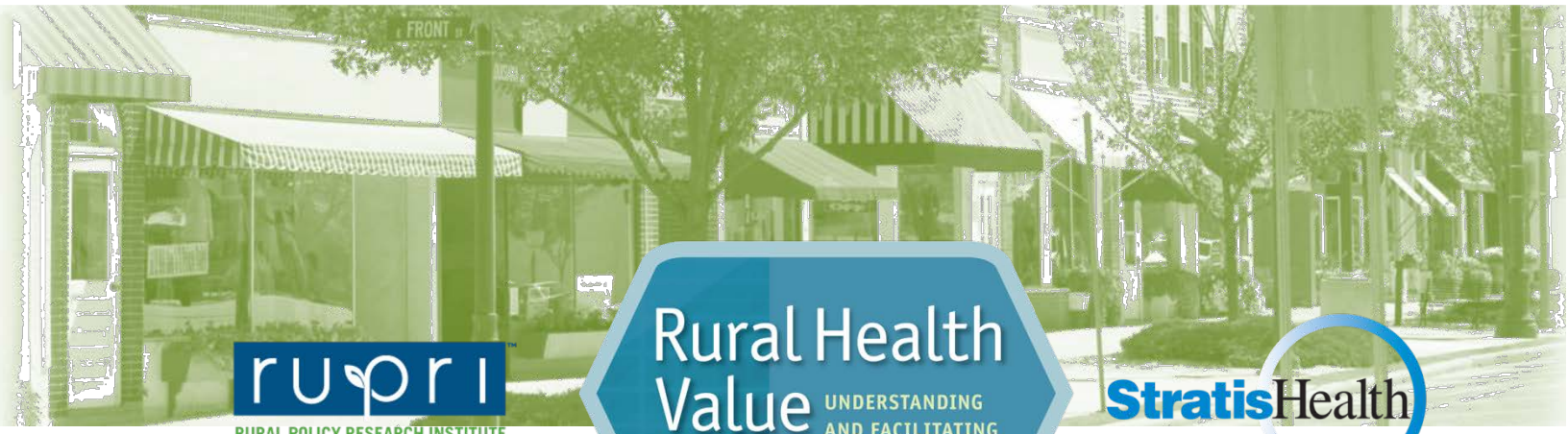

RUPRI
RURAL POLICY RESEARCH INSTITUTE
Center for Rural Health Policy Analysis

Rural Health Value
UNDERSTANDING AND FACILITATING RURAL HEALTH TRANSFORMATION.

StratisHealth

Rural Innovation Profile

Community Care Integration

What: Facilitate the integration of health care services and community supports across a 12-county region, through accountable care approaches.

Why: Enhance the quality of life and health for citizens across the region by addressing physical, emotional, and social factors.

Who: Southern Prairie, a 12-county collaboration in rural southwestern Minnesota.

How: A range of partnering agencies in the region share collective responsibility for patient care through a Medicaid accountable care organization (ACO) and a nonprofit center that implements initiatives to address major population health issues.

Key Points

- Leaders across a geographic region can come together to facilitate the integration of health care services and community supports provided across their communities.
- Multiple business structures allow access to funding opportunities that support regional work.
- Accessing the most appropriate services and models of care requires strong care coordination, especially for Medicaid clients facing numerous challenges.
- Total cost of care decreased by 10 to 15 percent for individuals treated by an Integrated Care team.
- Analyzing data in different ways—such as looking at different combinations of conditions, time periods, and services used—helps organizations and providers better understand a problem and focus intervention strategies.

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OVERVIEW

Southern Prairie is a collaboration of 12 counties in rural southwestern Minnesota with a mission to enhance the quality of life and health of their citizens by facilitating the integration of health services and community supports provided in their region. Southern Prairie includes two complementary, interconnected but independent organizations with separate goals and funding mechanisms that support a common mission, Southern Prairie Community Care (SPCC) and the Center for Community Health Improvement (CCHI).

"Our goal is to bridge the void of information and resources for the clients that we serve."

Wendy Augeson, Integrated Care Program Director Southern Prairie Community Care

SPCC is a joint powers organization that advances health in the 12-county region. SPCC was founded in 2012, several years after community leaders across many disciplines—including county commissioners, hospital administrators, nursing leadership, and others—began meeting to discuss health concerns in the region that they were not able to address independently. SPCC's primary focus is to serve as a Medicaid Accountable Care Organization (ACO) through Minnesota's Medical Assistance program (known in Minnesota as an Integrated Health Partnership (IHP)). SPCC leads integrated care, data-driven intervention strategies, and health information exchange. The organization mobilizes community services around populations with the highest needs, and leverages connections between its network participants: health and human service agencies, acute care clinics, mental health centers, and rural and critical access hospitals.

Initially, each county contributed funds to form SPCC and plan its approach. SPCC has also received grants under Minnesota's State Innovation Model (SIM), via the Center for Medicare & Medicaid Innovation. A 2013 SIM grant established SPCC's State-certified Health Information Organization (HIO), which offers health information exchange and related services, initially for SPCC but now throughout Minnesota. Through the SIM grant, the HIO strengthened SPCC's infrastructure to serve as an Accountable Community for Health (ACH), which focuses on meeting the clinical and social needs of a defined population through person-centered, coordinated care across a range of providers. A two-year SIM-ACH grant supported a community-wide initiative to delay and prevent the onset of type 2 diabetes in people most at risk.

The Southern Prairie Center for Community Health Improvement (CCHI), founded by SPCC in 2015, is a 501(c)3 nonprofit organization that pursues funding to support population health improvement that

advances health equity across the region. CCHI staff review major health trends in SPCC communities and build partnerships across sectors within the region to co-create unique solutions to address community needs, including culturally appropriate health and wellness strategies, and wellness education for chronic disease prevention, adverse childhood experiences, and trauma, as a means to address whole-person health and healing through a lens of health equity. The CCHI pursues funding sources not available to SPCC.

MEDICAID ACCOUNTABLE CARE ORGANIZATION

Since 2014 SPCC has served as a Minnesota Medicaid ACO, responsible for the health outcomes of the attributed Medicaid patients of its partnering agencies. At its peak, SPCC had 27 partnering agencies with more than 28,000 attributed individuals. The SPCC ACO provides a community-based, multidisciplinary approach that helps coordinate services using a patient-centered approach and aims to deliver high quality care while holding down cost.

The SPCC ACO refers to itself as a virtual network because SPCC does not have its own clinic facilities and does not have direct affiliation with primary providers. The SPCC ACO employs a small number of care coordinators. SPCC's network arrangement keeps care management local, led by the agencies in the region, not by a central office. Network participants have changed since the ACO's start. Some clinics and the smaller, community hospitals have left the network after being bought by larger health systems that operate their own Medicaid ACOs.

Through SPCC's HIO, partners in the ACO network provide different levels of access to their electronic health record systems, depending on how they define consent and patient preferences. The ACO works collaboratively with the different organizations in its region and requires cohesive communication and teamwork to support the aims of SPCC. It relies on the SPCC ACO network participants to submit clinical quality data, based on primary care and patient/family-centered care, needed to assess the ACO's success. SPCC staff work closely with each organization's quality staff to ensure data is submitted through the State reporting system.

The SPCC ACO retains 50 percent of the savings it produces. SPCC has earned shared savings in each year of its three performance years to date, receiving close to $8 million. It distributes half of that back to its partnering agencies and retains the other half to sustain the program and explore innovations.

INTEGRATED COMMUNITY CARE

A hallmark of SPCC's ACO is providing integrated community care for Medicaid patients who have gaps in their health care services. The SPCC Integrated Care Services team works with an average of 150 people per month. Total cost of care—which includes all acute care (inpatient and outpatient) and prescription expenses—has decreased by 10 to 15 percent for individuals whose care is coordinated by the Integrated Care Services team.

Clients are considered short-term when assistance is provided for 30 to 60 days—or long-term, when the need is longer than 60 days. Integrated care services are viewed as temporary to help clients overcome challenges and serve as a bridge to transition them to being served by the wealth of organizations in their community, including clergy, teachers, law enforcement, pharmacists, and mental health workers. For some clients, the goal is to reduce the reliance on community resources being used, and increase their independence.

The Integrated Care Services team of five registered nurses, an outreach representative, and a licensed alcohol and drug counselor are dispersed throughout the region, housed within the partnering agencies. These integration coordinators focus on social determinants of health; transportation and housing are key issues. They meet clients where they are, literally, whether in the client's home, before or after a doctor appointment, or in a park if they are homeless. They assess individual needs and issues that contribute to poor health, covering physical and mental health as well as social determinants of health. A care plan is developed with goals to meet those needs, first working through the issues that are important to the client.

Integration coordinators direct clients to the care that best meets their needs and are intentional about augmenting, not replicating, care provided by other existing models of care. This may mean matching clients to the services or other models of care such as a behavioral health home, a patient-centered medical home, or targeted case management.

DATA-DRIVEN INTERVENTION STRATEGIES

SPCC reviews claims data to identify trends and review total cost of care for its ACO. The Integrated Care Services team can use SPCC's data analysis to develop data-driven intervention strategies (DDIS). One DDIS included outreach to patients who have had two emergency room (ER) visits in a three-month period, to understand the reasons behind ER utilization that could be addressed by the Integrated Care Services team. Meeting the goals of this strategy resulted in a 50 percent reduction in total cost of care per patient. Another DDIS focused on medication assessment, education, and possible referral for medication therapy

management for individuals who had refilled seven or more maintenance medications at least three times. While this resulted in increased prescription costs as individuals adhered to their treatment plans, total cost of care for these patients declined more than 25 percent. Other interventions have focused on asthma and diabetes risk factors. One key to successful interventions has been to analyze data in different ways—such as looking at different combinations of conditions, time periods, services used—to better understand a problem and to refine the focus of intervention strategies.

ALWAYS INNOVATING

Through the CCHI, Southern Prairie takes a community-focused approach to population health, concentrating in part, on what it can do in communities to cultivate wellness and prevent chronic disease. One example of this approach is a grant that allowed CCHI to fund a Somali cultural liaison who provided medication education and adherence support for patients, cultural education for providers, and cultural literacy information for community members. Success with the Somali cultural liaison project led CCHI to establish a community health worker (CHW) model. The vision is to evolve it into a regional CHW hub that supports ongoing education and advocacy for CHWs, unites community and clinics, and establishes methods to reimburse local health systems that employee CHWs.

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For more information about the Rural Health Value project, contact:
University of Iowa | College of Public Health | Department of Health Management and Policy
www.RuralHealthValue.org | cph-rupri-inquiries@uiowa.edu | (319) 384-3831