The Minnesota Accountable Health Model
SIM Minnesota

ACCOUNTABLE COMMUNITIES FOR HEALTH
HEALTH CARE HOMES MINNESOTA’S FOUNDATION
Introduction

Minnesota Accountable Health Model, State Innovation Model

Rosemarie Rodriguez-Hager,
Community Integration Practice Transformation Unit Supervisor, Health Care Homes, Minnesota Department of Health

Rosemarie Rodriguez-Hager, is the Supervisor for the Community and Integration Partnership Unit, and is responsible for four grant programs which includes the Accountable Communities for Health. She is a part of the SIM Leadership Team at the state level, and is a co-lead for the interagency workgroup addressing community integration partnerships. Her work at the Minnesota Department of Health is closely tied to the Health Care Home program, and supports its programming through leading a HCH workgroup to address practice transformation. Prior to her SIM work she was the Latino health coordinator for the Office of Minority and Multicultural Health (OMMH), where she provided technical assistant and support to the 11 grantees that she manages. She also worked to increase the awareness of the health priorities for the Latino population in Minnesota, by partnering and collaborating with Latino agencies across the state. She has worked for the Minnesota Department of Health since 1998.
Minnesota Accountable Health Model

**Triple Aim**
Improving the individual experience of care
Reducing the per capita cost of care for populations
Improving the health of populations

**Goals**
- The majority of patients receive care that is patient-centered and coordinated across settings.
- The majority of providers are participating in Accountable Care Organizations 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.
- Communities, providers and payers have begun to implement new collaborative approaches to setting and achieving clinical and population health improvements.

**How we are doing**

- **Number of Minnesotans receiving care through a Medicaid Accountable Care Organization (ACO)**
  - 100,000
  - 200,000 2016 Goal
  - 205,000 2015 Progress

- **Percent of certified Health Care Homes (HCH) or Behavioral Health Homes (BHH) in Minnesota**
  - 30% 2013 Baseline
  - 53% 2015 Progress
  - 67% 2016 Goal

- **Integrated Health Partnership (IHP) cost savings**
  - $100M 2016 Goal
  - 2015 Progress $61.5M

**Accountable Communities for Health (ACH)**
Goal of 15 reached by 2015

- Percent of fully insured people covered by an ACO or Total Cost of Care (TCOC) Model
  - *41%* 2013 Baseline
  - *60%* 2014 Goal

*Minnesota health plans reported a high variation in the share of fully insured covered lives in accountable care arrangements with the weighted average of 41% to 44% in 2014. However, many health plans reported that over a half of their fully insured coverage base are attributed to accountable care arrangements.
Accountable Communities for Health

Minnesota defined:

Accountable Communities for Health (ACH) are innovative strategies to meet the clinical and social needs of a defined population through person-centered, coordinated care across a range of providers.
How ACHs work

• Community planned and led
• Target population with substantial health and social needs
• Community partners that contribute to a person’s health
• Integrate services using business agreements
• Identify and address structural barriers to health
ACH Requirements

- Community-led leadership
- Care coordination between multi-sectoral partners
- Population-based prevention
- Measurement
- Partnership with an Accountable Care Organization (ACO) or ACO-like type of organization
- Participation in an ACH learning community
- Sustainability planning
- Health equity focus
ACH Current Structure

- From 5 to 20+ partners
- All have at least one ACO partner
- LPH is a partner in 12 ACHs
- Target Population Participation
  - Individual Member/Leadership Team-6 (40%)
  - Agency representing target population/ Leadership Team member-2 (13%)
  - Other involvement (workgroups, focus groups)-13 (87%)
## Target Population

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Demographic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>At-risk/in crisis youth, adults, Native American</td>
</tr>
<tr>
<td>Diabetes, pre-diabetes</td>
<td>Latino, East African, Lower SES</td>
</tr>
<tr>
<td>Overall health wellness needs</td>
<td>families, correctional facilitation population</td>
</tr>
<tr>
<td>Complex chronic health conditions</td>
<td>adults/older adults</td>
</tr>
<tr>
<td>Chemical dependent, co-occurring chronic disease</td>
<td>adults/older adults</td>
</tr>
<tr>
<td>Disabilities</td>
<td>adults</td>
</tr>
<tr>
<td>Types of Care/Services Included in ACH Care Coordination Model</td>
<td># (%) of ACHs</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Primary/medical care</td>
<td>12 (80%)</td>
</tr>
<tr>
<td>Mental health/behavioral health care</td>
<td>11 (73%)</td>
</tr>
<tr>
<td>Substance abuse prevention/treatment</td>
<td>3 (20%)</td>
</tr>
<tr>
<td>Health education/promotion resources (includes health coaching)</td>
<td>5 (33%)</td>
</tr>
<tr>
<td>Immunizations/well-child care</td>
<td>1 (7%)</td>
</tr>
<tr>
<td>Dental care</td>
<td>3 (20%)</td>
</tr>
<tr>
<td>Vision care</td>
<td>1 (7%)</td>
</tr>
<tr>
<td>Public health services</td>
<td>1 (7%)</td>
</tr>
<tr>
<td>Community resources/services</td>
<td>8 (53%)</td>
</tr>
<tr>
<td>Social services</td>
<td>5 (33%)</td>
</tr>
<tr>
<td>Housing services</td>
<td>3 (20%)</td>
</tr>
<tr>
<td>Employment services</td>
<td>3 (20%)</td>
</tr>
<tr>
<td>Financial services</td>
<td>1 (7%)</td>
</tr>
</tbody>
</table>
Lessons Learned

- Organizational Capacity and Resources
- Community Engagement
- Collaborating with Partner Organizations
- Data Sharing and Privacy
- Non-clinical needs of patients/consumers
- Medical Services Needed: Dental and Mental Health
- Workforce Capacity
Empowering Communities to Achieve a Healthier Washington

Chase Napier
Community Transformation Manager
Washington State Health Care Authority
Chase is the Health Care Authority’s Community Transformation Manager, leading Healthier Washington’s Accountable Community of Health (ACH) effort and serving as an active member of the interagency Healthier Washington team. Over the last two years, he has collaborated with regional partners to develop and support multi-sector health improvement coalitions that collectively cover the entire state. Washington’s ACHs are comprised of multi-sector partners who are voluntarily organizing to coordinate activities, jointly implement health-related projects, and advise state agencies on how to best address local health needs. Chase’s background includes regional and state policy development, with an emphasis on community engagement and collective impact as critical components of policy development and process improvement.
Washington’s vision for creating healthier communities and a more sustainable health care system:

- **Building healthier communities through a collaborative regional approach**
- **Ensuring health care focuses on the whole person**
- **Improving how we pay for services**
An ACH is a locally driven model that unites an array of key partners, each of whom shares a common goal of health improvement, and who, by coordinating and aligning strategies across sectors, can strive to achieve sustainable health improvement by addressing multiple contributors to poor health.

(State levers to advance accountable communities of health. NASHP. May 2016)
We recognize that health is more than health care...

Health Care: 20%
Physical Environment: 10%
Health Behaviors: 30%
Socio-economic Factors: 40%

County Health Rankings Model, 2016, UWPHI
...and that clinical-community linkages are essential for better health outcomes.

**Healthier Washington System Supports**

- Information Technology / Infrastructure
- Data and Measurement
- Workforce Development
- Practice Transformation
- Payment Redesign
Accountable Communities of Health are:

- Bringing together diverse public and private community partners to work on shared regional health goals.
- Identifying opportunities for the ACH and community partners to understand and bridge health and quality of life issues.
- Coordinating systems so that services address all aspects of health at both the community and individual levels.
Lessons we are learning...

• Regional variation doesn’t necessarily mean the health needs and priorities are different
• Focus on the linkages between social determinants of health and the delivery system, not one at the expense of the other
• How is the system expected to sustain the transformation and health improvement, beyond cost savings and reinvestment?
For more information...

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Thank you

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The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.
Olympic Community of Health

Elya Moore, PhD
Director, Olympic Community of Health
Supported by Kitsap Public Health District
June 21, 2016
Olympic Community of Health

Elya Moore, PhD, Director

With 12 years of training as an epidemiologist and 5 years of experience leading a local nonprofit health collaborative, Elya Moore is grounded by the belief that health care is local, and therefore solutions to the problems that exist today must derive from the local experience. She drives toward improved population health by blending her experience and training with her passion for our communities. Elya spends her free time with her husband, Ryan, and two dogs, Bruno and Popper.
The case for the Olympic Community of Health

- **Health is local**... and is largely driven by factors outside of the health care delivery system.
- **Health care is local**... we need it, but it costs a lot.
- Major **changes are coming** to our health care system.
- It is critical for our communities to both understand and assert control over this change based on what is important to us.
- The OCH is the primary vehicle through which our communities can be heard and can participate in the process of change.
- We can accomplish much more together, across sector and county lines, inclusive of our Tribal nations, than we can separately.
Regional Vision. Local Action.

- Focusing on improving health outcomes across the population, including and beyond the health care system.
- Sharing a unified, regional voice on health priorities.
- Collaborating across systems to improve our community well-being.
- Utilizing a collaborative infrastructure that creates efficiency and scale.
- Delivering culturally competent services, which include language access.
- Driving action oriented measurable outcomes through the use of data and local voice.
The OCH is a locally-driven health collaborative focused on community health improvement through strategies to such as:

- community-wide disease prevention
- clinical-community linkages
- integration across medical, behavioral, and social service siloes
- policy change

For now, we accomplish these goals through tactics such as:

- convening multi-sector partners
- identifying shared regional needs
- implementing targeted projects that address shared needs
### Olympic Community of Health Shared Regional Health Priorities

<table>
<thead>
<tr>
<th>ACCESS</th>
<th>AGING</th>
<th>BEHAVIORAL HEALTH</th>
<th>CHRONIC DISEASE</th>
<th>EARLY CHILDHOOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>A continuum of physical, behavioral, and oral health care services are accessible to people of all ages and care is coordinated across providers.</td>
<td>Aging adults and their caregivers are safe and supported.</td>
<td>Individuals with behavioral health conditions receive integrated care in the best setting for recovery.</td>
<td>The burden of chronic diseases is dramatically reduced through prevention and disease management.</td>
<td>Children get the best start to lifelong health and their families are supported.</td>
</tr>
</tbody>
</table>

Progress on these priorities depends on improving health equity through **SOCIAL DETERMINANTS** – housing, education, workforce development, employment, transportation, safety, environmental conditions.
Olympic Community of Health
Governance structure

Board of Directors
(n=15 sectors + 7 Tribes)

Executive Committee
(n=5)

Partner Group
(formerly “Stakeholder Group”)

Regional Health Assessment and Planning Committee
(n=30)

Ad Hoc Governance Subcommittee
(n=8)

Director
1.0 FTE

Assistant
0.4 FTE

Epidemiologist
0.5 FTE
Olympic Community of Health
Where to from here?

Kitsap Public Health District

✅ Articles of incorporation
✅ Bylaws
✅ Policies

Legal Entity
501©3, LLC, LLP, Public Corporation or other Public-Private Partnership
Thank you!

Resources:
- Linkedin
  https://www.linkedin.com/groups/7050279
- Vermont State Health Care Innovation Project
  http://healthcareinnovation.vermont.gov/

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