</td>
<td>St. Mary's Hospice and Palliative Care</td>
</tr>
<tr>
<td>ISD 676</td>
<td>Northern Lights Clubhouse</td>
</tr>
<tr>
<td>ISD 2142</td>
<td>Vermilion Community College</td>
</tr>
<tr>
<td>Other:</td>
<td>Other:</td>
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</table>

5. When you sign this form it shows that you understand the following:
   • You are giving permission for the written and/or verbal release and exchange of your personal information as indicated in section 3, between those named in section 4.
   • No one will deny you help if you do not want us to share your personal information.
   • If you allow the release and exchange of information, this consent will expire in one year and/or you may cancel this consent at any time in writing to any agency listed above.
   • If you submit a request to stop sharing your information, the request does not apply to information already shared before the time of your request.
   • We shall release your information to protect the health/safety of you and/or others when required by law.
   • Information released by an agency is no longer controlled by that agency and could be re-disclosed if it is no longer protected by federal or state privacy laws.

   
<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
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<table>
<thead>
<tr>
<th>Legal Representative Signature</th>
<th>Print Name/Relationship</th>
<th>Date</th>
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Created by Essenta Health—Ely Clinic Community Care Team Leader Heidi Favet  heidi.favet@essentialhealth.org
SIM Funding
Expand CHW Capacity

• CHW role added
  – Local School
  – EH – Ely Clinic
  – Northern Lights Clubhouse
• Documenting the CHW Role for Replication
  » Is that backwards?
• CHW in Integrated Behavioral Health Program
CHW Role in Behavioral Health

- CHW gets everyone on the same page: patient, providers, primary care, county workers, payers, schools
- Insures treatment goals are communicated to appropriate parties
- Supports patients in meeting treatment goals
- Patient follow up – how is new med working?
- Coordinating transportation
- Addressing no shows
- Coordinating referrals
Evaluation
Number of Emergency Department Episodes at 3, 6, 9 and 12 Months

3, 6, 9, and 12 Month Totals

<table>
<thead>
<tr>
<th>Month</th>
<th>Pre</th>
<th>Post</th>
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<tbody>
<tr>
<td>3</td>
<td>69</td>
<td>35</td>
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<tr>
<td>6</td>
<td>116</td>
<td>62</td>
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<tr>
<td>9</td>
<td>150</td>
<td>123</td>
</tr>
<tr>
<td>12</td>
<td>190</td>
<td>167</td>
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</tbody>
</table>
Relationships Between Organizations: 2012 compared with 2015
Behavioral Health Network

**Mission:** Provides collaborative care to identify and address overall behavioral health and recovery needs for rural NE Iron Range Communities.

**Vision:** Routine behavioral health screening in combination with voluntary connection to services insures adequate resources are available to individuals with mental illness and their caregivers to meet their physical health, mental health and psychosocial needs. Professionals in health, education, and public service offer routine screening for behavioral health needs, provide timely referrals to evidenced based services and follow up to determine if the intervention met the individual’s needs.

**Purpose (Goals):**

1. To develop cross-agency system for screening, referral, interventions, and follow-up for behavioral health issues.
2. To build capacity in the community to address behavioral health needs.
3. To enable the community to embrace mental health as an integral part of health and wellness.
What We Learned - CCT

• Administrative and Professional Champions
• Right person in right position
• Dedicated CCT Leader
• All partners *truly* valued equally
• Leadership acts as facilitator not manager
• Evaluation crucial to successful development and sustainability
• Creativity required to help partners see benefit
• Must understand restrictions under which partners operate
• Get a win to build trust and support
• Be in for the long haul—not just for the grant cycle
• Need a backbone agency to get things started
What We Are Learning - CHW

- Role varies depending on the needs of the population
- Reimbursement is challenging currently
- CHW must be the “right person” for the role
- CHWs work best when community agencies understand the role
  - Must have access
Questions.....
Contacts

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• Heidi Haney Favet, CHW  Community Care Team Manager  
  heidi.favet@essentiahealth.org