Accountable Communities for Health

PERSPECTIVES ON GRANT PROJECTS AND FUTURE CONSIDERATIONS

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

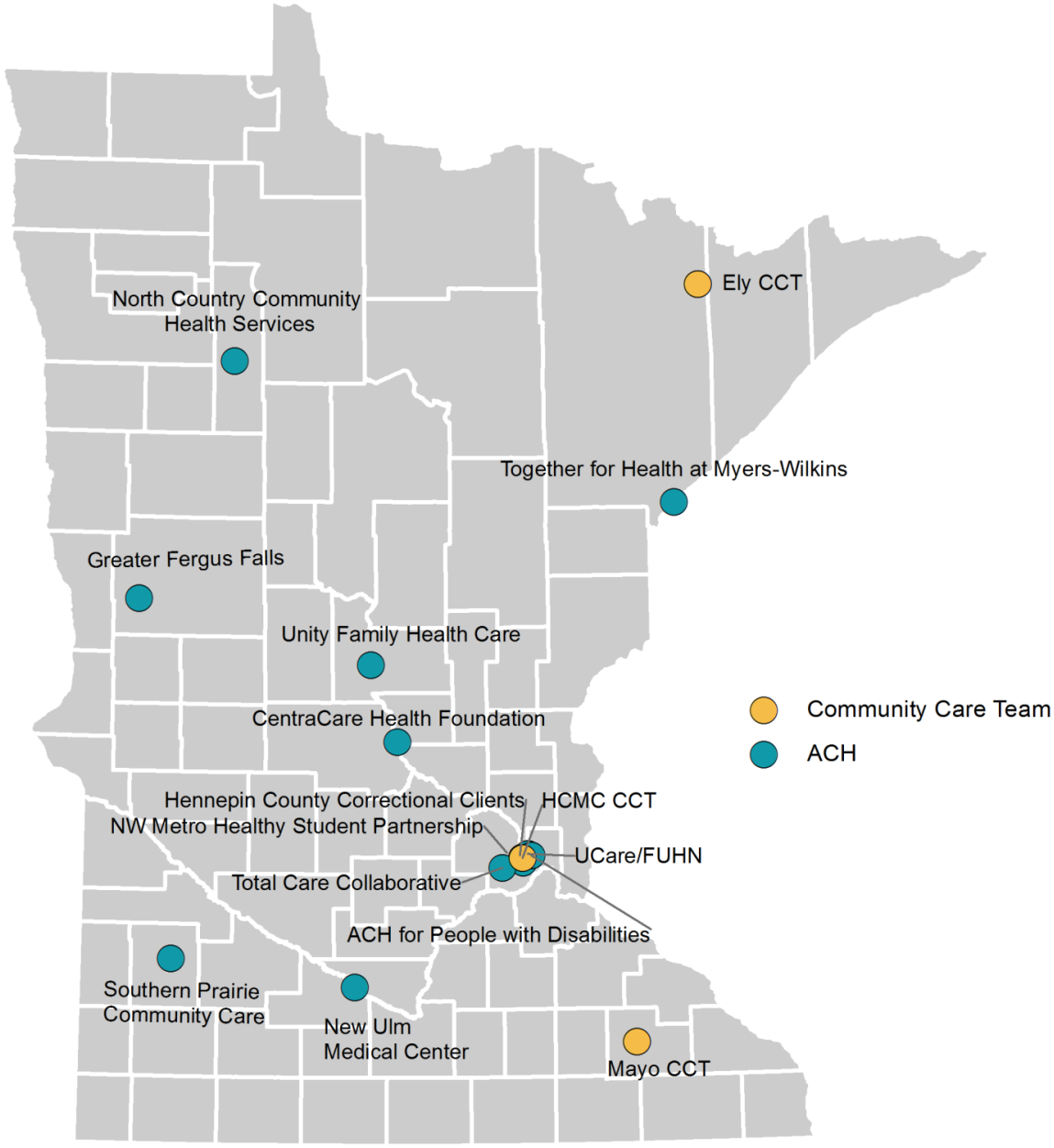
Contents

Summary

Accountable Communities for Health (ACH) expand the idea of team-based, integrated, coordinated care to transform health care delivery, accountability and payment. In Minnesota, 15 unique ACH projects have worked to address local challenges across the State using community-based care coordination models. ACHs drive health reform efforts by supporting provider organizations in partnership with communities to engage consumers, identify health and cost goals and take on accountability for population health. All ACH projects have contributed implementation lessons that may inform ongoing transformation of Minnesota's health system.

Minnesota is working to advance the Minnesota Accountable Health Model and expand active community participation with a broad range of stakeholders and providers in addressing local health needs. The Minnesota Accountable Health Model is funded through a $45 million grant from the Center for Medicare and Medicaid Innovation (CMMI) as part of the State Innovation Model Initiative (SIM). The goals of Minnesota's Accountable Health Model align with the Institute for Healthcare Improvement's "Triple Aim" which focuses on population health, experience of care and per capita cost. The ACH projects are part of an ongoing effort to ensure that every Minnesotan has the option to receive team-based, coordinated, patient-centered care that increases and facilitates access to medical care, behavioral health care, long term care and other services.

Figure 1. Distribution of ACH Projects in Minnesota



Source: State Health Access Data Assistance Center (SHADAC) (October 2015). "Database: Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative." University of Minnesota, School of Public Health. Minneapolis, Minnesota.

Overview of an ACH

The Accountable Communities for Health grant program is part of the Minnesota Accountable Health Model, funded by a State Innovation Model (SIM) testing grant of over $45 million from the Center for Medicare and Medicaid Innovation. Approximately $5.6 million, or 14 percent, of Minnesota's SIM funds were invested in 15 community-led ACH projects to help providers and communities work together and expand patient-centered, team-based care.

Accountable Communities for Health meet clinical and social needs of a defined population through coordinated care across a range of providers: acute and primary care, behavioral health, long term care, local public health, social service and other community-based supports. Through community engagement, ACH partnerships establish priorities for population health outcomes and plan activities to coordinate care with Accountable Care Organizations (ACO) within their community.

Foundations for Accountable Communities for Health

Minnesota's 2008 bipartisan health reform efforts established the Health Care Homes certification program. A health care home is an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic or complex health conditions. They strive to place patients and families at the center of their care and to provide the right care at the right time and right place. Health Care Home recertification standards encourage providers and clinics to take a proactive approach to planning and partnering with community resources to ensure their patients have access to needed resources and services. HCH certification is a voluntary program in which practices and providers, after meeting a rigorous set of certification standards, become eligible for receiving monthly per-person payments for care coordination activities.

The practice standards of a certified Health Care Home clinic became an important foundation to transforming primary care delivery. Recognizing that a potential limitation of the Health Care Homes program was its focus on medical care, in 2011 MDH designed a community care team pilot to improve coordination between clinics, local public health and community providers. The pilot was tested in three communities, Hennepin and Olmsted Counties and the Ely area. Grant funds were state-only dollars administered out of the Health Care Homes section.

Each of the community care team pilot projects met their goals to learn how to implement a community care team that included community members and community providers, to identity care coordination methods in their communities and to develop a sustainability plan with recommendations for the future. The important learnings from these pilots served as the foundation for the Accountable Communities for Health grant program. All three community care team pilots subsequently received SIM funds to extend their state-funded programs.

Community Care Team Pilots – Early ACHs

- **Essentia's Ely Clinic (Ely, MN)** is a sole provider of primary care and specialty outpatient services for this rural community, Ely Clinic services residents in northeastern St. Louis and northwestern Lake Counties. Their CCT grant focused on leveraging integration of services to meet the needs of young adults and of adults aged 55 years and older.
- **HCMC Community Care Team** (CCT) serves one of the most diverse ethnic and cultural populations in Minnesota, approximately the service area for HCMC's Brooklyn Park and Brooklyn Center clinics. The CCT goals and activities included families, patients and community members in northwest Hennepin County who were adults with Type 2 diabetes.
- **Mayo Community Care Team** served Olmsted County in southeastern Minnesota with a reach of approximately 124,000 people. The number of adults over age 65 is expected to increase by 117% from 2000 to 2030, nearly 1 in 5 living with at least one disability. This CCT focused on individuals at high risk for hospital or nursing home admission or use of emergency services.

To establish its Accountable Communities for Health model, Minnesota also reviewed literature, policy recommendations and the early work of community care teams in Vermont and North Carolina that had integrated health and social services. Like these two states, Minnesota centered its approach on community-defined needs, a "medical home" provider, local public health and community services, exchange and tracking of health information and not adding costs to patients.

Moving towards Greater Accountability and Improved Population Health

The Accountable Communities for Health model is focused on social needs and clinical care integration across a range of providers, guided by local leaders and community members with support of an accountable care organization (ACO).[1] This intentional partnership design aims to bring health care systems, particularly those participating in contracts that include performance incentives based on cost and quality, and community resources together to lessen fragmentation of services and move towards a more holistic approach to health. The ACH approach integrates health care with public health and social services, and includes multiple community stakeholders who come together as a coalition to address the needs of the whole person including social determinants of health.[2] Multi-disciplinary teams use a variety of methods to integrate services and

[1] An Accountable Care Organization (ACO) is a group of health care providers, with collective responsibility for patient care that helps coordinate services – delivering high quality care while holding down costs.

[2] See Tipirneni et. al. (2015) for definition and purpose of an accountable community for health.

coordinate care through enhanced referrals, transitions management and implementation of new practice guidelines.

ACH projects are community-led and community-driven initiatives that support needs across the spectrum of health. They invest in leadership for medical and non-medical needs of a community, and by partnering with accountable care organizations (ACO) they are often uniquely poised to increase responsibility for the health of an attributed population. The ACO-ACH partnership recognizes the impact of social determinants of health factors on health and the investment all community stakeholders make in health.

> The ACH approach integrates health care with public health and social services, and embeds the organization in a community where multiple stakeholders come together as a powerful coalition that share responsibility for tackling multiple determinants of health.
>
> Tipirneni, Diaz Vickery, Ehlinger

These new partnerships are intended to improve population health through aligned common goals. ACHs differ in their path for achieving this goal; some focus on population or patient management and others on broader policy, systems and environmental strategies which contribute to population health at the local level and state level.

Fifteen ACH projects represent a range of steady progress in rural, urban and suburban settings across Minnesota. Each ACH project features a unique mix of partner organizations and a focus on prevailing health and social conditions in order to address population-specific needs. These features advance new and innovative relationships by engaging a broad range of providers, public health and communities to plan for population health improvement activities and to deliver patient-centered coordinated care with increasing financial accountability for outcomes. Each ACH measures and develops population health plans that could lead to more strategic partnerships or towards greater accountability for an attributed population (e.g., accountable care organization).

ACH Grant Program

Within the context of the Minnesota Accountable Health Model, a Community Advisory Task Force subgroup was created to provide counsel on the criteria and implementation of ACHs. The ACH subgroup, comprised of 16 health and social service professionals, met three times in early 2014 and made recommendations for the ACH grant program. Subsequent regional meetings were held to solicit additional comments and engage

stakeholders in applying the model locally. The ACH subgroup and stakeholder discussions recommended these key components for successful ACH implementation[3]:

- Leadership structure
- Community-based care coordination system/team
- Population based prevention
- Advancing health equity
- Testing and measurement
- ACO participation
- Planning for sustainability

Eligible applicants were tribes, community or consumer organizations, public health agencies, health plans, counties, health care providers or any other non-profit or for profit entity located in the State of Minnesota. Grants were scheduled to run for two years, January 1, 2015 – December 31, 2016.

Twenty applications were received for the Accountable Communities for Health grant funding, and twelve grants were awarded through the competitive grant process. The three pre-existing community care teams were awarded ACH sole source grants in late 2014.

The request-for-proposal timeline ran from September 2, 2014 to January 1, 2015. The grant activity and timeline included the following:

- RFP posted Tuesday, September 2, 2014
- Optional informational webinar on RFP and Continuum of Accountability Matrix Wednesday, September 10, 2014
- Required non-binding Letter of Intent due to MDH (see letter template Form G) Friday, September 26, 2014
- Proposals due to MDH Monday, October 20, 2014
- Oral presentations for selected applicants November 6 and 7, 2014
- Notice of Awards Monday, November 24, 2014
- Estimated grant start date January 1, 2015

Selection

The State reviewed proposals based on criteria in the RFP and the applicant's level of capacity on a "continuum of accountability," which assessed applicant organizations and their partners on key skills necessary to succeed in accountability models. The selected proposals represented a range of progression

[3] See Accountable Communities for Health Advisory Subgroup description and recommendations. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=sim_tf_subgroup

towards accountability and integration of care. Including the three sole source awards, 15 projects were funded for a total of $5,543,160.

Table 1. Minnesota Accountable Communities for Health grant awards

ACH Name & *Lead Organization*	Location	Focus Population
ACH for People with Disabilities *Lutheran Social Service of Minnesota/Altair*	St. Paul/Anoka, Dakota, Hennepin, Ramsey, Washington Counties	6,300 people with disabilities served by Altair
CentraCare *CentraCare Health Foundation*	St. Cloud/Stearns County	Hispanic and East African patient population - diabetic and underserved
Community Care Team: Mayo Clinic, Olmsted Medical Center, Olmsted County Public Health *Mayo Clinic*	Rochester/Mayo Clinic and Olmsted Medical Center health care home service area	Adults with complex chronic health conditions with a focus on dually-eligible
Ely Community Care Team *Essentia Health Ely Clinic*	Ely/Babbitt, Ely, Embarrass, Soudan, Tower, Winton and surrounding townships	Individuals living in poverty or with behavioral health challenges
Greater Fergus Falls ACH *Partnership4Health CHB*	Fergus Falls/Otter Tail County	People on MN Healthcare Plans (MHCP) and uninsured low-income residents
HCMC Brooklyn Park ACH *Hennepin County Medical Center*	Minneapolis/HCMC Brooklyn Park Clinic service area	Clinic patients with depression
Hennepin County Correctional Clients ACH *Hennepin Health*	Minneapolis/Hennepin County	Hennepin County correctional population (in-house clients at Hennepin County Adult Correctional Facility and Hennepin Co Jail)
Morrison County Community Based Care Coordination: Prescription Drug Overuse *CHI St. Gabriel's Health*	Little Falls/Morrison County	Seniors on multiple meds, addicts

ACH Name & *Lead Organization*	Location	Focus Population
New Ulm Care Coordination *New Ulm Medical Center*	New Ulm/New Ulm and surrounding area	MA population receiving primary care at New Ulm Medical Center (low income, over age of 65, people with disabilities)
North Country ACH *North Country Community Health Services*	Bagley/Clearwater, Hubbard, Beltrami, Lake of the Woods Counties; Red Lake and White Earth Tribes	At-risk youth or youth in crisis
Northwest Metro Healthy Student Partnership *Allina Health Systems*	Anoka-Hennepin School District	High school students in the Anoka-Hennepin School District
Southern Prairie Community Care	Marshall/12-county area in southwestern MN	Persons at risk for Type 2 diabetes
Together for Health at Myers-Wilkins *Generations Health Care Initiatives*	Myers-Wilkins School, Duluth/St. Louis County	Students and family members from Myers-Wilkins Elementary School community
Total Care Collaborative *Vail Place*	Hopkins/NW Hennepin County	People with serious mental illness, chemical dependency issues, and co-occurring chronic diseases, focusing on MA
UCare-FUHN ACH *UCare*	Minneapolis/Metro area served by FUHN	Medical Assistance-eligible people with disabilities enrolled in the Special Needs Basic Care (SNBC) program

Accountable Communities for Health at the Midpoint

At the time of writing this report, ACH grantees are over half-way through the 2-year funding cycle, and more information is becoming available on their successes and challenges that can help to inform future work. ACH projects submitted quarterly reports beginning the first quarter of 2015 and completed an annual report summarizing progress during the first year. MDH grant managers conducted site visits and participated in frequent phone and email communications with ACH grantees. This section summarizes findings from these efforts.

Leadership

Each ACH has a lead organization (e.g., private foundation, non-profit social service agency, local public health agency or health care system) that serves as fiscal agent and resources manager. The lead organization is responsible for convening a multi-sectoral governing body with representation from partner organizations and the community. ACH projects are exploring and testing a variety of governance approaches such as charters, formal business agreements between partners and use of technical subcommittees. Some ACH lead organizations supplement their staff capacity for convening meetings and staffing the project by subcontracting additional personnel and technical expertise.

Together for Health at Myers-Wilkins ACH

This leadership team provides overall direction to ensure the project mission, goals, and objectives are met. The team includes a broad cross-section of individuals and organizations from the community including parents, community members, Myers-Wilkins School and school district, Myers-Wilkins Community School Cooperative, health care providers, public health, community organizations, evaluators and project administration. The project builds on the strengths and diversity of its partners, and partner organizations are committed to sharing resources and expertise to address needs and develop prevention and wellness initiatives.

ACH leadership team structure and makeup differs across ACHs. Some ACHs created an entirely new governance structure while others use existing committees, task forces, or advisory bodies (such as Statewide Health Improvement Program (SHIP) committees) to organize their work. Many ACHs began with frequent meetings, often bimonthly or quarterly, and then adjusted to fit the local roles and responsibilities of their team. For example, some leadership teams formed working subcommittees that meet more often to accelerate care coordination and oversee specific grant activities. Day-to-day work is largely done by core teams or technical subcommittees comprised of care coordinators, grant project managers and other staff.

Some ACHs have yet to develop a defined leadership team, relying on existing structures or meetings. Though this may be a more efficient and practical use of staff time, it risks making the ACH approach secondary to other efforts.

Partnerships are dynamic and contextual

Partners vary considerably depending on the target population, but all ACHs have an accountable care organization (ACO) partner and one or more local public health agencies. While each project has a required

written commitment from an ACO, the degree of involvement varies and warrants further investigation to determine how to best use the ACO partnership to achieve results. Most ACH projects added partners during the first year, which benefited the ACH by including perspectives and resources from a larger number of agencies. Many new partners are advocacy groups, churches and social and legal services organizations that represent or serve the target population.

Each ACH includes as few as six and up to 30 partnering agencies and organizations. Some ACHs only list entities serving on leadership or care coordination teams as partners whereas others cast a wider net and include partners less directly involved in the project. In some cases, an ACH partner is an organization made up of several organizations such as a task force or mutual assistance association. Partners are included in contracting arrangements in many ACHs, providing professional services or employing project staff.

Target population involvement also varies

Engaging with the community and including representatives from the target population in project leadership is a foundational requirement of the ACH grant program. While most ACH projects have a diverse leadership team that represents the broader needs of the target population, the extent to which representatives of the target population, both at the agency and individual level, play an active part on the leadership team varies. Participation has been dampened by policies that restrict the use of funds to facilitate involvement of consumers and community members in leadership meetings. For example, the Center for Medicare and Medicaid Innovation does not allow ACHs to reimburse community members for child care, transportation or other out-of-pocket expenses for being involved in the project or attending community meetings.

In response to requests from ACH projects for help with overcoming obstacles to engaging members of the target population, the ACH Learning Community has provided webinars and other opportunities for sharing successful strategies. Projects use a variety of approaches to engage the target population and it may take several attempts to develop successful partnerships with community members.

Community Care Coordination

The ACH model is intended to refocus care coordination from clinical to whole-person needs by expanding the care team to include non-traditional partners from the community such as education, social services and housing. The care coordination approach for each ACH differs based on the target population, available services, locus of care coordination activity (i.e., clinic vs. school) and the health and social conditions being addressed.

People with Disabilities ACH
Participants in this ACH each develop a LifePlan. This patient-centered practice reflects ongoing life events and goes beyond acute and chronic care by taking into account housing, employment, physical health, social wellbeing and behavioral health needs. The LifePlan system tracks individual progress in these areas as well as use of in-home and mobile medical services and participant satisfaction.

ACH partners report many benefits from community care coordination and are seeing an impact on the people they serve. While care coordination is at the center of the Minnesota ACH model, it is still a work in progress for many grant projects. The establishment of a community care coordination program takes considerable time, even for established partnerships and experienced organizations, and requires substantial technical support.

Care models differ by project

In Minnesota, no two ACHs coordinate care alike with the same mix of partner organizations or for the same total health needs. The original request for proposals allowed communities to define a target population that is experiencing substantial health issues and identify partner organizations that would work together. Even though some partnerships were required, such as the involvement of an accountable care organization, there was no standard set of services that had to be provided.

Some care models are structured much more like the original CCT approach in Minnesota. These projects link health care, behavioral health, public health and community services for high-utilizers. Other ACH projects are centered on health promotion activities with care coordination consisting of little more than referrals.

Care teams are evolving

ACHs are constantly reassessing and changing their care approach to meet project realities. Even ACHs that received early CCT funding are identifying new partners and updating care coordination protocols. Some ACH care systems are very advanced with features and tools to make the work easier, such as formal business agreements between organizations, dashboard portals to track referrals and the exchange of health records, while other projects are most challenged by care coordination and have difficulty connecting with providers despite it being a core aspect of the project.

Information exchange remains a barrier

Effectively and securely exchanging health information among providers while maintaining patient data privacy continues to be a major challenge to advancing care coordination. ACH projects were hampered early in the grant period by confusion about data use and privacy laws and a lack of systems and protocols for exchanging information. Industry-specific privacy statutes and policies reinforce silos among different ACH partner organizations, such as for health care, child welfare, chemical dependency and schools. ACH projects were compelled to navigate complicated health information and privacy issues before moving ahead with other elements of care coordination.

E-health is a main component of Minnesota's Accountable Health Model. An infrastructure that supports providers' ability to exchange and analyze health information can transform care delivery and improve patient outcomes and experiences. The State Innovation Model testing grant has funded e-health readiness planning and implementation initiatives for behavioral health, local public health, long term and post-acute care and social services, as well as providing support across the care continuum to providers struggling to understand how to stay in compliance with state and federal privacy and consent laws. Three ACH grantees, Greater Fergus Falls, Southern Prairie Community Care, and Lutheran Social Service, are dual recipients of ACH and e-

health grants. Unfortunately, ACH grantees were not able to benefit from advances in e-health capabilities at their onset in early 2015 as their efforts ran side-by-side with state funding for e-health testing grants.

Hennepin County Medical Center: Brooklyn Park uses an online system of care partnership (SOCP) tool developed to facilitate referrals and ensure individuals and families obtain clinical, school, and social services support when needed. This system allows a provider to view available resources, connect with the sources and determine if the loop has been closed on the referral. While not providing an integrated system of data sharing, the SOCP provides an external structure that allows for cross-system data linking and access.

E-health is an important but difficult area for ACH projects to advance. Minnesota state law is more restrictive than federal standards in terms of requirements for patient consent to share information, rendering best practices from other states and national technical assistance providers less applicable. Future ACHs will need Minnesota-specific guidance and tools—such as interagency consent forms, sample data sharing agreements and dashboards or tracking portals—to ensure compliance with relevant laws and avoid delays in service provision. Minnesota might also need to consider changes or clarification about privacy and consent laws to better coordinate care for a person's total health needs and exploring other options such as Direct Secure Messaging.

Health Care Homes certification is foundational

Involvement of certified Health Care Homes in ACH projects appears to help partners provide seamless services. Most ACH teams feature at least one certified Health Care Home clinic as either the lead organization or as a leadership team member and main service provider. Among the certification standards, a Health Care Home must be able to identify high-risk patients with complex needs, provide coordinated care services, use registry tools to track clients and improve transitions and referrals to outside services. This includes partnering and planning with community-based organizations and public health resources and ensuring participants are given the opportunity to fully engage in planning their health care and sharing in decisions about their care.

The original ACH request for proposals encouraged, but did not require, applicants to be certified Health Care Homes. However, certified Health Care Homes have more essential infrastructure to provide a care coordination foundation for the ACH project, making it easier to expand care models to community partners rather than building entirely new systems and approaches. Overall, the involvement of a certified Health Care Home clinic contributed to an increase in the ACH's capacity to initiate the care coordination process more readily and provide comprehensive services. Demonstrated successes with the ACH care coordination process have also influenced changes in how the clinic conducts care coordination.

Table 2. Certified Health Care Home Clinic participation in ACH Projects

	Certified Health Care Home is Lead Organization	Certified Health Care Home is Central Service Provider	Certified Health Care Home is Peripheral Service Provider or not a Partner
ACH	CentraCare Essentia Ely* HCMC Mayo Unity/CHI St. Gabriel's	UCare Greater Fergus Vail Place Lutheran Social Service Southern Prairie Community Care Together for Health at Myers Wilkins	Allina Hennepin North Country New Ulm
Characteristics of care coordination approach	-Strong linkages between care coordinators -Advanced tools and protocols to share health information -Ability to track client health outcomes	-Improving linkage between care coordinators -Health information sharing process in developmental stages -Some ability to track client health outcomes	-Coordination limited to screening and referral -Limited or no health information sharing between partners -Data tracking limited to simple outputs

*Essentia Health has a Level 3 certification from the National Committee for Quality Assurance. For more information: http://www.ncqa.org/Programs/Certification.aspx

ACH projects cannot provide all needed services

Care coordination efforts have identified many needs in the community—social and environmental supports, oral health services, transportation, housing and behavioral health services—that are difficult to meet with available resources. CMMI does not allow project funds to pay for direct services, so ACHs are often limited to services reimbursed by Medical Assistance or another payer, or already available from the county or other community service provider. Care coordination teams explore available options for getting the client needed services but cannot always locate resources or help.

> One of the biggest issues for this population is transportation; this is one reason why it is so critical for individuals to meet their case manager in the hospital. Clinic care coordinators report missed appointments due to transportation or other social stressors is a common occurrence… Transportation is an issue that the ACH will continue to have to problem-solve around.
>
> Total Care Collaborative

ACH projects consistently identify transportation as a major barrier for participants in keeping appointments, looking for work, obtaining healthy food and attending support groups, care coordination, and leadership team meetings. Besides transportation barriers, needs for training, education and support group participation have gone unmet due to lack of resources. This includes classes and other supports for parenting, diabetes management, chronic disease self-management, depression and anxiety, chemical health and physical activity and wellness. Health-related items that are needed in the home environment and for personal use also are not consistently available – clothing, athletic shoes, safety items, medical equipment and supplies and home-making support are among the items that cannot be provided.

Needs for available, appropriate housing and related supports such as heat and repairs often go unmet. Many ACHs reported a lack of affordable, safe housing due to a backlog of Section 8 applications and limited subsidized housing options. Access to healthy food is needed as well as help with educational and vocational development (resume writing, interviewing skills, GED classes, supportive employment and other social resources). Some participants cannot access needed health services because of a shortage of providers or lack of ability to pay. The most commonly cited health service needs are dental and behavioral health.

Many clients have physical or cognitive disabilities that prevent them from using public transportation, or are 'near poor' and do not quality for programs but still need assistance. Medicare beneficiaries who need medical equipment and supplies often cannot afford the copay. One participant with an oral health emergency had to choose between paying for housing or visiting the dentist.

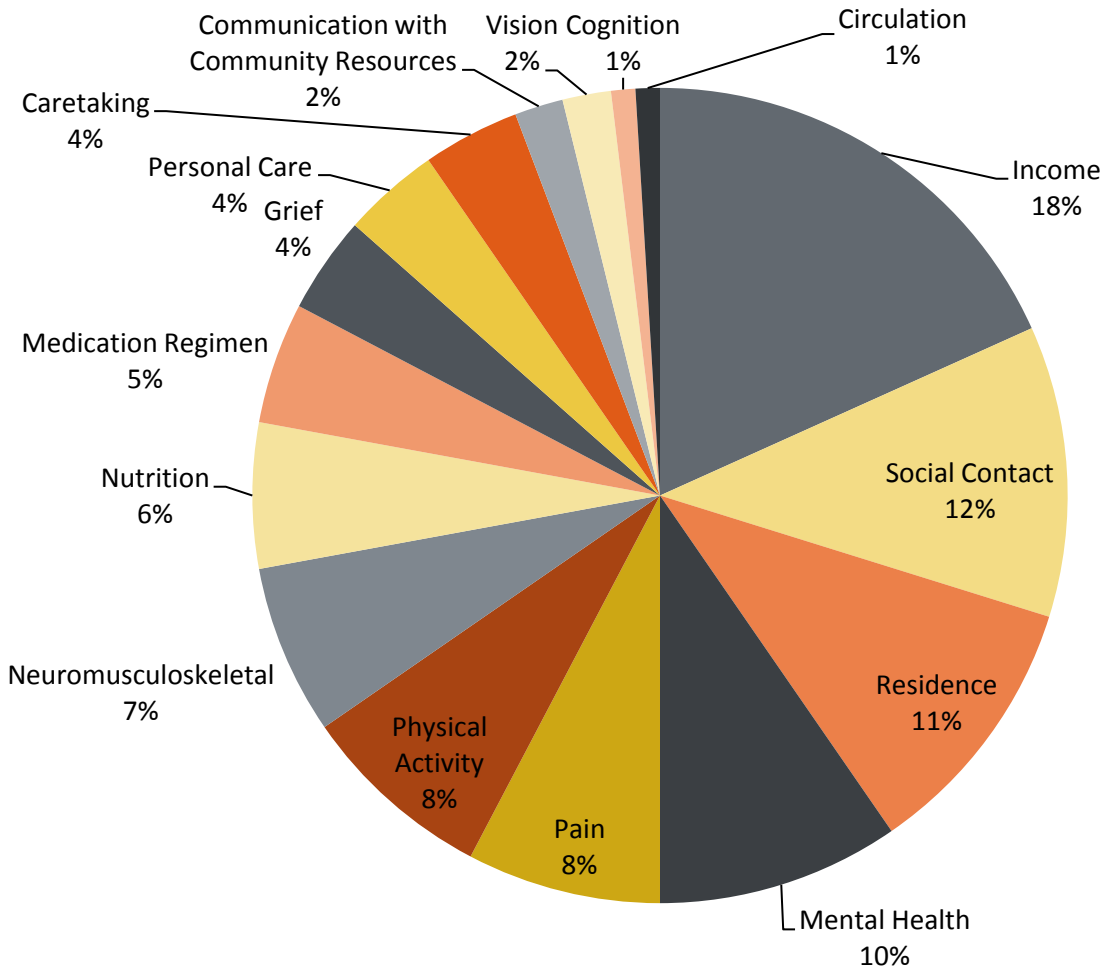
Some ACH projects have established funds to help care coordination participants with unmet needs. When New Ulm ACH patients were arriving for appointments without enough money to purchase gas for the return trip, the New Ulm Medical Center Foundation set up a fund to help with transportation, groceries and prescriptions. The ACH in the Ely area uses a wellness fund with contributions from member organizations to provide services that are not billable or covered by another source.

Measurement and Outcomes

For ACH projects, measurement is important to assess population health, experience of care coordination, utilization, costs, leadership and collaboration and target population involvement. To date, many ACH measurement efforts have concentrated on collecting performance measurements such as the number of people in the target population participating in care coordination and features of population health activities.

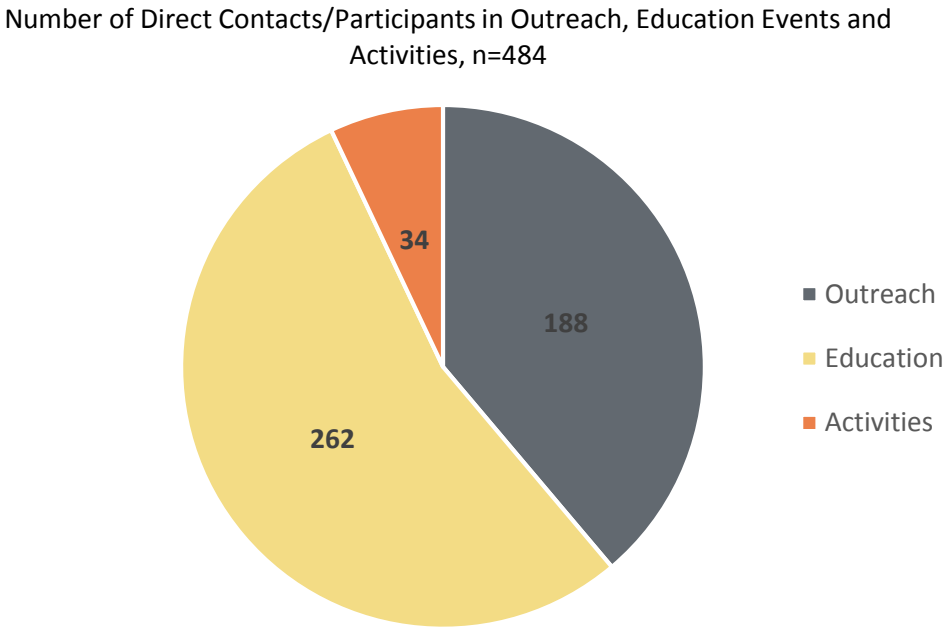
Several projects conduct pre and post assessments with care coordination participants and assess and analyze data on experience of care, referral sources and outcomes and participant demographics. The Community Care Team: Mayo Clinic, Olmsted Medical Center, Olmsted County Public Health ACH collects data on participant demographics, priority problems, outcomes and referrals. The chart below illustrates priority problems identified through the care coordination assessment process.

Figure 2. Mayo CCT, Priority Problems Identified by 36 CCT Participants 2015 (n=104)



Besides tracking care coordination processes and characteristics of members of the target population who participate, ACH teams are documenting population health improvement efforts including outreach, education and training. The Together for Health at Myers-Wilkins ACH in Duluth reached close to one-third (484) of the potential target population of 1,735 with its population health initiatives during the first year of the project.

Figure 3. Together for Health at Myers-Wilkins, Population Based Prevention 2015



ACH projects lack capacity to provide examples for total cost of care measurement at this stage in their development. ACH grantees, along with their ACO partners, are increasing efforts to measure outcomes and provide data, recognizing that measuring outcomes is vital to the understanding of an effective economic model for ACH-like systems and the sustainability of the projects. However, the lack of an attributable population, a small number of care coordination participants, and the short 24-month project timeframe hamper the ability to obtain sufficient data for reliable measures that might make a compelling argument for ACOs and potential funders to support the ACH at this time. As the table below illustrates, ACH projects are measuring activities and outcomes using a variety of methods and building a case for sustainability.

Table 3. ACH measurement activities

Area of Measurement	Performance Measure	Instrument/Tool/Data Source
Care Coordination (process/system/ outcomes)	Participant data (number served, demographics, gender, race/ethnicity) Participant strengths/needs/outcomes (priority needs, health, functioning, ability to manage chronic conditions, ability to adapt to adversity) Participant knowledge, behavior, status Referrals (made, completed, follow-up provided, reason for referral, source of referral)	Project-designed surveys Behavioral health needs survey SF-36 health and well-being Hospital (HCAHPS) Care Transitions PHQ2 and PHQ9 depression screening Electronic Medical Records (EMR) Meetings with participants and advisors Patient Assessment of Chronic Illness Care (PACIC)

Area of Measurement	Performance Measure	Instrument/Tool/Data Source
	Services provided and how (phone, home visit, clinic visit, etc.), services used Participant satisfaction, input on priorities, goals Corrections encounters, arrests Primary care continuity, number of visits	Global Health Scale Self-efficacy Scale Connor-Davidson Resilience Scale 10 (CD-RISC-10) Omaha System Outcome Measures PROMIS 29
Cost and Utilization	Emergency room and ED use, diagnosis Readmissions, hospitalizations, nursing home admissions Aggregate, condition-specific utilization	Electronic Medical Records (EMR) Prescription Monitoring Program
Project Implementation	Percent of target population participating Implementation integrity Project attrition Adoption and maintenance by team members and partners	ACH records, reports
Partnerships	Team satisfaction Social networks	Team member/partner survey of successes and barriers Social Network Analysis
Population Based Prevention	Number of staff trainings, health promotion events, education, activities, participants Percent, number of preventive care visits, screenings compared to baseline and targets Feedback on programming Population health indicators	Microsoft (Excel and Access) databases, other project-specific databases County Health Rankings Nightingale Notes Diabetes risk assessment

Evaluation and measurement challenges

Skills and resources for project evaluation vary across ACHs. Grant requirements and expectations on measurement did not include a uniform set of target outcomes and standardized assessment tools. In recognition of the fact that each ACH has a unique target population and set of interventions that they are testing, Minnesota SIM intentionally did not hold ACH projects to uniform program design and measurement standards. However, this design adds to the challenge of measuring success and comparing outcomes.

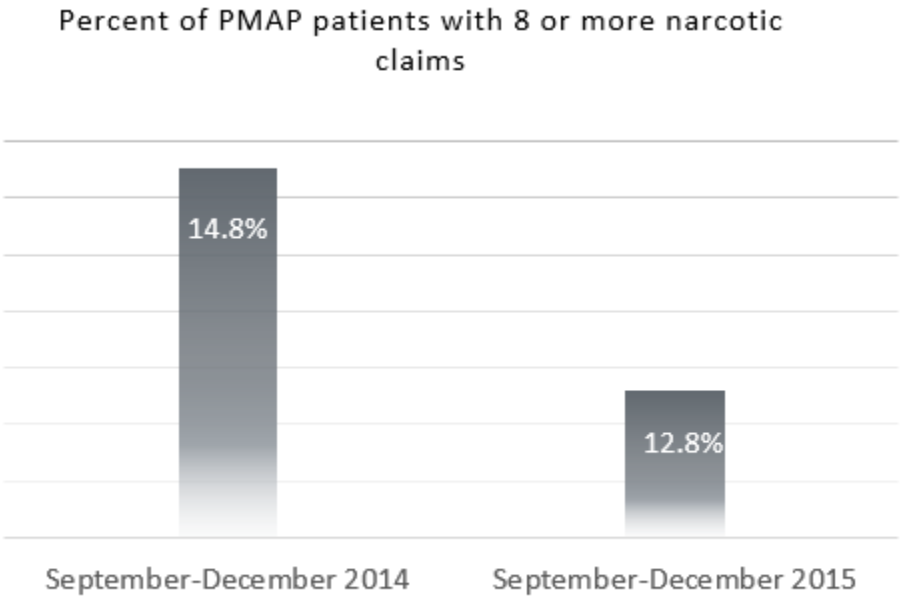
Overall, measurement plans, assessment tools and data analysis methods vary considerably from project to project, and there is a need to catalog effective examples of measurement activities through the formal SIM evaluation and other efforts. Process measures for some activities such as community engagement may be difficult to define, yet learning from efforts to engage and retain members of the target population and community organizations is critical for sustainability and growth of the ACH model. Processes and outcomes of ACH collaborative efforts that warrant evaluation and measurement include planning, leadership and governance, care coordination and population health services provided, resources generated, membership and community changes and actions.

Promising results emerging

While most ACH projects have not been able to capture cost savings to date, some have shown results in a fairly short time period through development of directly measurable goals and objectives and active ACO Involvement from the start of the project. Several promising efforts are described below.

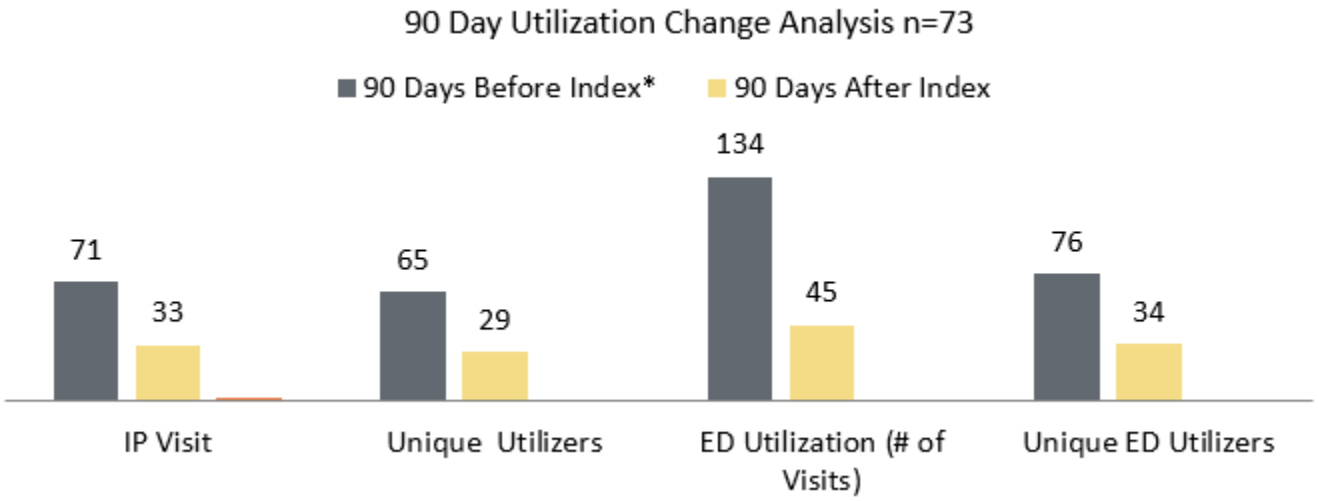
- *Morrison County Community Based Care Coordination: Prescription Drug Overuse ACH* created a care coordination model for controlled substance care that has shown measurable outcomes in the first year. South Country Health Alliance, a county-based health plan serving 12 counties in Minnesota, provides the ACH with utilization and cost data for members of the target population with eight or more narcotic drug claims who are enrolled in the Prepaid Medical Assistance Program (PMAP). The ACH compared narcotic prescription utilization for the 4-month period September to December 2014 with the same 4-month period in 2015 when the care coordination team became operational. A comparison of total claims paid showed a drop in spending of $439,674 from 2014 to 2015.

Figure 4. Morrison County ACH, Narcotic Prescription Utilization 2014-2015



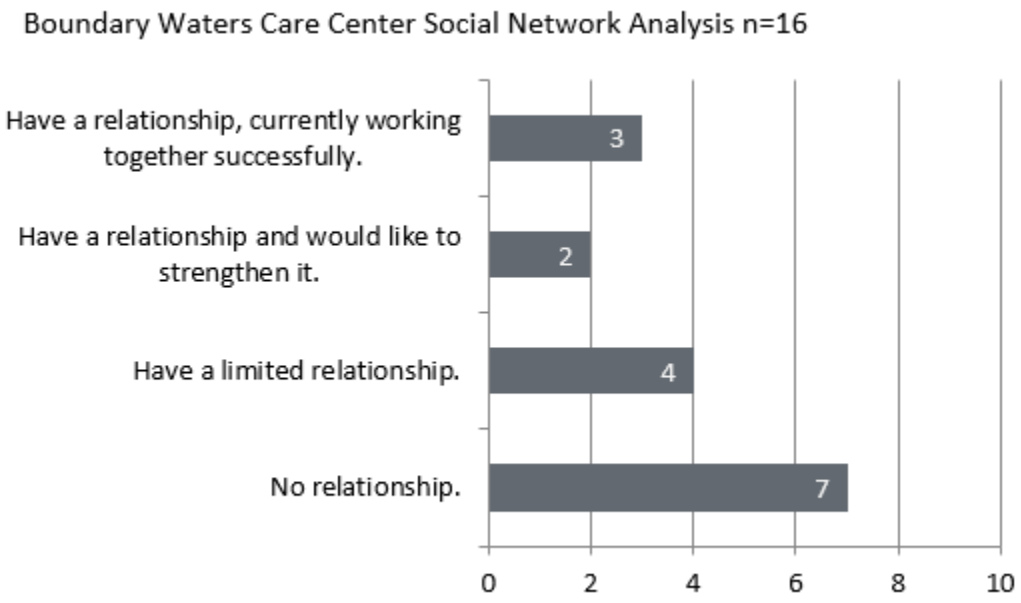
- *The Total Care Collaborative ACH* conducted an analysis of the population discharged from North Memorial's inpatient psychiatric unit who received ongoing coordination through Vail Place Case Managers and other community care team members including community paramedics and care coordinators. The ACH was able to show an overall decrease in inpatient and ED services after Vail Place case managers were engaged in the care of the high-risk patient population.

Figure 5. Total Care Collaborative Inpatient Utilization 2015



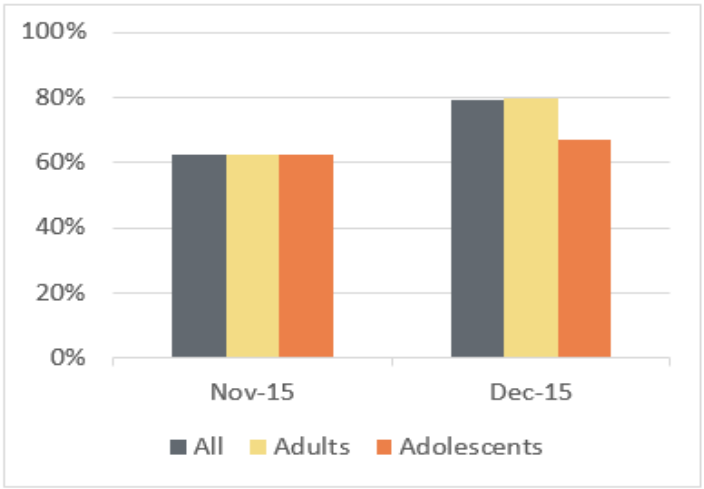
- The Ely Community Care Team conducts annual member and social network analysis to evaluate ACH partnerships. A network analysis question, "How would you define the relationship between your organization and other organizations in your region?" asks partners to describe their perception of the relationship they have with other CCT member organizations by selecting one of four options: no relationship, limited relationship, a relationship they would like to strengthen or currently working together successfully in a relationship. This question allows an organization to determine whether they are satisfied with their relationship with other organizations or if they wish to develop a plan to change relationships. Answers are not right or wrong, but descriptive. For instance, it would be logical that some organizations have no relationship and would have no need for a relationship or have a limited relationship, given each organization's mission. In other cases, an organization may wish to enhance a relationship and this data provides the opportunity to identify these situations. Figure 6 shows results of 16 organizations that reported their relationship with Boundary Waters Care Center (BWCC). Three of the 16 organizations currently have a relationship with BWCC and report they and BWCC are working together successfully. Four have a limited relationship; 7 have no relationship with BWCC. Two have a relationship and would like to strengthen it.

Figure 6. Ely CCT Social Network Analysis 2015



- *The Hennepin County Health Center (HCMC) ACH* has shown an increase in screening for depression using the easily administered PHQ2 and PHQ9 evidence-based depression screening tools. Brooklyn Park Clinic staff received training in use of screening tools and work flow in late 2015 and by December 2015, staff had initiated a standardized process for all clinic visits that included administering PHQ2 to all patients, and, if positive, administering the more extensive PHQ9. November 2015 data served as the baseline and are summary data for all age patients. Data is included for all patient visits with a physician, certified nurse-midwife, certified nurse practitioner or physician assistant during the time period.

Figure 7: HCMC Brooklyn Park Clinic Depression Screening Completion Rates (PHQ9) for Patients with Positive PHQ2



- *The Community Care Team: Mayo Clinic, Olmsted Medical Center, Olmsted County Public Health ACH* uses a variety of patient-focused instruments that are completed by clients at the baseline home visit and again during a home visit after they have completed the CCT program to evaluate effectiveness of the care coordination process. Table 4 illustrates results of baseline and follow-up assessments for a care coordination client. Measurement instruments include:
    - Patient Assessment of Chronic Illness Care (PACIC). Measures patients' perceptions of their chronic care experience.
    - Global Health Scale. Consists of 10 items that assess the general domains of health and functioning.
    - Self-Efficacy Scale. Measures individual's confidence to manage chronic health conditions.
    - Connor-Davidson Resilience Scale 10 (CD-RISC-10). Measures an individual's ability to adapt to adversity.

Table 4. Mayo CCT Patient Outcome Measures

Instrument	Subscale (Range)	Pre	Post	Difference
PACIC (n=10)	PACIC Overall (1-5)	3.61	4.10	**0.49**
	Patient Activation subscale (1-5)	3.73	3.67	**-0.07**
	Delivery System / Practice Design subscale (1-5)	3.88	4.10	**0.22**
	Goal Setting / Tailoring subscale (1-5)	3.16	4.05	**0.89**
	Problem Solving / Contextual subscale (1-5)	3.68	4.00	**0.33**
	Follow-up / Coordination subscale (1-5)	3.73	4.48	**0.75**
Global Health Scale (n=9)	General Health (1-5)	2.22	2.22	**0.00**
	General Quality of Life (1-5)	2.33	2.89	**0.56**
	Physical Health subscale T- score (0-100)	35.40	38.04	**2.64**
	Mental Health subscale T- score (0-100)	39.76	45.42	**5.67**
Self-Efficacy (n=10)	Overall (1-10)	5.37	6.20	**0.83**
CD-RISC-10 (n=9)	Overall (0-40)	25.67	26.78	**1.11**

Population Based Prevention

ACHs are required to align population based prevention aims with broader population health improvement initiatives in the community, and local public health is a key partner to this end. The population health focus of each ACH is most frequently tied to physical activity/ diet/obesity, diabetes, tobacco use and mental health. For two ACHs that have a community health board as their fiscal agent, the focus on population health is strong, but overall the level of local public health engagement varies widely by ACH project. In those ACH projects being led by a clinic or health system, the population health focus may be more closely aligned with the clinic population and clinical interventions to improve health outcomes.

Aligning with local planning and initiatives

There is a need to encourage greater local public health involvement to align ACH aims with other state efforts and plans, such as the Community Health Improvement Plan (CHIP), Statewide Health Improvement Program (SHIP) and Community Wellness Grants (CWG). An example of an ACH that has aligned population health efforts with broader planning is the North Country ACH. The ACH collaborates with the county SHIP initiative to increase awareness of adverse childhood experiences (ACEs) and mental health issues and works with local officials and employers to increase awareness of the benefits of mental health and its connection to physical health.

Alignment with state and local population health efforts is strong although the target population of the ACH may identify different population health goals than those identified for the broader population. The St. Louis County Public Health Department is closely integrated with the Together for Health at Myers Wilkins ACH, employing project staff who are co-located at the school. The ACH leadership team, including representatives from the target population, recognized social determinants of health barriers to population health and chose population health plan goals to address economic barriers such as job training and higher education as well as nutrition and physical activity, focusing specifically on needs identified for the target population.

Alignment of public health and health systems is limited at times due to capacity in some areas. Alignment can be hampered by processes and systems that are not set up to be aligned; hospitals and local public health conduct the community health needs assessments at different times, making it difficult for ACHs to participate in a meaningful way.

Plans and measurement

The short timeframe for ACH grants makes it difficult to demonstrate progress on population health measures and to invest resources in aggregating and analyzing population health data from a variety of sources. ACH projects are encouraged to set goals around alignment with local population health plans and initiatives and developing strong partnerships with local public health. Population health plans submitted after year one reflect limited alignment with local population-based prevention efforts, most likely due to lack of time to focus on that area given other more pressing work. The grant timeframe limits the opportunity for providing input on specific needs of the target population related to population health goals and revising county or regional plans.

ACHs are struggling to understand competing and confusing definitions of population health. This was apparent in the population health plans ACHs were required to complete by the end of 2015. Some plans resembled "population health management" plans for a panel of patients while others referred more broadly to "total population health." Adding to the confusion is that Minnesota's ACH model is not exclusively based on geography. Instead, Minnesota ACHs seek to improve health outcomes for a focused population while taking into account all of the factors that influence their health. Traditional political and public service boundaries do not always apply.

Sustainability

SIM grant funding has provided resources for partnering agencies and organizations to develop and pilot new approaches to improving health. ACHs are actively pursuing a variety of sustainability options. For example, many have received or are seeking other grant and foundation funding from state and non-state sources. ACH projects are forming subcommittees and actively planning to identify ways to keep the project going after grant funding ends and exploring ways to link community-based services into value-based payment models. This includes ACO partners that are increasingly engaged in analyzing ACH project outcomes.

Certain aspects of ACH work—such as new protocols or ways of doing business, improved care systems, enhanced referrals and better working relationships among partners—are likely to be continued after the project period ends whether or not additional funding is secured. However, to build and sustain an accountable model of health at the community level requires extensive staff time and outside technical assistance, which are resource dependent.

Policy and system changes

ACH projects are having a ripple effect in their communities, stimulating other initiatives and adoption of practices not necessarily directly a part of the ACH. Together for Health at Myers Wilkins ACH influenced system and policy changes in hiring at St. Louis County. The ACH leadership team and St. Louis County examined the recruitment process to identify possible barriers to hiring people who represent the target population including racially and ethnically diverse groups, and implemented changes to the system for recruiting, screening and interviewing job applicants that are intended to increase opportunities for a broader and more diverse pool of applicants.

Many of these promising practices have been adopted by the partnering clinic, health system, or other partner. In February 2015, Essentia Health began piloting the Ely Area Community Care Team care coordination model in two additional sites, a change from the Essentia system model of care coordination that had focused on chronic disease management and now includes an emphasis on the social determinants of health as well. The CCT-based model, called "care facilitation" within Essentia Health, is quickly gaining recognition as important in the upcoming redesign of the Essentia Health model.

Lasting Partnerships

ACHs report that local alliances and relationships they have established will continue beyond grant funding. Funding provided resources and an opportunity for community members to take on a broader role in improving health and stimulated partnerships in areas beyond the ACH. Many projects have written

agreements and operating procedures as part of establishing an ACH governance structure. For example, People with Disabilities ACH formalized partnerships and memorandums of understanding to ensure activities continue beyond the grant period. ACH project partners contribute substantial in-kind including staff and management salaries and benefits, IT, equipment, supplies, transportation, space and other resources.

Workforce enhancements

Minnesota has previously identified a current and growing shortage of primary care and related providers that will, if not addressed, present challenges to accomplishing the State´s health reform goals. Three new health professions have emerged in Minnesota, each with the potential to play a valuable role for care integration: community health workers (CHW), community paramedics and dental therapists/ advanced dental therapists. Emerging professions can act as a bridge between clinical or programmatic goals and broader outcomes such as population-based health initiatives.

ACHs offer these emerging professions an opportunity to work in a collaborative environment that can change the team's overall capacity and the patient's outcomes. For example, the CentraCare ACH is supporting two community health workers in obtaining CHW certification, and CentraCare Health is investigating other funding opportunities to retain the CHW positions. The Total Care Collaborative ACH team aligns work flow between clinic staff, care coordinators and community paramedics. Continued development of emerging professions contributes to the adoption of patient-centered, team-based models of care.

Learning Community

The ACH learning community offers all ACHs technical support and peer learning opportunities that focus on topics related to the implementation of an ACH. Representatives from all 15 ACH projects meet monthly in a focused, structured environment to address their common goals or interests and share best practices. Specific goals are to support the development and implementation of ACH leadership structures, community-clinical care partnerships, care coordination models and systems and sustainability plans. In April 2015, the National Rural Health Resource Center conducted a Needs Assessment Survey with the ACHs. The survey instrument was designed to be easily completed by respondents and to assemble information from ACH teams regarding the level of technical assistance needed as illustrated by the below responses by topic:

- Leadership - Leading Change Management Initiatives - 45% (n=24)
- Sustainability and Planning - Sustainability Planning - 61% (n=30)
- Workforce and Culture - Creating Cultural Awareness and Competency - 42% (n=22)
- People, Partners and Community - Engaging Stakeholders during Times of Change and Transition - 47% (n=25)
- Operations and Processes - Data and Health Information Sharing - 62% (n=33)
- Measurement, Feedback and Knowledge Management - Linking Data to Impact and Outcomes - 57% (n=30)
- Impact and Outcomes - Return on Community Investment (ROI) Statement - 68% (n=36)

Technical assistance was designed to be flexible and responsive to the needs of the ACHs, and included two in-person events a year. The spring learning event was coordinated with the Health Care Homes Learning Days, expanding the content of its sessions and attracting new audiences.

Other ACH Approaches

Numerous state, county, municipal, and tribal jurisdictions are implementing innovative approaches to health reform besides the accountable communities for health model. Other approaches include community care coordination systems and regional population health initiatives. Several initiatives focus on achieving triple aim improvements for the Medicaid population, going beyond care coordination in scope. For example, the Colorado Medicaid Accountable Care Collaborative includes seven regions with responsibility for developing provider networks, supporting providers with technical assistance and connecting members with non-medical services such as housing, child care and transportation.[4] Akron, Ohio started the Accountable Care Community in 2011, bringing together more than 70 different groups focused on community-wide efforts to prevent and control type 2 diabetes.[5]

State Accountable Communities for Health Models

Four states are currently testing ACH-like models or are about to award funds to start up ACHs. The states of Washington and Minnesota launched Accountable Communities for Health initiatives in 2015 with funding from the Centers for Medicare and Medicaid Innovation State Innovation Model (SIM) Initiative. California and Vermont announced funding opportunities in 2016 for accountable communities for health models although grants had not been awarded at the time this paper was released.

[4] Colorado Department of Health Care Policy & Financing, Accountable Care Collaborative. https://www.colorado.gov/pacific/hcpf/accountable-care-collaborative Accessed 7/5/2016.

[5] See Trust for America's Health (2014) meeting summary of discussion on steps to build systems to improve population health and reduce health disparities.

Table 5. State ACH Models

State	Key Features	Target Population & Conditions	Financing & Governance
California	• Fund up to 6 ACHs for up to 3 years ($250K first year, up to $300K next 2 years) • Timeframe 2016-18	• Defined geographic area • Include majority of population including those with disparities	• Financed by a consortium (foundations, Blues, Kaiser) • Backbone organization as facilitator and convener • Wellness fund
Minnesota	• Fund 15 ACHs for 2 years at $370K • Timeframe 2015-16	• Target population and conditions vary by ACH	• Financed by SIM • Lead agency/fiscal agent and governance structure varies
Vermont	• Fund up to 14 Peer Learning Labs • Timeframe 6/2016-6/2017 for planning; exploring sustainability options	• Serve entire population in defined geographic area • Communities propose focus areas	• Financed by SIM • Backbone organization convenes partners and guides activities (hospital)
Washington	• Fund 9 ACH regions aligned with Medicaid regional service areas • Timeframe 2015-2019 and beyond	• Serve entire population in defined geographic area • Regions choose priorities	• Financed by SIM • Formal governance structure and bylaws • Backbone is local public health or nonprofit org

California Accountable Communities for Health Initiative

Community Partners of California released an Accountable Communities for Health RFP in early 2016. The initiative will support up to six ACHs for as much as $850K each for up to three years. Community Partners (a foundation for emerging philanthropies) and a consortium of funders made up of California Endowment, Blue Shield Foundation of California and Kaiser Permanente are supporting the effort. ACH criteria include shared vision and goals, partnerships, leadership, backbone entity, data analytics and capacity, wellness fund and a portfolio of interventions. ACHs are to serve a defined geographic area that includes a significant number of persons who are experiencing health disparities. http://communitypartners.org/cachi

Vermont Accountable Communities for Health Peer Learning Lab

The 12-month (2016-17) ACH Peer Learning Lab is intended to explore development of the accountable communities for health model. The foundation for this initiative includes Vermont's Blueprint for Health patient-centered medical home program, three accountable care organizations and 14 county-based Unified Community Collaboratives (UCC)/Regional Clinic Performance Committees currently in place across the State. The nine core ACH elements are: mission, multi-sectoral partnership, integrator organization, governance, data and indicators, strategy and implementation, community member engagement, communications and sustainable financing.
http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/Resources/ACH%20Peer%20Learning%20Lab%20Recruitment%20Packet%201%2015%202016.pdf

Washington Accountable Communities of Health

The nine regional Accountable Communities of Health cover the entire State of Washington. ACHs used the first year of SIM funding to establish operations and governance structures, multi-sector and community engagement, regional health improvement plan (RHIP) efforts, and initial sustainability planning. Each ACH has a backbone organization that is either local public health, a community-based organization or a nonprofit, and a governing body made up of 15 to 44 members. Overall program goals are to improve regional health, promote health equity and advance the triple aim. Each ACH has developed a regional needs inventory and identified health priorities to inform their RHIP. Year 2 will be spent on active collaboration on local health improvement projects and broader state strategies.
http://www.hca.wa.gov/about-hca/healthier-washington/accountable-communities-health-ach
http://wsha-archive.seattlewebgroup.com/files/122/ACH%20handout%20double%20sided.pdf

CMS Accountable Health Communities Model

The Centers for Medicare & Medicaid Services released the Accountable Health Communities Model funding opportunity in February 2016; the application deadline was May 18, 2016. Over a five-year period, CMS will implement and test a three-track model based on promising service delivery approaches. Each track features interventions of varying intensity that link beneficiaries with community services. CMS will award 44 cooperative agreements ranging from $1 million to $4.5 million per site depending on the track.
https://innovation.cms.gov/initiatives/AHCM

Community Care Coordination Models

Several states have implemented a community care team (CCT) approach to extend the work of primary care and partner with community supports and services. North Carolina uses a community team model called Community Care Networks (CCNs).[6] In Vermont community health teams (CHTs) are established in hospital service areas among National Committee for Quality Assurance (NCQA) certified medical homes.[7] Oregon has Community Care Organizations for the Medicaid population that include addiction and oral health care providers. There are new CCT's that link with their versions of the patient centered medical home programs in Maine, New York State, Montana, Oklahoma and Alabama.

The CCT approach is similar to the Minnesota ACH model and may include a specific target population and disease focus and a more limited set of partners. The Minnesota ACH model evolved from a CCT approach and shares many features with these models. Some Minnesota ACH projects more closely resemble a CCT model than the regional ACH approaches in California, Vermont, and Washington.

[6] See Center for Health Care Strategies & State Health Access Data Assistance Center (2016) overview of state community care teams.

[7] Ibid.

Recommendations

The innovative work of 15 ACH projects has important implications for the future of health reform in Minnesota. ACHs are demonstrating promising approaches that warrant continued testing and evaluation, but projects are still in the developmental stage. While the relatively short grant period does not yet allow for consistent measurement of the ACH's impact on cost of care, patient outcomes, population health indicators, and health equity, these pilots are still performing an important function in helping us understand what works and how to improve the model going forward so that it can be sustainable and effective with broader implementation across the State.

Recommendations outlined here are primarily for Minnesota to consider for development of policies and models around future accountable communities for health or similar models. A summary of recommendations for the ACH model in Minnesota starts on page 39.

Community Care Coordination

Recommendations for the care coordination process include at least one clinical partner, preferably a certified health care home, to ensure a link to quality primary care, and to integrate behavioral health, oral health and other health services. Borrowing from the HCH care coordination model, all providers should be making referrals to care coordination, all care teams should understand how to refer into care coordination, and all staff should be knowledgeable in the delivery model.

Besides health sector involvement, the ACH should include social and community services and supports that have been shown to have a positive effect on health: primary, secondary and higher education; income supports; transportation; environment; public safety; and housing.[8] Investment in three social services in particular is associated with improvements in health and cost savings: housing support, nutritional assistance and case management.[9] To identify specific needs in these areas, ACH care coordination should include an assessment of social determinants of health indicators and follow-through on referrals for needed services.

For an effective community care coordination process that assists community members in meeting all health-related needs, a funding mechanism is needed to ensure participants are able to access necessary services and supports. The California ACH model will include a wellness fund to pay for necessary services, and other population health initiatives such as the Akron ACC operate on investments from stakeholders. Some states obtain waivers to use Medicaid funds to support spending on health-related supportive services such as housing, employment, education and training, environmental modifications and support groups, all areas of unmet need identified by Minnesota ACHs.

[8] See Bradley et. al. (2016) for comparison of spending rates on health care and social services and the association between spending and state level health outcomes.

[9] See Taylor et. al. (2016) for health and cost impacts of addressing social determinants of health.

Ely Community Care Team wellness fund braids resources from ACH organizations. The Ely CCT lead agency administers the fund and the leadership team determines how funds are to be spent.

Health Care Homes

The original community care teams were based on the Minnesota Health Care Home (HCH) model, and most ACH projects currently include at least one certified health care home clinic as a partner or lead. Alignment with Health Care Home certified clinics contributes to the ability of ACHs to ensure improved quality and experience of care, lower health care costs, and access to team-based, coordinated, person-centered care.

HCH and ACH models are building blocks for improving how health care is delivered, and for moving towards a model for care delivery that seeks to improve overall health. As the Health Care Homes program evolves it will look to the ACH model for ways to improve key features of primary care delivery – increased emphasis on understanding and addressing social determinants of health and health equity, a broader spectrum of community social supports and services integrated into the care coordination process, inter-professional teams that include emerging professions, and community partnerships focused on improving population health.

Other programs & initiatives

Other Minnesota programs and initiatives operate under goals that align with a care coordination model and include Minnesota Family Services and Children's Mental Health Collaboratives, Minnesota's Help Me Grow and Family Group Decision Making. HCH section staff have met with representatives from some of these programs to explore opportunities for coordinating efforts. HCH is also collaborating with the MDH Oral Health Program on a project funded by the Health Resources and Services Administration Grants to States to Support Oral Health Workforce Activities. The grant is designed to improve care coordination with dental services providers at certified HCH clinics in the CentraCare system in Stearns County.

Further collaboration is needed to strengthen the success of all of these efforts and identify additional programs, agencies and initiatives that should be part of the ACH model discussion. This includes exploration with potential partner agencies at the state level including Departments of Transportation, Education, Agriculture, Corrections and Housing.

Financial Support

The ACH model requires financial support for its infrastructure and to provide services to meet the health-related needs of the population. Infrastructure support is necessary to build trust among partners, convene meetings, recruit new partners, lead planning, implementation, and evaluation efforts, and provide fiscal management and administration. Greater flexibility with project funds is necessary to help future ACHs address a client's total needs and encourage community member participation in leadership teams and other committees.

As the State moves forward in planning for a continuation or expansion of the ACH model, exploration of a variety of financing mechanisms for sustaining ACH-like efforts will be necessary. Options include, but are not limited to, braided health care and social services funding streams, foundation or private sector support, commitment to up-front and ongoing support for ACH activities from commercial health insurance carriers or ACOs, community wellness funds or trusts, and exploring strategies for partners to reinvest in the ACH through shared savings programs. The JSI Research & Training Institute report, Accountable Communities for Health: Strategies for Financial Sustainability, discusses a number of strategies and considerations for financing besides tying financing to actual cost savings. This report is a good resource on financing options available to ACHs at various levels of maturity.[10]

Foundations, non-profit hospital community benefits, federal grants, providers and hospitals, payers, private investors, federal, state, and local government, and employers are potential funding sources to explore for ACH financing either at the state or local level. Hospital foundations have already contributed to local ACH projects through emergency funds and overall project sustainability. Besides reinvestment options and pursuing funding sources such as grants and foundation funding, payers have supported care coordination, integrator and other ACH functions.

An ACO or an ACO-like arrangement strengthens the business case for participation in an ACH because the accountable entities have financially aligned incentives for providing effective and high quality care coordination. With the growing recognition that social and community factors such as stable housing, regular access to affordable and healthy food, transportation, social networks and supports and a safe community are the most important determinants of health, ACO-like arrangements can help to drive the development of broader and deeper community partnerships and data sharing to achieve cost and quality goals. ACO's typically also have access to data related to their populations' utilization, experience and quality of care. This arrangement allows an ACO to understand non-clinic supports that improve health outcomes and participate in developing shared goals and priorities around population health.[11]

To better facilitate these connections, the ACH should have an attributable population covered by the ACO rather than a non-attributed subcategory of people. This is consistent with ACH projects in California, Vermont and Washington. By engaging with the population in a region, the ACH could attract a greater variety of partners such as employers, and a cross-section of the health services sector that could foresee economic benefits to participating and increase chances of sustainable financing.

[10] See Cantor et. al. (2015).

[11] See Casalino, et. al. (2015) for a discussion on ACO and hospital investment in improving population health.

Governance & Partnerships

The structure of the ACH should include a governing body (leadership team) made up of multiple organizations that includes representatives of the population served by the ACH. ACH leadership should be active and develop a vision, decision-making protocols and other operating procedures and bylaws. The ACH leadership body should collaborate with other efforts and groups in the community but should not be subsumed by another advisory body or group.

Ongoing collaboration with organizations, agencies and other entities from both health and non-health sectors is essential for the ACH to meet the health needs of the population. The ACH should update and add partners on an ongoing basis. All health plans and systems serving the population should participate in the ACH. Local public health must be an active partner, and local political leaders, government officials and other leaders should be invited to participate. Most importantly, the governing body should ensure that health equity is a key feature of the ACH vision and goals and that persons experiencing health disparities are represented in ACH partnerships, mission and vision.

No matter how they are structured, ACH leadership teams should oversee the purpose and work of the project and assume responsibility for assessing community needs, sustaining the work of the ACH, evaluating project processes and outcomes and implementing quality improvement.

Besides leadership and governance, the ACH must have a 'backbone' or lead organization to serve as convener and integrator. ACH projects currently have a variety of entities serving as the lead agency, and each type of lead organization brings unique attributes to the role. The lead agency should have the capacity for sharing data with partnering organizations, disseminating resources and information and convening leadership team meetings, and have staff and other infrastructure to be capable of carrying out the functions of being the lead organization. Experience has shown that reliance on contracting for core leadership and coordination may not contribute to sustainability and capacity in the project.

Health Information Exchange & Health Information Technology

Health information exchange (HIE), or the ability to securely exchange data among partners within a care team, is critical for ACH projects to effectively coordinate care. ACHs will need ongoing technical assistance and tools to meet requirements for privacy, security and consent. ACHs should be updated on an ongoing basis about the statewide HIE efforts being led by the MDH Office of Health Information Technology, including new guidance or standards, development of shared services for HIE, and legal guidance or education. These developments will provide needed advancements to improve HIE capabilities for the ACH projects.

To accurately assess the effectiveness of ACH projects, ACH partners must use health information technology, such as electronic health records, for measurement of experience of care, utilization and cost indicators. Care coordination data should include social determinants of health screening and other patient experience and assessment findings, based on state or national standards when they exist. This includes all community services the individual receives through the care coordination process. Exchange of information between all clinical and community partners is essential to the coordination of services.

Workforce

Community health workers (CHW), community paramedics and other professionals in new and emerging fields are making valuable contributions to ACH projects. CHWs meet an important need by representing diverse communities with populations experiencing health disparities. Community paramedics assist individuals in a variety of settings and prevent hospital admissions and other unnecessary and costly encounters with the medical services system. More than half of the 15 ACH projects include CHWs or community paramedics in their work.

ACH projects have identified barriers to maximizing the important contributions of emerging professions workers and needs for other emerging professions, such as dental therapists, advanced dental therapists and peer specialists. Projects have had difficulty recruiting CHWs, especially in non-metro areas, and anecdotal reports indicate insufficient reimbursement for CHWs and community paramedics.

Emerging professions should continue to be included in ACHs for their unique and vital roles and contribution to a more efficient clinical services model where professionals work at the top of their license.

Population Health

ACH projects have focused on a subset of the population in a given geographic area, creating challenges for obtaining population health data on the target population and aligning goals with broader local efforts such as the Statewide Health Improvement Plan (SHIP), Community Health Improvement Plan (CHIP), Community Health Needs Assessment (CHNA) and Community Wellness Grants (CWG). Going forward, ACHs will need to refine their population health plans and work with community partners to define population health objectives and metrics to measure performance.[12]

A broadened community-wide approach, as opposed to a focus just on a clinical population or patient panel, is needed for an ACH to contribute to improvements in population health. All ACH partners should be involved in supporting local assessment and planning efforts to achieve population health goals. By aligning ACH focus areas with population health efforts in the community, the ACH will contribute toward improvements in population health through the use of best practices and advocacy for the target population.

In the future, ACH objectives and activities should include the following aims related to population health:

- Increase partner awareness and understanding of population health and roles in improving population health.
- Align with the hospital community health needs assessment (CHNA), the local public health community health needs assessment and CHIP, and SHIP.
- Review community population health data including data on health equity and social determinants of health, the physical environment and social and economic factors.

[12] See Prybil (2015) et. al. for discussion on the importance of showing evidence of the impact of community coalitions on improvements in population health for financial sustainability and success of the partnership.

- Develop and work toward achieving specific and measurable population health goals that align with community plans and data and address health equity and disparities.

Health Equity

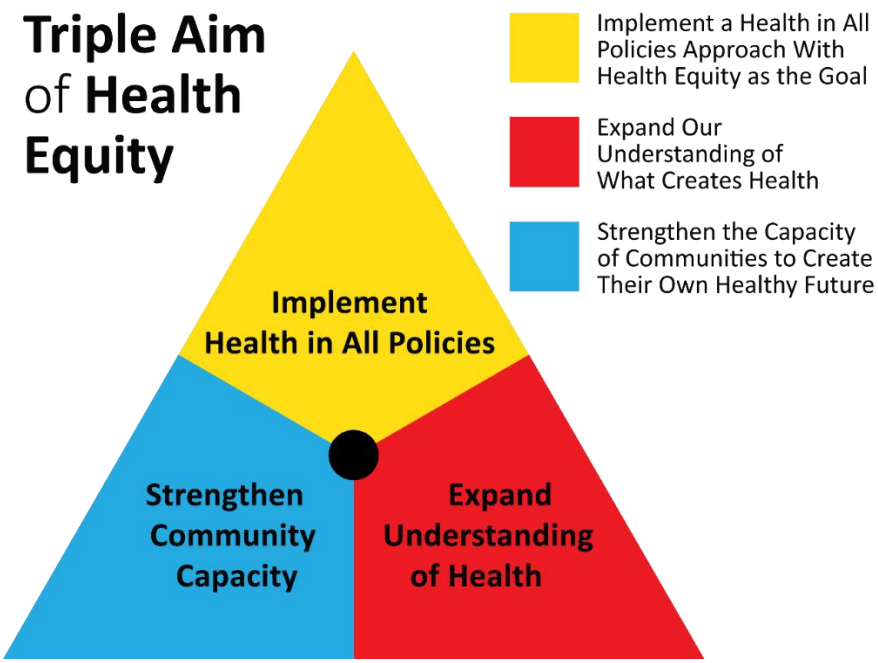
While there are structural and social barriers that challenge clinical providers and community partners to coordinate care effectively, many health care systems are in the process of implementing ways to improve health for the populations they serve. In Minnesota, the ACH projects are testing ways health care providers can partner more effectively with community resources to better use community services and to lessen fragmentation of care.

Each ACH partner brings their unique perspective on how to serve the target population. Integrated partnerships allow ACHs to address health disparities of a population, and to decrease the damaging effects of disparities on health. Authentic inclusion of the target population is critical to these efforts, and ACH models will need to include strategies to strengthen community participation.

While the IHI Triple Aim has been the focus of SIM, health equity is equally important for attainment of ACH program goals. The Minnesota Department of Health has developed a Triple Aim of Health Equity, shown below, to highlight the importance of health equity in achieving universal health improvement in communities. This framework recognizes that integrated care is an approach to health and not a set of discrete activities that alone achieves health equity.

Recommendations for health equity include the following:

- Authentic inclusion of target population.
- Compensation for time and other expenses such as transportation, childcare and accessible meeting space and times.
- Integration of Triple Aim of Health Equity concepts into ACH program goals.



Timeframe

Both the experiences of Minnesota ACHs, and the timeframes for ACH models in California, Vermont and Washington and CMS Accountable Health Communities, reinforce the need for a longer testing period beyond two years, with up-front time for planning the model. Building relationships and trust, identifying population health needs and gaps and authentically engaging community members and partners in developing and implementing programs all take significant time, and two-year grants don't allow sufficient time for these activities to take place. In recognition of that fact, California is funding ACHs for three years, the Washington ACH timeline spans four years, Vermont is funding a one-year pilot with plans for integration and sustainability into ongoing health reform efforts, and CMS will be funding Accountable Health Communities for five years. The Washington ACH model allowed a full year for setting up the organizational structure, conducting community engagement and developing a population health plan with improvement priorities.

Recommendations Summary

SIM supported a variety of ACH projects on a continuum of development, with different target populations, leadership structures and goals. While we will continue to learn from these projects over the remaining months of the SIM grant, ACH experiences to date are already informing our knowledge of promising practices and strategies for future ACH or similar models to succeed. The recommendations for the next iteration of ACH development will provide for an extended timeframe to demonstrate outcomes, implement additional measures and include a more extensive evaluation.

Based on what has been learned from the SIM ACH grant program to date, the following is an outline of key components for future ACH projects.

Area	Recommendation
Scope	Define the population by a specific geographic area, and require attribution to an ACO. Assure the health care partners in the area are able to reach the majority of the population and the population size is adequate to demonstrate measurable impact. Include identification of a chronic disease condition relevant to the population health plan. Choose a community experiencing significant disparities related to the social determinants of health and identified chronic disease condition.
Community care coordination	Include at least one certified Health Care Home as a partner. Include administration of a Social Determinants of Health Assessment. Integrate community care coordination activities with ACH partners.
Financing	Identify the level of funding that will be needed to support successful implementation of ACHs in the future, based on lessons learned from current ACHs. Explore options for multi-payer financial support for ongoing ACH operations, including: community wellness funds or trusts, braiding of health care and social service funding streams and expansion of total cost of care payment models that include distribution of a portion of shared savings across partnering organizations. Continue to require an ACO or ACO-like entity as a partner. Include a match requirement of 20% for future funding. Consider options for stepping down state grant funding over time while requiring enhanced support from other funders.
Infrastructure	Ensure backbone organization has staff and resources with the capacity to administer and coordinate the ACH operations. Require ability to share certain types of information with partners in compliance with state and federal laws. Require a leadership team dedicated to the ACH, consisting of multi-sectoral organizations, and individuals representing the population. Dedicate a coordinator for the ACH.
Governance	Require policies and organizational structure and bylaws that describe how the ACH operates, including decision-making, community engagement policies and development of vision and purpose of the ACH.

Area	Recommendation
Partnerships	Required: local public health, payers, clinics, hospitals, ACO and social and community services. Recommended based on population served: behavioral health, education, employers, local government, dental, pharmacy, public safety, housing, transportation and corrections.
HIE & HIT	Require ACH to have a system for collecting and sharing information in compliance with state and federal laws. Include strong measurement/data analytics capacity.
Workforce	Integrate emerging professions.
Population Health	Collect data on specific measures that align with local plans and address health equity and disparities. Require all partners participate in population health data review and planning efforts.
Evaluation	Conduct overall project evaluation to assess ability of ACHs to meet cost, quality, patient experience and other statewide goals. Require reporting on outcomes and process measures and demonstrating measurable progress towards goals.
Health Equity	Conduct assessments and act on results of social determinants of health screenings for housing, transportation, food security, etc. Implement community engagement activities to encourage ongoing community member representation in ACH governance and operations.
Timeline	Support ACHs for at a minimum of a four year period to ensure the ACH ability to build meaningful partnerships and to meet programmatic goals.
Alignment with Additional Programs	Align ACH development with Accountable Health Communities (AHC), Integrated Health Partnerships (IHP), Health Care Homes (HCH) or other programs as appropriate.

Conclusion

In Minnesota, the goals for Accountable Communities for Health were to test models for establishing partnerships and care coordination processes among multi-sectoral partners to serve people with greater needs and to advance population health aims in their region. ACH projects have successfully formed relationships and shared workflows between their partners. However, the two-year funding timeframe of the SIM grant has not allowed ACH projects to fully accomplish the culture change and workflow processes needed to establish policies and systems across independent organizations or to measure improved health outcomes.

Still, at the midway point of their work, Accountable Communities for Health are demonstrating promising strategies that can inform Minnesota's future approach to supporting these types of models. Collectively, through the ACH grants, approximately 220 partner organizations are linking services and care for an estimated 1,600 people with substantial health and social needs, and that number is expected to grow by the end of the grant period. Accountable Communities for Health are using formal business agreements, registries and integrated care coordination workflows to better serve whole-person needs. Many Accountable Communities for Health have already produced measurable results, such as reduced emergency department use and greater uptake of services. Individual ACH projects are motivated to continue their work and warrant additional investment beyond the current grant period.

The ACH grant program supports community partnerships as they develop new ways to achieve lasting improvements in population health, but ensuring that this work can continue – and expand - will require new ways of working together with communities, providers, payers and other stakeholders, and the development of new approaches to ensure financial sustainability. There are several challenges created by these new ways of working together. Confusion about privacy laws and other HIT concerns hamper the ability to share detailed client information outside of the traditional health system. In addition, there are opportunities for Accountable Communities for Health and broader public health entities to do a better job of aligning their efforts. The State of Minnesota has the opportunity to not only continue the work of Accountable Communities for Health but to strengthen the approach based on lessons learned over the past two years and other innovations and models underway in Minnesota and other states.

References

Bradley E, Canavan M, Rogan E, Talbert-Slagle K, et. al. Variation in Health Outcomes: The Role of Spending on Social Services, Public Health and Health Care, 2000-09. *Health Affairs*. 2016;35(5):760-768.

Braveman p, Gottlieb L. The Social Determinants of Health: It's Time to Consider the Causes of the Causes. *Public Health Reports*. 2014;129:19-31.

Cantor J, Tobey R, Houston K, Greenberg E. Accountable Communities for Health: Strategies for Financial Sustainability. JSI Research & Training Institute, Inc. 2015. Available at http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=15660&lid=3

Casalino L, Erb N, Joshi M, Shortell S. Accountable Care Organizations and Population Health Organizations. *Journal of Health Politics, Policy and Law*. 2015;40(4):819-835.

Center for Community Health and Evaluation. Building the Foundation for Regional Health Improvement: Evaluating Washington's Accountable Communities of Health. 2016. Available at http://www.hca.wa.gov/assets/ach_evalreport_year_1.pdf

Center for Health Care Strategies & State Health Access Data Assistance Center. Community Care Teams: an overview of state approaches. 2016. Available at http://www.chcs.org/resource/community-care-teams-overview-state-approaches/

ChangeLab Solutions. Accountable Communities for Health: Legal & Practical Recommendations. 2014. Available at http://www.chhs.ca.gov/InnovationPlan/ACHLegalPracticalRecommendationsReportFinal.pdf

ChangeLab Solutions. Financing Prevention: How States are balancing delivery system & public health roles. 2014. Available at http://www.changelabsolutions.org/sites/default/files/Financing_Prevention-NASHP_FINAL_20140410.pdf

Halfon N, Larson K, Russ S. Why Social Determinants? *Healthcare Quarterly*. 2010;14:9-20.

Heider F, Kniffin T, Rosenthatl J. National Academy for State Health Policy. State Levers to Advance Accountable Communities for Health. 2016. Available at http://nashp.org/state-levers-to-advance-accountable-communities-for-health/

Innovation Plan ACH Workgroup. Report to the California Health and Human Services Agency Secretary, Diana S. Dooley. Recommendations for the California State Healthcare Innovation Plan Accountable Communities for Health Initiative. 2015. Available at http://www.chhs.ca.gov/InnovationPlan/ACH%20Work%20Group%20Report%20FINAL.pdf

Kindig D. What are we talking about when we talk about population health? Health Affairs Blog. 2015. Available at http://healthaffairs.org/blog/2015/04/06/what-are-we-talking-about-when-we-talk-about-population-health/

Kindig D, Isham G. Population Health Improvement: A Community Health Business Model That Engages Partners in All Sectors. *Health Administration Press*. 2014;30(4):3-20.

Prybil L, Jarris P, Montero J. Discussion paper: A perspective on public-private collaboration in the health sector. Washington DC: National Academy of Medicine. Available at http://nam.edu/a-perspective-on-public-private-collaboration-in-the-health-sector/

Stiefel M, Nolan K. A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2012. Available at http://www.ihi.org/resources/pages/ihiwhitepapers/aguidetomeasuringtripleaim.aspx

Taylor L, Tan A, Caitlin E, Ndumele C, et. al. Leveraging the Social Determinants of Health: What Works? Yale Global Health Leadership Institute. 2016. Available at http://journals.plos.org/plosone/article/asset?id=10.1371%2Fjournal.pone.0160217.PDF

Tipirneni R, Diaz Vickery K, Ehlinger E. Accountable Communities for Health: Moving From Providing Accountable Care to Creating Health. *Annals of Family Medicine*; 2015; 13(4):367-369.

Trust for America's Health. Two Pillars of Transformation: Delivery System Redesign and Paying for Prevention. Meeting summary. 2014. Available at http://healthyamericans.org/health-issues/wp-content/uploads/2014/09/Twin-Pillars-of-Transformation-Summary-November-2013.pdf