SIM "STACK" IN MINNESOTA

A Case Study of Otter Tail County Public Health

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INTRODUCTION

The State Innovation Model (SIM) in Minnesota, known as the Minnesota Accountable Health Model, aims to develop or accelerate new care delivery and payment reform efforts in order to achieve a health care system that provides patient-centered, coordinated care; holds providers accountable for costs and quality of care; aligns financial incentives to promote the Triple Aim; and implements collaborative approaches to set and achieve health improvement goals. These SIM goals are supported by five primary "drivers," under which most activities have been organized:

Driver 1. Expansion of e-Health
Driver 2. Improved data analytics across the state's Integrated Health Partnerships (IHPs)
Driver 3. Practice transformation to achieve team-based integrated/coordinated care
Driver 4. Implementation of Accountable Communities for Health (ACHs)
Driver 5. Alignment of Accountable Care Organization (ACO) components across payers related to performance measurement, competencies, and payment methods.

The Minnesota Departments of Human Services and Health (DHS and MDH) have been implementing SIM strategies since 2014, under a cooperative agreement with the federal Center for Medicare and Medicaid Innovation (CMMI). With this support, the key mechanisms the state has used to execute its primary drivers are grants and contracts, technical assistance, and other resources to community and health care providers and other organizations in the state.

The University of Minnesota's State Health Access Data Assistance Center (SHADAC) is conducting the state evaluation of the Minnesota Accountable Health Model under a contract with DHS and in collaboration with both DHS and MDH. One element of the state-level evaluation is to investigate the experiences of organizations participating in multiple SIM grants and contracts across more than one unique driver or strategy. The state refers to these cases as SIM program "stacking." According to SHADAC's evaluation organization database, approximately 400 organizations are involved in SIM in Minnesota, of which only 37 organizations are participating in three or more unique SIM programs, as a lead agency, partner agency, or recipient of SIM supports.[1]

SHADAC selected a case study approach to examine the interaction and impacts of SIM program "stacking" on one organization's ability to advance the Minnesota Accountable Health Model aims.[2] SHADAC examined two organizations, both SIM priority setting providers, as the potential focus of this case study, ultimately identifying OTCPH, a local public health agency, as the case that would illuminate multiple aspects of the program "stacking" phenomenon.[3]

OTCPH first became involved in SIM in 2013; the Public Health Director led the county's effort to apply for SIM funding. Work on SIM will conclude by September 2017.[4] OTCPH led work in the e-Health Collaborative Grant Program and participated in e-Health Roadmap work, intended to facilitate electronic health information exchange (Driver 1). It led the Greater Fergus Falls ACH (Driver 4), which promoted team-based care coordination. OTCPH also participated in the Emerging Professions Integration Grant Program (Driver 3), which integrated community paramedics into care teams. See the

timeline in Figure 1 for OTCPH's role and period of participation on each SIM grant program. Though target populations vary slightly for each grant program, efforts across all grant programs are targeting individuals receiving medical assistance.

Figure 1: Timeline of Otter Tail County Public Health SIM Participation
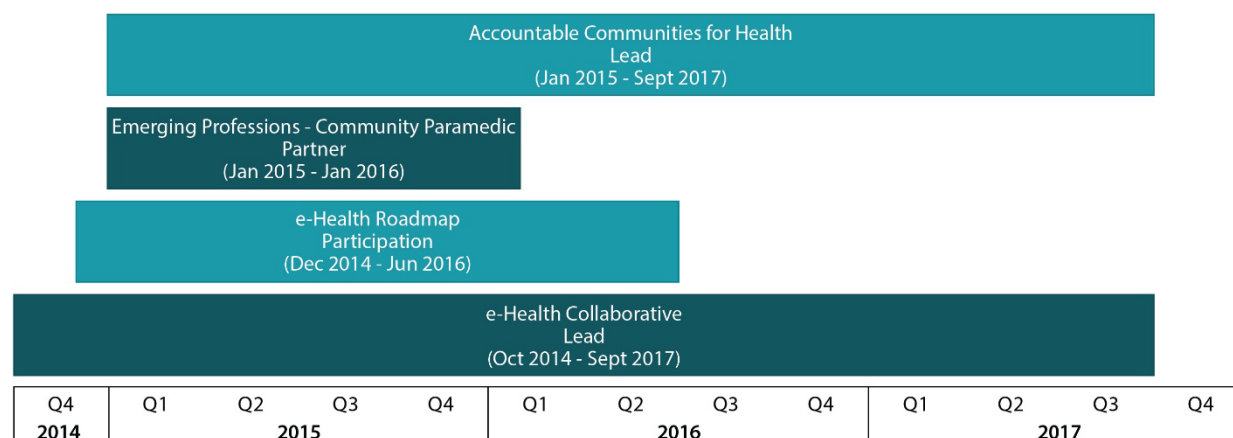
Source: SHADAC, *Database: Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative,* University of Minnesota, School of Public Health. Minneapolis, Minnesota. November 2016.

OTCPH works collaboratively with other organizations based in Otter Tail County to implement SIM programs. Table 1 below demonstrates OTCPH's and key partners' "stacking" of SIM grants. Note that many of the community organizations had partnered with OTCPH on more than one SIM initiative.

Table 1: Otter Tail County Public Health and Key Partners' SIM Participation

Organization (type)	e-Health Fergus Falls Community of Practice	e-Health Roadmap	Emerging Professions Community Paramedics	Greater Fergus Falls ACH
Otter Tail County Public Health	✓	✓	✓	✓
Lake Region Healthcare [a, b]	✓	-	✓	✓
Otter Tail County Human Services	✓	✓	✓	✓
Lakeland Mental Health Center [c]	✓	-	✓	✓
LB Homes (LTPAC)	✓	-	-	✓
Pioneer Care (LTPAC)	✓	-	✓	✓
Productive Alternatives (vocational services)	✓	-	✓	✓
Ringdahl EMS	-	-	✓	✓
A Place to Belong (behavioral health services)	-	-	✓	✓
Salvation Army	-	-	✓	✓

"a" denotes Integrated Health Partnership
"b" denotes Health Care Home
"c" denotes Behavioral Health Home

Sources: SHADAC, *Database: Organizations Participating in the Minnesota State Innovation Model (SIM) Initiative,* University of Minnesota, School of Public Health. Minneapolis, Minnesota. November 2016; document review (e.g., quarterly reports, presentations); in-person and phone interviews.

SHADAC researchers conducted interviews with 21 individuals and reviewed relevant materials, e.g., SIM quarterly reports, in order to explore the characteristics and context of OTCPH and identify the interaction and impacts of participation in multiple SIM grant programs.[5] The interviews and document review generated several key findings related to OTCPH's experience with "stacking" multiple SIM grant opportunities.

Summary of Key Findings

Key case study finding, described in more detail below, include the following:

- OTCPH was well-positioned to succeed as a result of a history of collaboration, strong leadership, and shared community vision.
- OTCPH employed an evolving approach to implementation that built on previous work and responded to community needs but was not without administrative challenges.
- "Stacking" resulted in expansion or tightening of partnerships, enhanced care coordination, and improved community engagement, which led to improved access to community services.
- OTCPH and participating organizations expressed a high likelihood of sustaining a community-wide effort towards delivery system and payment reform.

Note that although OTCPH is the site selected for this case study, SIM grant programs were implemented collaboratively and were intended to impact the community served. As such, findings are not described in isolation but rather relative to the Otter Tail community.

Findings from this case study relate not only to organizations participating in SIM but also to other local public health agencies, grant makers, and other stakeholders that are working together towards health care payment and delivery reform.

OVERVIEW OF OTTER TAIL COUNTY PUBLIC HEALTH

Located in rural northwest Minnesota, OTCPH serves 22 cities, more than 60 townships, and two unincorporated communities. In 2015, the county's population was 57,303, of which the overwhelming majority was white (96 percent), and 20 percent of the population is age 65 or older.[6] Approximately 11 percent of the overall Otter Tail population and 16 percent of children ages 0–17 lived below the federal poverty level (FPL) in 2014.[7] Otter Tail County government is located in Fergus Falls on the west side of the county. With a population of 13,281 in 2015, Fergus Falls is considered a rural city.[8]

Like many local public health agencies, OTCPH's core functions include assuring quality and accessibility of health services; preventing the spread of disease, epidemics, and injuries; promoting healthy behaviors; protecting against environmental hazards; and responding to disasters.[9] OTCPH provides direct services to the community (e.g., child and teen checkup outreach, home visits for first time mothers, immunizations, and care coordination for health plans). Its leadership and staff of 33 also evaluate the need for public health programs in the community (e.g., refugee health), manage and

administer program services (e.g., Women, Infants, and Children), and collaborate with other agencies and schools (e.g., Family Services Collaborative) to provide direct services to the community.

In Minnesota, Community Health Boards (CHBs) are the legal governing authority for local public health. OTCPH is a part of the Partnership4Health CHB comprised of Becker, Clay, Wilkin, and Otter Tail Counties.[10] Partnership4Health delegates grant seeking and budgetary work back to individual county agencies.

Otter Tail County and the other three counties that make up the CHB are also involved in PartnerSHIP4Health, which is a separate public health initiative carried out by the Partnership 4 Health CHB.[11] SHIP is a collaboration of community partners to reduce costs associated with chronic disease and improve the health of county residents. SHIP works with communities, worksites, and health care organizations to implement proven policy, system, and environment changes.[12]

CASE STUDY FINDINGS

Interviews with organizations from Otter Tail County that are participating in multiple SIM programs revealed several key findings related to OTCPH's experience with "stacking" multiple SIM grant opportunities, many of which align with the vision recently laid out in the Public Health 3.0 framework for pioneering state and local public health agencies.[13]

Findings Related to "Stack" Readiness

A number of key factors emerged that made the Otter Tail community a favorable environment in which to "stack" multiple SIM programs, including a long history of collaboration, strong leadership from OTCPH, and a shared community vision.

History of Collaboration

The Otter Tail community has a long history of collaboration among organizations that are now partners on the various SIM grants. Interview respondents referred to informal breakfast discussions attended by community and health care providers and hosted in 2004 by Lake Region Healthcare, the local health care delivery system, and in 2008 by the more formalized SHIP project.[14] SHIP work led to cross-organization and cross-county collaboration, and it launched an investigation into forthcoming policy and environmental changes. As one county agency staff put it, "Because of the work with the SHIP project … we learned that this model [of collaboration across partners] is the model to really create some effective programs."

More than a decade prior to the collaborative work convened by Lake Region Healthcare, several of the current SIM partners were also involved in the DHS Otter Tail Family Services Collaborative since it was first mandated in 1992. OTCPH had also participated in the MDH Building Health Information Exchange (HIE) Capacity Workgroup in the 18 months prior to SIM.[15]

Through the processes of applying for and implementing SIM work, there was a deliberate effort to build on previous work and community relationships. For example, an interagency agreement developed by the Family Services Collaborative was used as the template for the SIM collaborative efforts. Lake Region Healthcare's SIM IHP Data Analytics application (Driver 2) provided examples of collaboration with OTCPH, Partnership 4 Health, and other ACH partners, specifically referencing the community conversations described above as well as Otter Tail partners' efforts to become "an accountable health community."

In deciding whether to apply for SIM, the Otter Tail community partners considered their shared vision (described further below) and how this grant work would advance that vision. OTCPH was chosen to lead the collaborative efforts as this agency is viewed as a neutral party and a community convener. It was noted that part of the community's deliberate strategy in applying for SIM grants was to consider who would be the best lead for each initiative based on the organizations' target populations and services provided.

Strong Leadership

Otter Tail has benefited from strong leadership from a single long-time leader who is widely known, trusted, and respected. Respondents said that the Director of Public Health, who has directed OTCPH for over three decades, drove the community's decision to apply for SIM funding and was reportedly key to the community's success with implementing multiple SIM grants. She volunteered to write proposals, led many of the administrative functions across grants, and is largely recognized as the focal point and driving force behind these efforts. Public health was seen by county agency staff as a natural leader of this work because it "look[s] at the bigger picture across the silos of how to meet the population needs of our community by bringing these community resources together"

In addition to helping facilitate "stack," the OTCPH director's "exceptional executive leadership" was described as organized, enthusiastic, competent, and calm, and it reportedly kept community partners on-track for milestone completion and motivated the community to continue in this work despite competing demands and technical barriers.

Shared Community Vision

Otter Tail community partners reported sharing a "community first attitude" in which community needs come before competition between partners. They described their vision for the community as a "rural health model that works." Partners are reportedly "bringing the community work and the health care provider systems together to make that [model] happen."

Rather than treating each other like competitors, community partners work together to solve community problems. One respondent noted, "[the strategy is,] 'here's our problem, now how do we solve it?' versus, 'here's our problem, what's in it for us?'"

Another provider said, "I think we've all articulated that we're all basically asking that fundamental question in different ways, is there a better way of serving the vulnerable folks in our community? And that's deeply ingrained in the missions of all of our organizations."

Otter Tail agency staff understood the importance of working together to serve the community and recognized that the partners around the table are "a key piece of the continuum of care that's needed. And by working together, [they] achieve what's needed in our community as opposed to working separately in siloes [*sic*]."

Stakeholders external to the Otter Tail community (e.g., state staff, consultant) who have worked across the state with other SIM participants also noticed this sense of shared vision within the community. One respondent said, "I remember being impressed early on with how well these people got along and jointly problem solved. There was no sense of silos or protectiveness."

SIM funding allowed OTCPH and other community providers to test new models of care delivery and payment while pursuing their shared vision. According to one interview respondent, the activities pursued (i.e., e-Health, Emerging Professions) would not have otherwise been prioritized by community partners.

One county agency staff member said, "[SIM] has allowed us to work on these SIM drivers that had we not had the SIM funding, I would not have spent the time and effort on these areas at all. I don't know that our partnership would have been as developed. But we would not have spent near the time and effort on any of this if we didn't have the SIM grants."

Findings Related to Implementation

OTCPH leveraged existing relationships, attempted to keep partners aware of efforts on all work, and evolved its approach to implementation as collaboratives learned more about the community they were serving. Even so, they experience some "stack"-related challenges.

Approach to Implementation

As a result of the shared vision, history of collaboration and strong leadership referenced above, the Otter Tail community was well-positioned to "stack" multiple SIM efforts.

As noted in Table 1, many Otter Tail community providers are participating with OTCPH on multiple SIM efforts. As a result, community leaders are made aware of the progress on other SIM grants through both formal inclusion on meeting agendas and informal conversations by community partners. Interviewees noted that during SIM project meetings there are frequent discussions about work underway in other SIM projects simply because the same people are sitting around the table. Partners are aware of all SIM efforts, whether or not they are the lead on a particular driver.

OTCPH viewed its e-Health work as foundational to the ACH, recognizing that establishing an HIE infrastructure would be critical to coordinating care and meeting patients in need where they are (i.e., community paramedic home visits and staff trainings in the community.) It also made an effort to align SIM work with previous community work. For example, the SHIP target population of low income individuals aligns closely with the SIM target populations.

Evolving Approach

Importantly, the Otter Tail community also evolved their approach to care coordination based on lessons from previous SIM grant programs. For example, Ringdahl Emergency Medical Services had a seat at the table in the ACH work from the beginning of the grant period, but it was not until its Emerging Professions Community Paramedic work was underway and ACH leadership began to see its impact on the community, that they decided to leverage this new model of care delivery for community-wide care coordination. After learning that clients receiving care coordination were calling an ambulance when they needed a ride to routine appointments, the ACH leadership team recently began exploring providing transportation as part of their care coordination model.

Challenges to "Stacking" Multiple SIM Grants

In spite of this supportive environment, Otter Tail County organizations faced multiple barriers to the implementation of multiple SIM grant programs. Interviewees noted the challenges of implementing HIE stemming from issues related to governance (i.e., state certification of vendors), technology (i.e., limitations of Direct Secure Messaging), and their workforce (i.e., an aging population unfamiliar with technology). These challenges prevented the Otter Tail community from leveraging the e-Health work in their community care coordination model (ACH) as they had intended.

Interviewees also reported drawbacks related to the administration of multiple grants. Both the grantees and the state respondents described the challenges of managing competing demands and finding time to complete milestones for all of the grant programs of which the community is a part.

One county agency staff noted that "when you stack opportunities, you stack yourself into a corner. Because of all the time commitment you're going to have."

State agency staff also noted the potential drawbacks of "stacking" multiple SIM grants. One respondent said, "I think […] the stacking provided opportunities potentially to do more. But we also think that a little bit of the administrative burden of having three or four grants to administer in different programs potentially was a detriment to potentially even getting more done if it had been able to be more coordinated."

Findings Related to Impacts of "Stacking" Multiple SIM Grants

Despite these challenges the Otter Tail community cited a number of positive impacts related to "stacking" multiple SIM grants that align with the Minnesota Accountable Health Model aims. The Otter Tail community reports that it has expanded partnerships, enhanced care coordination, and improved community engagement as a result of their efforts.

"Success breeds success. So as we see some of these neat things happening, and …, all of a sudden people get excited. The meeting is there and people show up. Because there's some success and people want to help others and that leads to the next thing. Community paramedic, … we couldn't have been accomplished all that without this because you still need somebody to help that contact so they don't show up at the emergency room just because, or call the ambulance for a 911 call because they didn't have transportation to go get their flu shot or something. So there's still that synergy and excitement that comes from success. And I think that's been one of the things that has helped us a lot."

- Provider

Expansion and Tightening of Partnerships

Although the community has a long history of collaboration and a shared vision, nearly every grantee interviewed reported a closer connection to partners as a result of participation in SIM programs. One county agency staff said, "I think [the extent of our relationship] has increased, because I think we've been called forward to be more of an active player and have the opportunity to really identify all the different populations that can be impacted through the SIM grants. We've had that [relationship] predating SIM; now we can multiply on that and increase some of our interactions…" The community also brought SIM partners into existing community initiatives (i.e., SHIP).

Enhanced Care Coordination

The Otter Tail community had personnel coordinating services or care (e.g., case managers, public health nurses, social workers) in a number of different settings prior to SIM but has been able to improve and streamline care coordination for its most vulnerable populations through the efforts of the community paramedics as well as those of the collaboratives. Community paramedics are working closely with medical and community providers to identify at-risk populations for their services, particularly those who would benefit from but do not qualify for home health services. Several respondents reported that the community paramedics' efforts to coordinate care has resulted in fewer emergency room visits and fewer calls to the paramedics (see case from the field for an example).

Two long-term care facilities have also developed or expanded tele-monitoring for home health patients as a result of their SIM collaborative work, which reportedly is helping to keep people out of hospitals and reducing "routine repeaters."

Case from the field:
A 56 year old with developmental delays, diabetes, and hypertension with an A1C >14 and at risk for out of home placement now has an A1C of 7.9 and is able to remain in his own home.

Improved Community Engagement

SIM participation has resulted in the identification of new ways to engage with and serve the Fergus Falls community. Interviewees reported that SIM participation forced community providers to take a step back and consider the barriers to participating in a program hosted in a traditional medical provider setting (e.g., nutrition classes in the hospital). Through the work on the ACH, providers, including community paramedics, recognized a need to "meet people where they're at" and began holding classes and screenings where vulnerable populations already feel comfortable, such as the Salvation Army and A Place to Belong, which works with those who experience mental health challenges .

One county agency staff member said, "If you go to places where [care coordination clients] already are … and have conversations with them, that was where we could see where continuing to develop our relationship with Salvation Army and A Place to Belong could help us reach a subset of the population that do experience low income, but also have the comorbidity of mental health issues."

This strategy of meeting people where they already feel comfortable is improving turnout. One provider noted, "And so we go to where the people are and guess what? It isn't that they didn't want to participate, it's that they didn't have a means to or they didn't feel comfortable in that setting. So meet people where they're at. And I think we're going to see more of that going on." By simply changing the location, they were able to draw 13 people to a class that previously had not been well-attended.

Providers have also explored new ways to better understand the needs of their target population under SIM. SIM funding supported trainings that help providers (e.g., county workers, social workers, and other community providers) understand how poverty impacts individuals' lives. Interviewees reported these providers reportedly would not have attended such trainings without SIM dollars.

Looking Forward to Sustainability

The community has been successful in leveraging their experiences in SIM to seek additional grant funding. For example, Otter Tail County was awarded a CMS Testing Experience and Functional Tools (TEFT) grants[16] and a DHS Live Well at Home[17] grant, both of which built on their SIM e-Health work. The Greater Fergus Falls ACH was also recently awarded expansion funding. These projects will continue and expand progress towards e-Health, care coordination, and other SIM goals. With ACH work continuing through September 2017, members of the ACH leadership and care coordination teams are planning to continue meeting on a regular basis to identify community needs and opportunities to intervene. Lake Region Healthcare is planning to support a community health coordinator role when grant funding runs out.

In addition, respondents referred to future plans to coordinate among the various patient-centered, integrated care models. For example, Lake Region Healthcare has Health Care Home certified clinics, and Lakeland Mental Health Center is becoming a certified Behavioral Health Home.

Respondents agreed that the partnerships and efforts to engage communities under multiple SIM efforts will continue in some form or another as long as they demonstrate progress toward the shared

vision, citing their strong and long history of collaboration and evidence of success as key drivers to sustaining the delivery system reform and other changes achieved through SIM "stacking".

One provider noted, "I think this group is going to continue to meet in some fashion because I think we have a vision of what we want to accomplish."

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[1] SHADAC identified 104 organizations that were participating in two or more SIM programs. Organization participation is defined as an active organization currently involved in any of the SIM-funded programs including: e-Health, e-Health Roadmap, ACH, Practice Transformation, Practice Facilitation, Emerging Professions, Learning Communities, or IHP Data Analytics. Counts exclude programs for which participants were vendors, including e-Health Toolkit; Privacy, Security, and Consent Management; Learning Days; Community Engagement; and ACO Baseline.

[2] Stake, Robert E. 1995. The Art of Case Study Research, p.3. Thousand Oaks, CA: Sage Publications, Inc.

[3] In its administration of SIM programs, the state intended to reach beyond traditional medical providers by requiring the inclusion of priority settings in select drivers. SIM priority setting providers include behavioral health, long-term and post-acute care (LTPAC), local public health and social services providers.

[4] Work was originally scheduled to conclude in December of 2016, but OTCPH received a no cost extension for its e-Health and ACH activities.

[5] SHADAC is grateful for the opportunity to have conducted individual and group interviews with four state agency staff, four Otter Tail County agency staff (including public health and human services), ten community or health care providers within the county, a representative from PartnerSHIP4Health – a Statewide Health Improvement Program (SHIP), an e-Health consultant to OTCPH, and a consumer advocate in the county.

[6] "Population Estimates, July 1, 2015, (V2015)." Otter Tail County Minnesota QuickFacts from the US Census Bureau. n.p., n.d. Web. 30 Nov. 2016.

[7] "United States Department of Agriculture Economic Research Service." Poverty. N.p., 03 Feb. 2015. Web. 30 Nov. 2016.

[8] "Population Estimates, July 1, 2015, (V2015)." Fergus Falls Minnesota QuickFacts from the US Census Bureau. n.p., n.d. Web. 30 Nov. 2016.

[9] "Public Health | Otter Tail County, MN - Official Website." Public Health | Otter Tail County, MN - Official Website. n.p., n.d. Web. 30 Nov. 2016.

[10] Partnership 4 Health CHB was formed in 2008 by merging three existing CHBs in order to pool resources, create efficiencies, and improve program effectiveness; see http://www.co.otter-tail.mn.us/1151/Community-Health-Board.

[11] MDH State Health Improvement Program (SHIP) is the prevention component of Minnesota's 2008 Health Care Reform.

[12] "About Us." Partnership for Health - About Us. N.p., n.d. Web. 30 Nov. 2016.

[13] Office of the Assistant Secretary for Health, US Department of Health and Human Services. Public Health 3.0: A Call to Action to Create a 21st Century Public Health Infrastructure. n.d. Web. 30 Nov. 2016.

[14] For more info see: http://www.health.state.mn.us/ship/

[15] State Community Health Services Advisory Committee. "SCHSAC 2013 Annual Report." (2013): n. p. Mar. 2014. Web. 30 Nov. 2016.

[16] TEFT grants were awarded to nine states to test quality measurement tools and demonstrate e-Health in Medicaid community-based LTSS. In Minnesota, the work is focused on developing a personal Health Record (PHR). See https://www.medicaid.gov/medicaid/ltss/teft-program/index.html for more details.

[17] Live Well at Home provides risk screening, education, education, professional consultation, and other solutions for living at home. See http://www.mnlivewellathome.org/en/About%20the%20Program.aspx for more details.