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MINNESOTA'S ACCOUNTABLE COMMUNITIES FOR HEALTH: CONTEXT AND CORE COMPONENTS

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INTRODUCTION

Minnesota's Accountable Communities for Health, or ACHs, are community-led models of delivering medical and non-medical care and services to improve the health of a target population with substantial health and social needs. ACHs bring together diverse community partners, driven by the specific needs of the target population and the prevailing health and social conditions in the community.[1] This brief provides the context surrounding the development and implementation of Minnesota's ACHs and describes key components of ACH models implemented across the state. Subsequent briefs will spotlight ACH activities, outcomes, and sustainability, including findings from data collected from participating providers.

Funding: The Federal SIM Initiative

ACHs in Minnesota were funded through a $45 million State Innovation Model (SIM) cooperative agreement, awarded to the Minnesota Department of Human Services in 2013 by the Center for Medicare and Medicaid Innovation (The CMS Innovation Center). Administered by the Minnesota Departments of Health and Human Services, the funding was used to implement the Minnesota Accountable Health Model Framework.

State-Led Evaluation: SHADAC

The Innovation Center required a federal multistate evaluation of the SIM initiative as well as individual state evaluations. The Minnesota Department of Human Services contracted with SHADAC to design and conduct the state evaluation of Minnesota's SIM initiative. The evaluation was conducted between 2015 and 2017.

The results of this evaluation are not endorsed by the federal government. These findings do not reflect the views of and may differ from the federal government's evaluation.

Evaluation Approach & Data Collection

SHADAC's evaluation of SIM in Minnesota relied on both existing and new data sources and incorporated both quantitative and qualitative methods. The evaluation of Minnesota's ACHs, in particular, relied on (a) initial and final semi-structured qualitative interviews with state staff and with individuals engaged in each of the ACHs; (b) a survey of health care and other care/service providers; (c) a survey of organizations participating in the SIM initiative in Minnesota; and (d) ongoing systematic review of state, grant, and contract materials.

Scope of This Brief

Minnesota's ACHs are described in this brief as implemented during the course of the ACH initiative. ACHs that have sustained beyond SIM funding may have changed in structure, scope, and activities.

BACKGROUND: ACHS IN CONTEXT

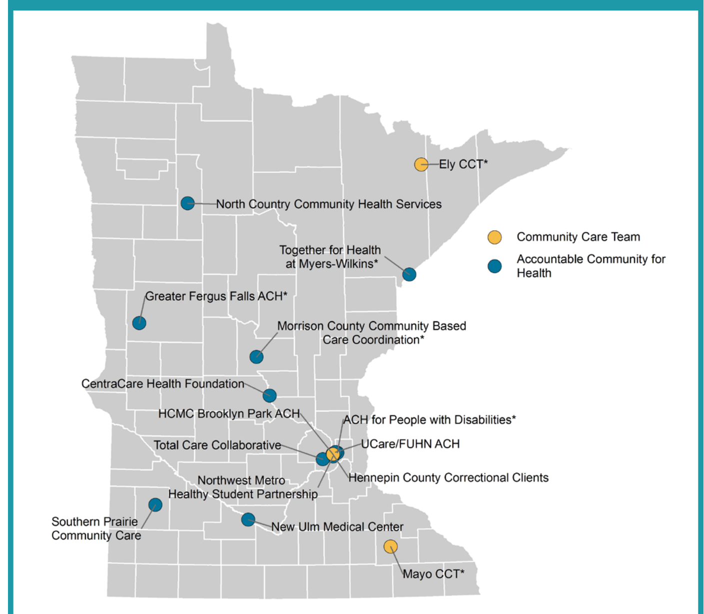
State Context

Minnesota was one of six states that received a State Innovations Model (SIM) award in 2013 to fund the implementation and testing of its particular model for payment and delivery system reform through December 2017.[2] As part of its model, Minnesota established Accountable Communities for Health (ACHs) wherein health care providers, community and social services organizations, and other partners work across sectors to improve overall health in a given community by addressing the health and social needs of populations facing barriers to health equity.

Minnesota's ACHs have their state roots in an earlier grant program, called the Community Care Team (CCT) Pilot. The CCT program was administered from 2011 to 2012 by the Minnesota Department of Health's patient-centered medical home initiative, called the Health Care Home (HCH) program, which focuses on providing patient-centered primary care for individuals with chronic/complex health conditions. The CCT initiative was meant to expand beyond the medical focus of HCHs and to that end provided resources to health care providers to improve existing partnerships between local hospitals, primary care clinics, public health, behavioral health, social services, and other community services.[3]

The state awarded grants to fund the creation of 15 ACHs under SIM (Figure 1).[4] In all, eight ACHs were anchored in urban areas, six were located in rural areas, and one had both an urban and rural presence. Three of the ACHs established in Minnesota under SIM were outgrowths of CCT pilots.[5] Minnesota's ACH vision called for the integration and coordination of social services and clinical care for a population identified by the community (e.g., people living within a particular geographic area, high utilizers of health care resources, individuals with a specific health condition or disability, specific underserved or marginalized groups, etc.) across a range of providers with leadership from community stakeholders. Eight ACHs established care coordination models that focused broadly on the medical and social needs of their target populations without regard to a specific category of health condition; four were focused on mental and behavioral health (e.g., depression, substance abuse, serious and persistent mental illness, etc.) within their target populations; and three focused on specific or comorbid chronic medical conditions within their target populations. (Importantly, while CCT pilots had been driven specifically by health care providers, ACHs and their care coordination efforts could be (and were) led by a variety of types of medical and non-medical service providers.

Figure 1:
Accountable Community for Health (ACH) Grantees



National Context: ACHs across the Country

Minnesota was not alone in establishing Accountable Communities for Health as part of its SIM model, with a number of states, including California, Michigan, Oregon, Vermont, and Washington, also designing and implementing ACH models as part of their larger health system transformation strategies.[6] However, ACH-like models pre-date the SIM initiative. In addition to Minnesota's own CCT pilot, ACH-like arrangements that pre-dated SIM include, among others: Community Care of North Carolina; Vermont's Community Care Teams; Maryland's Community-Integrated Medical Home model; and the Community Health Partnership in Baltimore.[7]

Concurrent Efforts:
The Accountable Health Communities Model

Just as ACH-like arrangements pre-dated the SIM initiative, similar arrangements have continued to emerge and evolve outside of SIM.

Most notably, the Innovation Center launched its Accountable Health Communities (AHC) Model in late 2016. The AHC Model aims to test whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries through screening, referral, and community navigation services will impact health care costs and reduce health care utilization. To this end, the CMS Innovation Center is supporting "bridge organizations" to act as hubs in their communities, forming and coordinating consortia that will focus on bridging the gap between clinical and community service providers in one of two ways: (a) Assisting high-risk beneficiaries with community service navigation so they can access services to address their health-related social needs; or (b) encouraging partner alignment to ensure that community services are available and responsive to the needs of beneficiaries.[1]

[1] CMS Innovation Center. "Accountable Health Communities Model." Retrieved from https://innovation.cms.gov/initiatives/ahcm/

ACHS IN MINNESOTA

The ACH grant program in Minnesota included several core requirements for individual ACHs: the establishment of a collaborative leadership structure that involved community partners, the development and implementation of a community-based care coordination system or team, and the implementation of population-based health prevention plan. Other key elements of Minnesota's ACH model include a sustainability plan, a measurement plan, and participation in a Learning Collaborative and evaluation activities.

ACH Leadership and Partners

Minnesota required that each ACH establish a collaborative leadership team with representation from a broad range of providers and organizations in the community as well as from individual community members and members of the ACH target population. The types of organizations involved in a given ACH as leadership team members and/or operational partners varied widely and included, among others: health systems, health clinics, hospitals, local public health organizations, behavioral health providers, health plans, human service and social service agencies, schools and/or school districts, housing resources, disability service providers, long-term care providers, correctional facilities, law enforcement, faith-based organizations, legal services, and city governments. Many of the ACHs built on existing collaboratives and partnerships among providers and organizations, but the majority of ACHs did include new partnering organizations as well. In all, ACHs identified 279 organizational partners, including partners who held played both leadership and operational roles. The number of partners involved in any individual ACH ranged from six to 34.

ACHs were also required to identify one partner as the lead agency for the project. In several cases, medical systems or clinics were chosen as the lead agencies because of a strong connection between ACH goals and HCH activities; in other cases, lead agencies were determined based on agency resources/project management capacity, general partner consensus about agency fit, or agency interest.[8]

Partnership with Accountable Care Organizations

Although ACHs were not required to establish payment arrangements for ACH activities, they were required to have at least one active provider or organization partner engaged in an Accountable Care Organization (ACO) or a similar accountable care model based on performance on measures of cost, quality, and experience. This partner could be involved in a Medicaid Integrated Health Partnership (IHP; Minnesota's Medicaid ACOs), a Medicare ACO (Shared Savings or Pioneer), a commercial ACO, or another ACO or ACO-like arrangement. Among ACHs, ACO partners included an IHP fiscal agent, specific clinics/providers participating in an IHP or ACO arrangement, a health plan, and a managed care plan. In nearly all (14) ACHs, an ACO representative or provider participant served on the ACH leadership team. When the ACH target population and the ACO attributed populations overlapped, select ACO partners provided data, data analytics, and connections with providers and have been a source of patients/referrals for the ACHs.

Partnership with Local Public Health

While not a requirement, ACHs were encouraged to engage local public health organizations in their efforts. Two-thirds (10) of ACHs did involve a local public health partner in their work; the extent and nature of this involvement varied across sites, with local public health serving as the lead agency for two ACHs and serving on the leadership team in seven ACHs. ACHs with a public health partner reported that public health organizations brought a health promotion focus, hired key coordination staff, conducted population health activities, contributed data and evaluation expertise, and supported community engagement and relationship building.

Community and Target Population Involvement

The requirement to include community members and members of the ACH target population on the ACH leadership body was meant to ensure that these individuals would have not just an advisory role but a decision-making role in ACH development and implementation. In all, nine ACHs were successful in including at least one community or target population member on their leadership teams. ACHs also encouraged and facilitated community participation through other means, such as the care coordination team, or through focus groups, surveys, interviews, or other activities. In all except one of the ACHs, members of the community or target population were involved in the ACH in some capacity, even if not at the leadership level. Five ACHs also relied on existing approaches to and structures for community engagement among participating organizations, such as community, patient, or consumer councils, or patient representation on clinic boards.[9,10]

Innovation Highlight:
Community Consultants

One ACH, Together for Health at Myers-Wilkins, implemented a particularly innovative approach to community engagement, contracting with individual community members as paid "community consultants" on the ACH leadership team and further supporting their involvement by providing transportation and childcare for meetings and events.

ACH Community-Based Care Coordination System or Team

The goal of care coordination within the ACHs was to address the challenges that individuals, especially those with complex conditions, face in getting the care they need—challenges that are often rooted in the social determinants of health and therefore extend beyond the capacity of the medical realm. Community-based care coordination, as its name suggests, integrates the delivery of medical and non-medical services by leveraging resources available in the community to address non-medical health and social needs. Like medical care coordination, community-based care coordination involves the management of referrals and the facilitation of care transitions to reduce care fragmentation and avoid the risk of duplicative care coordination efforts; however, community-based care coordination extends—and may originate—beyond the medical realm in this work.[11]

Minnesota afforded applicants, and ultimately 15 awardees, flexibility in terms of how they could implement model requirements, so individual ACHs in Minnesota varied widely across key ACH elements, including care coordination. As a result of this variability, ACHs also varied in terms of care coordination reach, with the average number of individuals reached per quarter by a given ACH ranging from fewer than 100 to more than 300 in 2016.[12]

Because of the flexibility of the ACH program, as a result of which the ACHs were working with a broad range of target populations across a variety of settings, no single care coordination model accurately captures the various ACH care coordination approaches, as the table below shows.[13] These models can be conceptualized by looking at the locus/anchor of care coordination and the intensity of care coordination services provided.

Table 1: Overview of ACH Care Coordination Models

ACH Name	Care Coordination Model and Target Population
ACH for People with Disabilities	Implemented the cloud-based LifePlan tool (a comprehensive care plan) among **people with intellectual and developmental disabilities who live in the Metro area** and conducted assessments, created action plans, and provided services using the tool.
CentraCare Health Foundation	Community health workers provided services to the **Latino and East African patient populations in Stearns County** at CentraCare Family Health Center in St. Cloud in order to reduce the incidence of unmanaged diabetes among this population.
Ely CCT	CCT partnering organizations provided collaborative and targeted care coordination using a "no wrong door" approach to **people living in poverty or with behavioral health challenges in Ely and surrounding communities.** These services included referrals, warm hand-offs, removing barriers to care, and team coordination of care. They sometimes also involved referrals to a CCT care facilitator and/or being part of a care team with a CCT care facilitator.
Greater Fergus Falls ACH	Ringdahl Ambulance provided community paramedic services to **people on Minnesota Healthcare Plans and uninsured low-income residents in Becker, Clay, and Otter Tail counties** based on referrals sent by Lake Region Healthcare in order to coordinate health and social services among this population.
HCMC Brooklyn Park ACH	Depression screening, treatment, and care coordination were provided by a community health worker, behavioral health specialist, and/or family advocate to **patients at HCMC Brooklyn Park Clinic**.
Hennepin County Correctional Clients	Vocational, housing, and health care services and referrals were provided by employment consultants and community health workers for **individuals incarcerated at the Hennepin County Adult Correctional Facility (ACF)** in order to improve health program enrollment, reduce homelessness, increase employment, and reduce recidivism among this group.
Mayo CCT	A community-based care coordination team developed action plans across primary care, public health, and community services to address the health and social needs of **community-dwelling adults with chronic health conditions in the Rochester area**.
Morrison County Community Based Care Coordination	The controlled substance care team consisting of a social worker, nurse, physician, and pharmacist provided services at St. Gabriel's Hospital and Family Medical Center to **seniors and other individuals in Morrison County** in order to mitigate the need for, overuse of, and access to prescription narcotics among this population.
New Ulm Medical Center	Clinic care coordination services and referrals were provided by nurses and social workers for patients at New Ulm Medical Center in order to decrease emergency department visits and inpatient admissions, and improve health outcomes in **New Ulm's Medical Assistance population**.

* Bold text indicates target population for care coordination.

Table 1: Overview of ACH Care Coordination Models (cont.)

ACH Name	Care Coordination Model and Target Population
North Country Community Health Services	Mental health support services and/or referrals were provided by a care coordinator for students at Wake of the Woods Elementary and Paul Bunyan Elementary in order to improve the region's capacity to support **at-risk youth in crisis**.
Northwest Metro Healthy Student Partnership	Services and referrals were provided by staff for **students at Anoka, Andover, Blaine, Champlin Park, Coon Rapids, and Anoka-Hennepin Regional High Schools** to address individual student needs as indicated on the 10th grade health survey.
Southern Prairie Community Care	Diabetes risk screening and "I Can Prevent Diabetes" program capacity building were provided in order to delay and ultimately prevent Type 2 diabetes among **those at risk in a 12-county area in southwestern Minnesota**.
Together for Health at Myers-Wilkins	Services and referrals were provided by a community health worker and a public health nurse to **students and family members of Myers-Wilkins Elementary School and the surrounding neighborhood of Duluth** in order to address the health and wellness needs of this population.
Total Care Collaborative	Three models—Rapid Access to Case Management; Care Navigation; and Rising Risk Care Conferences—were employed at North Memorial Health Care, Broadway Family Medicine Clinic, and Vail Place to increase person-centered care **for individuals with serious mental illness living with chemical dependency issues and co-occurring chronic diseases in North Minneapolis, Robbinsdale, Brooklyn Center, and Brooklyn Park**.
UCare/Federally Qualified Health Center Urban Health Network (FUHN) ACH	Enhanced care coordination and outreach services were provided in order to strengthen the processes of care for **UCare members enrolled in Special Needs Basic Care at four FUHN clinics in the metro area**.

* Bold text indicates target population for care coordination.
Source: SHADAC, "Accountable Communities for Health (ACH) Provider Survey." *University of Minnesota School of Public Health,* June 2017.

Locus of Care Coordination

Minnesota's ACH community-based care coordination efforts were anchored in three different contexts: Nine conducted care coordination from the starting point of a medical facility or organization (clinic, hospital, health plan); four initiated care coordination within a community organization (social service agency, school, group living community); and two used a combination of medical and community-based starting points.

With medically-anchored ACH care coordination, non-medical components of coordination involve the identification of community resources for individuals who need assistance with social determinants of health. Individuals were then generally connected outward to community organizations and social service agencies that could help directly with these issues. When ACH care coordination was anchored within a community organization, social determinants of health were addressed within the non-medical community, either by the anchor organization itself or by connecting the individual to other non-medical resources, which were typically brought to the individual at the anchor care coordination organization. Individuals who had medical service needs were then connected outward to medical organizations (clinics or hospitals). In the two cases where ACH care coordination involved a combination of medical and community-based starting points, the ACHs used a "no wrong door" approach to care coordination entry, such that individuals were connected to both medical and non-medical services through a web of organizational connections in the community.[14]

Intensity of Care Coordination

ACH care coordination activities can be broadly understood within a framework that scales care coordination activities along a continuum of intensity that increases in tandem with patient needs. In this framework, lower-intensity coordination includes activities such as assessments and referrals. As patient needs expand and care coordination intensifies, coordination activities expand to include elements such as the development of individualized care plans, patient and family education and patient engagement, the involvement of a collaborative care team, and ongoing monitoring and follow-up.[15]

The care coordination efforts of about half of the ACHs fall at multiple points along this continuum, with services ranging from the provision of information and resources to a referral and/or handoff to an extensive wraparound. Other ACHs tended to concentrate their work at certain points along the care coordination continuum, depending largely on the needs of their target populations. Four ACHs, for example, targeted particularly high-need individuals such as those with developmental disabilities and mental illness, and therefore focused on high-intensity coordination work.

ACH Population-Heath Based Prevention Plans

The Minnesota ACH Grant Program required ACHs to develop and implement a population-based prevention plan that aligned with its care coordination target population or focused on diabetes management and prevention, tobacco cessation, hypertension, obesity, or adverse childhood experiences (ACEs).[16,17] In developing their population health plans, ACHs were encouraged to build upon prevention work initiated or underway through other community efforts—for example, the Statewide Health Improvement Program (SHIP; leveraged by six ACHs), Community Transformation Grants (leveraged by three ACHs), or other local public health initiatives (leveraged by nine ACHs). ACHs also leveraged a variety of resources in developing their population goals, with Community Health Needs Assessments and input from community members being the most commonly used. In the end, all ACHs focused in whole or in part on the same populations for both their care coordination and population health components.[18] Moreover, there was frequent overlap between care coordination and population health activities, although some ACHs did implement separate activities for each component. Table 2 below summarizes population health improvement goals, target populations, and key population health activities pursued by ACHs. As with care coordination, ACHs varied in terms of population health reach. Where data was provided/available, ACHs reported reaching anywhere from 201 to 3000 individuals each through population health programming and activities.

CONCLUSION

The overview provided here is meant to paint a broad picture of Minnesota's 15 unique ACH models across their key characteristics. Subsequent briefs will dive into the variation across specific ACH components, profile individual ACHs, and present lessons learned across Minnesota's ACH initiative.

Table 2: Overview of ACH Population Health Activities

ACH Name	Population Health Goals, Target Population and Activities
ACH for People with Disabilities	Provided education around benefits of physical activity for people with disabilities in order to increase physical activity among **people with developmental and/or intellectual disabilities in the Metro area**.
CentraCare Health Foundation	Raise diabetes prevention awareness and self-management among **east African and Hispanic populations in Stearns County** by providing education about diabetes prevention and treatment.
Ely CCT	Increase walk-ability and bike-ability in the **Ely community** by increasing bike rack availability; designing kiosks to highlight walking and biking opportunities; and offering a community event to promote education, safety, and awareness around biking and walking.
Greater Fergus Falls ACH	Address chronic disease prevalence in the **Greater Fergus Falls community** by coordinating with the State Health Improvement Program (SHIP) to continue ongoing population health activities around healthy behaviors.
HCMC Brooklyn Park ACH	Move toward the Triple Aim in the **Hennepin County community at-large, with a particular focus on patients attending Brooklyn Park Clinic**, by improving clinic-community care coordination delivery model for people with depression in the Brooklyn Park community; developing and implementing strategies that promoted a community of health (e.g., culture cohorts); and creating sustainable community relationships.
Hennepin County Correctional Clients	Increase the dietary health and physical activity of **individuals incarcerated at the Hennepin County Adult Correctional Facility (ACF)** after release by providing education around healthy eating, physical activity, lifestyle changes, and decreased smoking.
Mayo CCT	Coordinated with Olmstead County's Community Health Improvement Program (CHIP) workgroups using a "population health management approach" to target CCT activities for **community dwelling adults with multiple chronic conditions in the Rochester area** that align with Olmstead County's Community Health Improvement Program (CHIP) financial stress/homelessness and mental health priorities.
Morrison County Community Based Care Coordination	Mitigate the need for prescription drugs through pain management, modify patient access to multiple narcotic prescriptions, overcome barriers to patient treatment, and coordinate chemical dependence treatment in the **Greater Morrison County community** by implementing a care coordination model focused on pain management; raising awareness about long-term effects of opioid use and addiction as well as about treatment options; raising awareness about safe disposal of unused prescriptions; and changing the prescribing practices of providers.
New Ulm Medical Center	Improve health equity and overall health in core measures **among New Ulm residence on medical assistance with chronic conditions** by promoting healthy eating, physical activity, and tobacco cessation; improving access to healthy food; and improving bike-ability and walk-ability in New Ulm, focusing on "hot spot" neighborhoods.

* Bold text indicates target population for population health activities.

Table 2: Overview of ACH Population Health Activities (cont.)

ACH Name	Population Health Goals, Target Population and Activities
North Country Community Health Services	Increase awareness of mental health issues and awareness and adoption of positive mental health strategies (and their benefits) among **youth and at-risk youth in Clearwater, Hubbard, Beltrami, and Lake of the Woods counties and among adults who work directly with and support these groups (e.g., teachers, school administrators)** by collaborating with SHIP on opportunities to improve the mental health of at risk-children and youth; advocating for ACEs awareness and mental health issues in the region where the target population lives; and coordinating care for youth in crisis within school settings.
Northwest Metro Healthy Student Partnership	Promotee wellness and a school-wide culture of health among **students and teachers who attend/work at high schools in the Anoka-Hennepin School District** by providing proactive health education and programming around tobacco use, physical activity, healthy eating, and wellness.
Southern Prairie Community Care	Delay and ultimately prevent type 2 diabetes among **community members at risk for the disease in the 12-county SPCC area** by implementing I Can Prevent Diabetes curriculum throughout the community and providing free diabetes screenings and education about physical activity and healthy eating.
Together for Health at Myers-Wilkins	Provide access for s**tudents and family members of Myers-Wilkins Elementary School and the surrounding neighborhood of Duluth** to a greater number of resources that Myers-Wilkins families have identified as key to creating a healthy community including: economic pathways, mental health pathways, healthy lifestyle supports, and expanded community engagement in improving population health.
Total Care Collaborative	Reduce overall readmissions and ED utilization among **individuals with serious mental illness and serious and persistent mental illness** by providing improved coordination and transitions of care using a population management approach.
UCare/Federally Qualified Health Center Urban Health Network (FUHN) ACH	Enhance linkages between care coordination entities serving the **UCare Special Needs Basic Care enrollees at four FUHN clinics in the metro area** using a population management approach to care coordination.

* Bold text indicates target population for population health activities.
Source: ACH self-reported annual reports (2016), quarterly progress reports (2017) and interviews with ACH participants.

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ENDNOTES

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[5] Ibid.

[6] Minnesota, Oregon, and Vermont received Round One (2013) SIM Model Test Awards; Michigan and Washington received SIM Round One Model Design Awards and SIM Round Two (2014) Model Test Awards; California received a SIM Round Two Model Design Award but did not receive SIM testing funds. Source: Centers for Medicare & Medicaid Services. "State Innovation Models Initiative: General Information." Innovation Center. Retrieved from https://innovation.cms.gov/initiatives/state-innovations/

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[9] Ibid.

[10] SHADAC. (September 2017). "Evaluation of the Minnesota Accountable Health Model: Final Report – Full Report." University of Minnesota, School of Public Health. Retrieved from https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&dDocName=DHS-297901

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[12] It is important to note that quarterly data provided by ACHs may be cumulative or not depending on the ACH and quarterly counts, upon which averages are based, and may include outreach and service provision.

[13] SHADAC. (May 6, 2016). "Evaluation of the Minnesota Accountable Health Model: First Annual Report – Full Report." University of Minnesota, School of Public Health. Retrieved from http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs-287574

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[18] Ibid.