Minnesota Department of Health – Health Care Homes and
Minnesota Department of Human Services – The Minnesota Accountable Health Model – SIM Minnesota
are proud to host:

Health Care Homes – State Innovation Model
2017 Learning Days

OUR JOURNEY TOWARD ACCOUNTABLE HEALTH

April 4-5, 2017

River's Edge Convention Center
10 4th Avenue South | St. Cloud, MN 56301

REGISTER ONLINE:
www.hchsimlearningdays.org

WELCOME

Welcome to Learning Days! We are so pleased to have you with us for this annual learning event where health care home and behavioral health providers, State Innovation Model grantees, public health and community partners come together to share best practice, learn from each other, and form collaborative relationships. This year's theme, "Our Journey toward Accountable Health," is reflective of the path we are on together to expand the care continuum into the community and improve health equity. Thank you for being here. Have a great Learning Days!

ABOUT THE CONFERENCE

This year's event features two full days of programming and offerings in five key learning tracks at beginning, intermediate and advanced levels. We have two fantastic keynote speakers who are leaders in health care transformation and an exciting array of presenters ready to deliver interactive, peer-based learning and take-home skills that you can use. Networking time and exhibit hours have been expanded. Please take time to visit our exhibits, where you can learn about products and services to support your transformation.

Register online at www.hchsimlearningdays.org.

LEARNING OBJECTIVES

Learning Days will prepare participants for accountable health by enhancing knowledge and skills for:

- Transforming primary care to improve patient experience, health outcomes and total cost of care.
- Implementing team-based care that engages patients, families, consumers, clinics and communities.
- Developing partnerships between health care providers and community institutions to address social determinants of health.
- Understanding and improving health equity.

EVALUATION

An electronic survey will be sent to all registered participants shortly after the conference. Please take the time to provide feedback so we can continually improve this learning opportunity for you.

CONTINUING EDUCATION CREDITS

Certificates of attendance will be available upon completion of the online evaluation following the conference. Please submit the certificate to your licensing board to obtain CEU credits. Application for CME is pending with the American Academy of Family Physicians.

PRESENTATION AVAILABLE ONLINE

Conference presentations and handouts may be found online after the conference at hchsimlearningdays.org/sessions.

THANK YOU LEARNING DAYS PLANNING TEAM

Georgia Anderson, Minnesota Department of Health, Health Care Homes
Carol Bauer, Minnesota Department of Health, Health Care Homes
Mark Caldwell, Minnesota Department of Health, Health Care Homes
Kathleen Conboy, Minnesota Department of Health, Health Care Homes
Barb Dalbec, Minnesota Department of Health, Children and Youth with Special Health Needs
Negma Farah, Minnesota Department of Health, Health Care Homes
Danette Holznagel, Minnesota Department of Health, Health Care Homes
Alice Johnson, GTS Educational Events
David Kurtzon, Minnesota Department of Health, Health Care Homes
Bonnie LaPlante, Minnesota Department of Health, Health Care Homes
Sida Ly-Xiong,, Minnesota Department of Health, Minnesota Accountable Health Model (State Innovation Model)
Amy Michael, Minnesota Department of Health, Office of Statewide Health Improvement
Dolly Parker, GTS Educational Events
Rosemarie Rodriguez-Hager, Minnesota Department of Health, Minnesota Accountable Health Model
Anne Schloegel, Minnesota Department of Health, Office of Health Information Technology
Michelle Schowalter, GTS Educational Events
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Terri Swanson, GTS Educational Events
Whitney Terrill, Minnesota Department of Health, Minnesota Accountable Health Model (State Innovation Model)
Kayla Vang, Minnesota Department of Health, Health Care Homes
Traci Warnberg-Lemm, Minnesota Department of Human Services, Minnesota Accountable Health Model
Kim Wielinski, GTS Educational Events

LEARNING COLLABORATIVE WORK GROUP

Dustin Chapman, LADC, Fairview Health Services
Carolyn Allshouse, Family Voices
Joanne Forman, RN, BAN, Institute for Clinical Systems Improvement
Dennis Maurer, MD, Community University Health Care Center
Eileen Weber, DNP, JD, PHN, BSN, RN, University of Minnesota School of Nursing
Ken Joslyn, MD, Retired Physician
Kristin Erickson, Partnership4Health/Ottertail County
Mary E. Kautto, MA, BSN, RN, Gillette Children's Specialty Healthcare
Marie Stevens, Patient/Consumer
Kate Onyeneho, PhD, LISW, Center for Africans Now in America
Laura Ehrlich Sanka, MPH, WellShare International

SCHEDULE-AT-A-GLANCE

Tuesday, April 4

TIME	SESSION
7:00 AM	REGISTRATION OPENS
7:30 AM - 5:00 PM	EXHIBITS
KEYNOTE 8:00 – 9:00 AM	Health Equity for All: Looking Back and Moving Forward with Health Reform in America
WORKSHOPS 9:30 - 11:30 AM	Charting a Pathway for Health in Native America: A Fresh Perspective on Social Determinants for Health and Equity
	Integrating Community Health Promotion Programs and Primary Care across Minnesota
	Integrating Behavioral Health and Primary Care: A Closer Look at the Policy Opportunities and Challenges
BREAKOUTS 9:30 - 10:30 a.m.	Sharing the Care: An Enhanced Medical Assistant Role
	Transitioning to Value Based Care
BREAKOUTS 10:45 - 11:45 a.m.	Tips and Tools for Privacy and Consent Procedures to Advance Health Information Exchange
	Chronic Opioid Use, Addiction and Heroin - A Care Team Approach
11:45 a.m. - 1:00 p.m.	LUNCH
WORKSHOPS (Invitation Only) 1:15 - 4:15 p.m.	CWG Learning Session (Invitation Only)
	Accountable Communities for Health Sharing and Learning on Project Sustainability (Invitation Only)
BREAKOUTS 1:15 - 2:15 p.m.	Longitudinal Plan of Care: Patient and Provider Views
	Improving Asthma Management in Robbinsdale
	Working across Silos
BREAKOUTS 2:30 - 3:30 p.m.	Integrated Health for Children with Complex Medical and Mental Health Concerns
	Improving Behavioral Health Coordination and Care by Strengthening Community Collaborations
	Empowering the Patient
BREAKOUTS 3:45 - 4:45 p.m.	Health Care Legal Partnerships: Advancing Health Equity
	Comprehensive Planning for Successful Transition of Youth to Adult Healthcare

SCHEDULE-AT-A-GLANCE

Wednesday, April 5

TIME	SESSION
7:00 a.m.	REGISTRATION OPENS
7:30 a.m. - 3:30 p.m.	EXHIBITS
KEYNOTE 8:00 – 9:00 a.m.	Redesigning the System to Achieve Meaningful Engagement and Patient and Family Centered Care
WORKSHOPS 9:30 to 11:30 a.m.	Race, Racism and Health Inequity: What can we do about it?
	Meaningful Conversations: Shaping the Future of Care Coordination
	Using Health Information Exchange and Data Analytics to Support Accountable Health
BREAKOUTS 9:30 to 10:30 a.m.	Filling Your Improvement Toolbox: The Shift from Volume to Value
	SmartCare: Right Care, Right Time Right Way, Right Person
BREAKOUTS 10:45 - 11:45 a.m.	Total Care Collaborative, A SIM ACH: Interventions, Impact and Outcomes
	Shared Decision Making and Depression Treatment in Primary Care
11:45 a.m. - 1:00 p.m.	LUNCH
WORKSHOPS 1:15 to 3:15 p.m.	Gaining Cognitive Control: Taking Charge of Implicit Bias
	Minnesota's Public Behavioral Health Services System: Overview and Providers
	Quality Improvement Basics: Simple Tools for Successful Projects
BREAKOUTS 1:15 to 2:15 p.m.	Preventing Hospital Readmissions through Effective Transitions of Care
	Expanding Missions of Rural Community Care Teams: Accomplishments and Challenges
BREAKOUTS 2:30 to 3:30 p.m.	Healthy Student Partnership: Exploring the Intersection of Healthcare and Education
	Your Accountable Health Journey in the Quality Payment Program

TUESDAY, APRIL 4

Keynote Speaker
8:00 - 9:00 AM

Health Equity for All: Looking Back and Moving Forward with Health Reform in America

Daniel E. Dawes, *JD, Attorney, healthcare strategist, commentator, and author of "150 Years of ObamaCare"*

Almost 35 years ago, a movement was born to advance health equity in America: The notion that everyone should be able to reach their optimal level of health. This presentation will take a past, present and future look at health reform and put attendees in the front seat so they get a clear view of the incredible turning points in the health equity and health reform movements. An engaging and thought-provoking view on the creation, impact and future of Obamacare will be provided along with a road map for a more equitable, accessible and person-centered health system moving forward.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Expand their understanding of health equity through an exploration of its historical context and prioritization via federal laws and public policies.
- Explain how health is a "state of being" impacted by a vast array of factors that reach beyond the clinic walls.
- Envision a way forward to promote equity and address the social and behavioral determinants of health.

Workshops
9:30 - 11:30 AM

Charting a Pathway for Health in Native America: A Fresh Perspective on Social Determinants for Health and Equity

Learning track: Social Determinants of Health
Learning level: Beginning

Anton Treuer, *, PhD, Author and Professor of Ojibwe, Bemidji State University*

With a fresh perspective and new tools, Ojibwe scholar and racial equity coach Anton Treuer will blend storytelling and brave conversations to help professionals meet the challenge of charting a pathway for health in Native America.

KEY	
LEARNING TRACKS	**LEARNING LEVELS**
Expanding the Teams	Beginning
Health Equity	Intermediate
Practice Transformation	Advanced
Social Determinants of Health	
Value Based Care	

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Gain insights into cultural competence and from best practices.

Integrating Community Health Promotion Programs and Primary Care across Minnesota

Learning track: Practice Transformation
Learning level: Intermediate

Aaron Leppin, *MD, MSc, Research Associate, Knowledge and Evaluation Research Unit; Assistant Professor, Division of Health Care and Policy Research, Mayo Clinic*

Paula Woischke*, Program Developer, Central Minnesota Council on Aging*

Current evidence-based health promotion programs in Minnesota will be reviewed along with an introduction to an initiative to build a statewide network for integrating these programs with primary care. A demonstration of the technology developed for this integration work will be provided. Attendees will join a facilitated group representing healthcare or community to discuss strategies and practice skills critical to their respective roles in creating local partnerships. Groups will reconvene based on geographic regions and brainstorm strategies for moving forward with their local manifestation of the emerging statewide network.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Refer patient to evidence-based programs for diabetes prevention; chronic disease and pain self-management; and falls prevention in the community.
- Describe the emerging statewide network for program implementation and to use its technology to search for, and refer to, local programs.
- Explain the important role that regional partnerships play in integrating health promotion programs in the community and make connections to facilitate this activity.

Integrating Behavioral Health and Primary Care: A Closer Look at the Policy Opportunities and Challenges

Learning track: Health Equity
Learning level: Beginning

Daniel E. Dawes, *JD, Attorney, healthcare strategist, commentator, and author of "150 Years of ObamaCare"*

This workshop will examine the laws and policies from President Carter's mental health reform efforts to the present that have had a significant impact on the country's behavioral health system. Four major behavioral health-related statutes under the Obama administration will be examined along with the opportunities and challenges that the new administration and Congress present for integrating behavioral health and primary care.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Gain insights into behavioral health equity through an exploration of its historical context and prioritization via federal laws and public policies.
- Plan a way forward to integrate care and promote health equity by addressing the social and behavioral determinants of health.

Breakouts
9:30 - 10:30 AM

Sharing the Care: An Enhanced Medical Assistant Role

Learning track: Expanding the Team
Learning level: Beginning

Kristi Van Riper*, MPH, CHES, Clinical Quality Manager, University of Minnesota Physicians, Family Medicine*

While primary care is facing problems of insufficient capacity and provider burnout, team-based care may be part of the solution. Enhancing the role of the medical assistant (MA) within the clinic team may be a successful method to address these challenges. Two processes to expand the MA role called Enhanced Rooming and Visit Assistance were developed and implemented in four Family Medicine residency clinics. Measures were tracked and results have shown shortened turnaround times for visits; increased mammogram ordering rates; and increased After Visit Summary printing rates.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Explain how this emerging model of care was developed.
- Identify the new rooming components medical assistants complete for each patient office visit.
- Describe the improvement methodology used to build this emerging model of care.

Transitioning to Value Based Care

Learning track: Value Based Care
Learning level: Advanced

Joanna Chua*, MPH, CHES, Community Health Initiatives Project Coordinator, Lake Region Healthcare, Fergus Falls*

Nicole Burrows*, RN, Medical Home Care Coordinator, Lake Region Healthcare, Fergus Falls*

Diane Thorson*, MS, RN, PHN, Director, Otter Tail County Public Health Department, Fergus Falls*

An Accountable Care Organization (ACO) aims to reduce health care costs while improving quality by having a network of providers be accountable for the cost and quality of care for primary care patients. This shift from a volume- to a value-based system is essential for health care sustainability. This session examines the challenges and opportunities of being an ACO and how technology and focusing on prevention and chronic disease management are essential to success.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Describe Accountable Care Organizations.
- Understand the impact of prevention and chronic disease management on patients' quality of life and care experience, and the healthcare organization's bottom line.
- Identify ACO issues and challenges.
- Explain the key role that technology has in providing better care and lowering costs.

Breakouts
10:45 - 11:45 AM

Tips and Tools for Privacy and Consent Procedures to Advance Health Information Exchange

Learning track: Value Based Care
Learning level: Intermediate

Jesse Berg*, JD, Gray Plant Mooty*

Julia Reiland*, JD, Associate, Health Law, Gray Plant Mooty*

Privacy, security and consent management are increasingly important topics as the use of electronic health records (EHRs) and electronic health information exchange (HIE) are expanding. Learn about the Minnesota Department of Health's grant-funded work to ensure that health care providers have access to the knowledge and tools required to use, disclose and share health information in a safe and secure manner. This session will provide information on educational materials for implementing leading practices for enabling safe and secure HIE across settings for care coordination and other activities.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Gain insights from current state initiatives working to improve health information exchange, privacy and security in Minnesota.
- Describe the privacy, security and consent requirements for health information exchange.
- Learn about new privacy tools and discuss how to best use available documents in practice.

Chronic Opioid Use, Addiction and Heroin - A Care Team Approach

Learning track: Social Determinants of Health
Learning level: Intermediate

Marya Albrecht, *RN, Health Navigator, St. Gabriel's Health, Family Medical Center*

Dr. Heather Bell, *MD, Family Medicine Physician, St. Gabriel's Health Family Medical Center*

Kurt Devine, *MD, Family Medicine Physician, St. Gabriel's Health, Family Medical Center*

Kimberly Moffitt, *Behavioral Health Care Coordinator, St. Gabriel's Health, Family Medical Center*

Theresa Sweeney, *LICSW, Social Worker, St. Gabriel's Health, Family Medical Center*

This session examines a patient-centric care model designed for those prescribed chronic pain medicine and patients with addictions (such as heroin) in a primary care setting. Presenters will outline the roles and significance of care team members and describe how community partnerships are integral to ongoing care management for patients prescribed chronic opioids. Unique partnership designs with behavioral health specialists applying collaborative care coordination will be reviewed. Physicians will also discuss how medication-assisted therapy via Suboxone treatment was introduced into the primary care setting. Important care-planning considerations needed for integrating these programs into other primary care clinics will be presented.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Explain the importance of a comprehensive care-team approach for chronic opioid use; the roles of care team members; and the importance of community partnerships.
- Gain insights from a model implemented in primary care to treat addiction and heroin-use for patients in rural communities.
- Describe alternative care-team models featuring collaboration with behavioral health partners for treatment and care coordination.

Workshops (Invitation Only) 1:15 - 4:15 PM

CWG Learning Session (Invitation Only)

Learning track: Not applicable
Learning level: Not applicable

Dialogue among Community Wellness Grant grantees and partner organizations.

This workshop will bring together staff from clinics, local public health, and the Minnesota Department of Health to share their progress on the important work happening around pre-diabetes and hypertension in CDC-funded Community Wellness Grant (CWG) regions.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Use clinical quality-measure data to assess performance- and process-improvement strategies.
- Discuss lessons learned from the CWG health system activities.
- Explore bi-directional communication strategies.

Accountable Communities for Health Sharing and Learning on Project Sustainability (Invitation Only)

Learning track: Not applicable
Learning level: Not applicable

Presentations and dialogue - Accountable Communities for Health

Accountable Communities for Health (ACH) team members will discuss how they plan to sustain efforts to meet the clinical and social needs of a defined population through person-centered, coordinated care across a range of providers. ACH projects are funded to evaluate community-led ACH model results for improvements in quality, cost and experience of care. Approximately $5.6 million, or 14 percent, of Minnesota's State Innovation Model funds are dedicated to 15 ACH grant projects. ACH staff will present the value, outcomes and plans for their ACH model after the conclusion of State Innovation Model grant funds in 2017.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Gain insights on ACH sustainability.
- Identify e-health strategies that are relevant to sustaining the ACH care coordination model.

Breakouts
1:15 - 2:15 PM

Longitudinal Plan of Care: Patient and Provider Views

Learning track: Practice Transformation
Learning level: Beginning

Jane Kluge, *RN, BSN, Ambulatory Care Management Coordinator, CentraCare Health- Central MN*

Comparing the differences and similarities of a patient's longitudinal plan of care in Epic from the patient and provider views, this presentation explores each area of the care plan and how it benefits patient care across the health system. Details on who can document or modify care plans will be shared.

OBJECTIVES
At the conclusion of this session, participants will be able to:
- Describe the longitudinal plan of care.
- Explain the differences between the patient and provider views of the care plan.

Improving Asthma Management in Robbinsdale

Learning track: Expanding the Team
Learning level: Advanced

Maggie Carlson*, Clinic Manager, Park Nicollet Plymouth Clinic*

Alison Salita*, RN, BSN, CDE, Clinical Quality Project Manager, Park Nicollet Health Services*

Amber Spaniol*, RN, PHN, LSN, Health Services Program Director, Robbinsdale School District*

The TEAMS project aims to improve child health by supporting school districts in making improvements to their health services and better preparing students for academic success. This presentation will showcase how the Robbinsdale Area Schools and Park Nicollet Health Services leveraged the TEAMS framework to foster partnerships to improve asthma care and management for students and patients.

OBJECTIVES
At the conclusion of this session, participants will be able to:
- Identify how Park Nicollet and the school district leveraged this framework to support improvements in the health care services they deliver to students and patients.
- Explain how the team assessed current school health services, policies, practices, infrastructure and barriers, along with key areas for improvement around asthma management.
- Gain insights from the process changes implemented around asthma management plans and staff education, and implementation results.

Working across Silos

Learning track: Health Equity
Learning level: Intermediate

Clarence Jones, *BA, Med, Outreach Director, Southside Community Services*

Sam Simmons*, CEO, Sam Simmons Consulting; Co-Chair, Hue-MAN*

Angie Stevens*, Systems Change Coordinator, Minnesota Department of Health Sage Program, Health Promotion and Chronic Disease Division*

Va Yang*, Community Outreach Coordinator- Government Market Solutions, Blue Cross Blue Shield of Minnesota*

The Hue-MAN Partnership Project focuses on medical health and community outreach to address the health crisis among young and middle-aged men, especially men of color. A play on words for men of all "hues" and "humans," Hue-MAN reduces health disparities by empowering men to make healthy choices for themselves, their families and communities.

OBJECTIVES
At the conclusion of this session, participants will be able to:
- Develop effective strategies to build relationships across silos.
- Describe ways to create a common vision and mission for community health.
- Identify ways to work through difficult conversations among partners.

Breakouts
2:30 - 3:30 PM

Integrated Health for Children with Complex Medical and Mental Health Concerns

Learning track: Practice Transformation
Learning level: Beginning

Christine Bentley*, BS, Interim Director, Fraser Integrated Healthcare, Fraser, Bloomington*

Emily Castro, MHP*, Systems Navigator, Fraser, Bloomington*

Ellie Chase-Andresen*, RN, MN, Integration Specialist, Fraser, Bloomington*

Building on its autism expertise, in 2016 Fraser launched Behavioral Health Home, an integrated health model that coordinates all medical and mental health care to support families in managing their child's health and well-being. The presentation will feature the program's design tools and operations along with lessons learned during this first year of implementation.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Gain insights from the Behavioral Health Home model's first year of implementation.
- Describe the team care model including design, roles and responsibilities of internal and external team members.
- Adapt and use the Behavioral Health Home tools and protocols designed to meet client and program needs.

Improving Behavioral Health Coordination and Care by Strengthening Community Collaborations

Learning track: Social Determinants of Health
Learning level: Intermediate

Jan Carr-Harseth, *LICSW, Director of Behavioral Health, Social Services, and Chronic Disease Management; Life Care Medical Center*

Alyssa Meller, *MA, Chief Operating Officer, Rural Health Innovations, a subsidiary of the National Rural Health Resource Center*

Jen Peterson, *MSW, LGSW, Social Work Supervisor, FirstLight Health System*

Rural hospital emergency departments often struggle to meet the behavioral health needs of their community. In response, the Minnesota Department of Health's Office of Rural Health and Primary Care awarded a grant to provide customizable technical assistance to help rural hospitals. Each hospital identified a specific population, providers and community organizations to help develop strategic objectives to meet community needs. This presentation will provide an overview of the project's process and two hospitals will share ways they partnered with providers and community organizations to proactively address their communities' behavioral health needs.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Describe the technical assistance provided to support hospitals in improving the experience and outcomes for behavioral health patients.
- Explain ways hospitals engaged patients, families and community agencies to enhance team-based care for behavioral health patients.
- Gain insights from the innovative ways hospitals utilize available community resources to create a stronger safety net for behavioral health patients.

Empowering the Patient

Learning track: Health Equity
Learning level: Intermediate

George Klauser, *Executive Director, Altair-Lutheran Social Services*

Nate Tyler, *Chief Service Officer, Simply Connect*

With the disability population as an example, this session presents a model that empowers patients and guardians to make decisions on their individual care plans. Designs, learnings and examples of model implementation will be explored.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Gain insights from two case studies examining results from before and after model implementation.
- Review our experiences from a patient/person-centered perspective.
- Understand how to apply tools to their health equity designs.

Breakouts
3:45 - 4:45 PM

Health Care Legal Partnerships: Advancing Health Equity

Learning track: Health Equity
Learning level: Beginning or Intermediate

Colleen McDonald Diouf, *Chief Executive Officer, Community University Health Care Center (CUHCC)*

Eileen Weber, DNP, JD, BSN, PHN, RN, *Clinical Assistant Professor, U of M School of Nursing, Upper Midwest Healthcare Legal Partnership Learning Collaborative*

One in six low income persons needs legal help to improve their health such as eliminating the need for a kidney transplant by restoring food stamps to a wrongfully denied diabetic patient, or reducing emergency department visits by demanding that a landlord remove mold. Healthcare Legal Partnerships (HLPs) exist to meet needs like these by adding lawyers to the healthcare team. Minnesota has 11 HLPs and growing and the U.S. Health Resources and Services Administration includes legal aid as a Federally Qualified Health Center "enabling service." This presentation offers strategies and resources to help those working to advance health equity by exploring the potential of starting an HLP.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Identify strategies for using healthcare legal partnerships to combat negative social determinants of health.
- Explore possible funding sources to support healthcare legal partnerships.
- Describe the effectiveness and return on investment (ROI) of healthcare legal partnerships.

Comprehensive Planning for Successful Transition of Youth to Adult Healthcare

Learning track: Practice Transformation
Learning level: Beginning

Wendy Berghorst*, MS, RN, PHN, Transition Specialist, Minnesota Department of Health, Children and Youth with Special Health Needs*

Linda Goldman Cherwitz*, MD, Health Advocate, Health Information Center, PACER Center, Bloomington MN*

Supporting adolescents with special health needs transition to adult life through a coordinated, comprehensive approach is key for their continued health and wellbeing. This session will review key elements needed to successfully improve the quality of the life transition process for youth with the help of the family, health care team and community. Strategies to optimize their ability to assume adult roles and activities by accessing developmentally-appropriate services will be included.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Identify key components that should be addressed in transition planning for youth with special health needs.
- Describe transition tools and resources that support client assessment and decision-making in the transition process.
- Differentiate the roles and responsibilities of youth with special health needs, their families and care teams for successful transition planning.
- Implement a variety of practical strategies for a quality-improvement transition project in your setting.

WEDNESDAY, APRIL 5

KEY	
LEARNING TRACKS	**LEARNING LEVELS**
Expanding the Teams	Beginning
Health Equity	Intermediate
Practice Transformation	Advanced
Social Determinants of Health	
Value Based Care	

Keynote Speaker
8:00 - 9:00 AM

Redesigning the System to Achieve Meaningful Engagement and Patient and Family Centered Care

Melissa Thomason, *Patient and Family Advisor, Vidant Health System, North Carolina; Chair, Patient Advisory Council, East Carolina Heart Institute; member, North Carolina Institute of Medicine's Patient and Family Engagement Taskforce*

A former public school teacher, Melissa Thomason underwent open-heart surgery at the age of 28 and two more the year after. Eventually diagnosed with a rare disorder called Loeys Dietz Syndrome (LDS), she discovered that no one on her healthcare team had heard of LDS. Melissa quickly became her own best advocate and a champion for patient engagement and now inspires others to believe in the transformational power of patient engagement. She has shared her story with hundreds of healthcare workers and has finally "found purpose in all of the pain.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Gain insights on how culture impacts health outcomes.
- Explain how meaningful patient engagement promotes accountable care.
- Implement strategies to deliver patient- and family-centered care.

Workshops
9:30 - 11:30 AM

Race, Racism and Health Inequity: What can we do about it?

Learning track: Health Equity
Learning level: Beginning

Stephen C. Nelson*, MD, Director, Hemoglobinopathy Program; Co-Director, Vascular Anomalies Clinic; Adjunct Assistant Professor, Department of Pediatrics, University of Minnesota, Children's Hospitals and Clinics of Minnesota*

This presentation is born out of Dr. Nelson's work as a physician and the recognition of the impact that racism and provider bias has on racial disparities in health care. The sessions draws from five years of research and racial justice trainings for physicians, nurses, students and others. A wealth of information regarding the transformation of racial disparities will be provided.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Explain how race functions as an independent factor in health equity.
- Describe the barriers to health equity, including how racism affects health.
- Gain insights on how providers' unconscious biases and stereotyping impacts racial disparities in health care.
- Appreciate how education on issues of race, racism and whiteness can help provide a critical race lens for providers.
- Apply concrete tools to move towards health equity and improve providers' self-efficacy in treating patients of color.

Meaningful Conversations: Shaping the Future of Care Coordination

Learning track: Practice Transformation
Learning level: Beginning

Kathleen Conboy*, RN, BSN, PHN, Senior Nurse Planner, Metro Health Care Homes, Minnesota Department of Health, Health Policy Division*

Danette Holznagel*, RN, BAN, PHN, CDE, FCN, Senior Nurse Planner - North, Health Care Homes, Minnesota Department of Health, Health Policy Division*

Joan Kindt*, RN-C, BSN, PHN, Senior Nurse Planner - South, Health Care Homes, Minnesota Department of Health, Health Policy Division*

Tina Peters*, MPH, RN, PHN, Senior Nurse Planner - Metro, Behavioral Health Integration Nurse Coordinator, Health Care Homes, Minnesota Department of Health, Health Policy Division*

This interactive workshop is designed around care coordination themes and questions relevant to real-life concerns of health care home clinics. Conversations will occur through small group discussions, providing an opportunity to meet new people, actively contribute, exchange perspectives and obtain new insights. Topic examples include caseloads; training; staff turn-over; social determinants of health and non-medical complexities; community partnerships and resources; patient activation and engagement; patient-centered goals; care coordinator roles; and transitions of care.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Gain insights from sharing experiences around patient- and family-centered care coordination models along with the challenges and solutions.
- Identify care coordination processes being utilized in different settings and populations.

Using Health Information Exchange and Data Analytics to Support Accountable Health

Learning track: Value Based Care
Learning level: Advanced

***Susan Voigt**, Executive Director, Minnesota Community Healthcare Network, Minneapolis*

***Will Muenchow**, Southern Prairie Community Care, Marshall*

***Anne Schloegel**, Minnesota Department of Health, Office of Health Information Technology*

This session will provide an understanding of how health information exchange (HIE) and data analytics will help achieve more coordinated care, improved health and shared cost. Learn about Minnesota's approach to and current status of HIE, along with lessons learned from grant-funded HIE implementation projects.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Explain how Minnesota's HIE activities will help achieve more coordinated care, improved health and shared cost.
- Gain insights from e-health and HIE tools such as the Minnesota e-Health Roadmap and HIE Framework.
- Learn from community collaboratives that are implementing HIE and data analytics.

Breakouts
9:30 - 10:30 AM

Filling Your Improvement Toolbox: The Shift from Volume to Value

Learning track: Practice Transformation
Learning level: Beginning

***Candy Hanson**, BSN, PHN, LHIT-HP, CPF, Program Manager, Stratis Health*

***Jeyn Monkman**, MA, BSN, PHN, NE-BC, Project Manager and Healthcare Consultant, Institute for Clinical Systems Improvement*

Health care is constantly changing and the shift to value-based care has been long anticipated. The year 2017 promises even more change and learning as organizations move to better understand value-based payment, including Medicare's Quality Payment Program and how this impacts care delivery. Ensuring that quality improvement is incorporated into patient care and affordability is essential. This session focuses on important elements needed to enhance internal capacities for improvement activities. Practical tools created during State Innovation Model - Practice Facilitator (SIM-PF) work will be shared for novices to experience.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Explain the essential elements required for care-delivery transformation.
- Identify practical tools for improvement that aide in building and supporting the infrastructure needed for improved care delivery.

SmartCare: Right Care, Right Time Right Way, Right Person

Learning track: Value Based Care
Learning level: Advanced

***Tasha Gastony**, PA-C, Regional Medical Director and Clinic Medical Director SmartCare, Park Nicollet Health Services*

SmartCare is a new primary care clinic piloted by Park Nicollet in January 2016 with a model aimed at reducing care costs. The clinic team has a 1:3 ratio of medical doctors to nurse practitioners/physician assistants and four registered nurses. The session will examine how a single, comprehensive visit with patients and well-documented care plans reduces costs by decreasing face-to-face visits. Examples of how clinic staff offer phone and video visits, and registered nurses (RNs) work under a broad set of standing orders, will be discussed.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Determine how to navigate care to the right team member (MD, NP, PA or RN).
- Apply the electronic medical record (EMR) to the highest level: the one team member that is always with the patient.
- Expand hours and care options (on-line, telephone or video) to improve access to care and reduce costs.

Breakouts
10:45 - 11:45 AM

Total Care Collaborative, A SIM ACH: Interventions, Impact and Outcomes

Learning track: Expanding the Team
Learning level: Intermediate

***Emily Hedlund**, MHA, Manager of Care Coordination, North Memorial Health Care*

***Rebecca Nixon**, RMA, Care Coordinator, North Memorial Clinic*

***Khalea Zobel**, LSW, Social Work Care Coordinator, Broadway Family Medicine*

***Shelly Zuzek**, MSW, LICSW, Director of Integrated Care, Vail Place*

The Total Care Collaborative (TCC) addresses adults with serious mental illnesses and co-occurring medical diagnoses who access three primary models of care: rapid access case management; care navigation; and care coordination for "rising risk" individuals. The presentation will provide an overview of successful TCC programs, interventions and outcomes, along with case examples. TCC is a State Innovation Model (SIM) Accountable Community of Health with partners including Vail Place, North Memorial, Broadway Family Medicine Clinic, and Portico HealthNet.

Shared Decision Making and Depression Treatment in Primary Care

Learning track: Practice Transformation
Learning level: Intermediate

***Tasha Gastony**, PA-C, Regional Medical Director and Clinic Medical Director SmartCare, Park Nicollet Health Services*

***Patty Graham**, Senior Quality Consultant, Health Partners*

A depression diagnosis and understanding recommended treatment options can be overwhelming. Using shared decision making can aid in creating a care plan that reflects the patient's beliefs and wishes, and can lead to improved outcomes. This session will review strategies to integrate shared decision making into the depression diagnosis and care planning process. A toolkit developed by a collaboration of Minnesota Prepaid Medical Assistance Program health plans will be provided with resources for providers working with patients experiencing depression.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Explain how shared decision making can be used for depression treatment in primary care.
- Identify practical strategies for incorporating shared decision making into depression treatment in primary care.

Workshops
1:15 - 3:15 PM

Gaining Cognitive Control: Taking Charge of Implicit Bias

Learning track: Health Equity
Learning level: Beginning

***Andre Koen**, MA, Chief Facilitator, AM Horizon*

Learn how to gain cognitive control and take charge of implicit bias personally and within an organization or workplace. This workshop will provide strategies to eliminate and replace harmful stereotypes and cultural prejudice to create space for diversity, equity and inclusion so staff and and organizations can flourish. Participants will take part in engaging conversations to illuminate the problem of implicit bias and how it limits our ability to develop cross-cultural competence.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Apply culturally-responsive conceptualization skills to explain how clients' privileged and marginalized status influence culture, worldviews, experiences and presenting challenges.
- Eliminate the use of harmful stereotypes and cultural prejudice to create space for diversity, equity and inclusion in organizations.

Minnesota's Public Behavioral Health Services System: Overview and Providers

Learning track: Social Determinants of Health
Learning level: Beginning

***Richard Moldenhauer**, MS, LADC, ICADC, LPCC, Treatment Services Consultant and State Opioid Treatment Authority, Minnesota Department of Human Services, Community Supports Administration, Alcohol and Drug Abuse Division*

***Lucas Peterson**, BA, Mental Health Policy Specialist, Minnesota Department of Human Services, Community Sports Administration, Mental Health Division*

***Bill Wyss**, MPA, Deputy Director of Children's Mental Health, Minnesota Department of Human Services, Community Supports Administration, Mental Health Division*

This session will review mental health and substance abuse treatment services available to patients with co-occurring physical and behavioral health conditions. Information will be provided on where to refer patients: for behavioral services; to get assessed for a mental illness or addiction; and who are experiencing a mental health crisis to get needed services without ending up in the emergency department.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Refer to a range of public mental health and substance abuse along with information links to service providers across Minnesota.
- Identify eligibility information and funding opportunities for specific target populations.

Quality Improvement Basics: Simple Tools for Successful Projects

Learning track: Quality Improvement
Learning level: Beginning

Sarah Horst Evans*, MA, Project Manager and Health Care Consultant, Institute for Clinical Systems Improvement*

Jeyn Monkman*, MA, BSN, NE-BC, Project Manager and Health Care Consultant, Institute for Clinical Systems Improvement*

Learn how the Model for Improvement's three simple questions can be applied to any quality improvement need, big or small. Discover the impact of the rapid Plan-Do-Study-Act cycle as a tool to thoughtfully acquire the knowledge and learning needed to create changes that stick. Learn how to empower and engage teams through process mapping; using data to tell your story; and addressing the adaptive challenges that come with all improvement work.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Describe the Model for Improvement.
- Use small tests of change (Plan-Do-Study-Act cycles) to acquire the knowledge and learning needed to improve.
- Gain insights from data's role in improvement work.
- Describe the difference between a technical problem and an adaptive challenge

Breakouts 1:15 – 2:15 PM

Preventing Hospital Readmissions through Effective Transitions of Care

Learning track: Expanding the Team
Learning level: Intermediate

Emily Goetzke, *MSN, RN, Manager of Population Health and Care Management, Mankato Clinic, Ltd.*

Hospital readmissions can be prevented when transitions of care are well managed. The transition from acute care to a skilled nursing home can be particularly challenging because of the importance of continuity of care due to patient complexity. The Mankato Clinic has partnered with an area hospital and with skilled nursing facilities to identify and solve issues related to transitions between the hospital, facility and home. This presentation will describe the development of the partnership and steps taken to promote seamless transitions.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Describe the challenges with transitions of care to and from skilled nursing facilities.
- Identify the impact of organizational partnerships to manage transitions of care.
- Discuss opportunities for partnerships in their own community.

Expanding Missions of Rural Community Care Teams: Accomplishments and Challenges

Learning track: Expanding the Team
Learning level: Intermediate

Pat Conway*, PhD, MSW, Senior Research Scientist, Essentia Institute of Rural Health*

Heidi Favet*, BS, Certified Community Health Worker, Essentia Health Ely Clinic; Ely Community Care Team Leader*

Jenny Uhrich, BA, MPA*, Executive Director, Well Being Development-Ely*

Developed as a subgroup of the successful Community Care Team, the Behavioral Health Network (BHN) coordinates, expands access to, and improves the quality of behavioral health care services through care coordination in remote rural communities. This session will focus on strategies to successfully establish, grow and sustain networks. Topics will include building value for network members from various disciplines; making evaluation an asset; and overcoming challenges and barriers to networks.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Explain how to expand the care team model to include other teams with focused missions.
- Identify challenges and solutions to network development within and among organizations regionally and statewide.
- Plan for long-term outcomes while accomplishing short-term wins.

Breakouts
2:30 – 3:30 PM

Healthy Student Partnership: Exploring the Intersection of Healthcare and Education

Learning track: Social Determinants of Health
Learning level: Beginning or Intermediate

***Karen Manikowski**, MPH, CHES, Project Manager, Healthy Student Partnership, Allina Health, Northwest Metro*

The Accountable Communities for Health grant has allowed for the expansion of the Northwest Metro Healthy Student Partnership which targets high school students in the Anoka-Hennepin School District. The expansion has provided a rich understanding of how healthcare systems, such as Allina Health, can successfully partner with school districts and community-based organizations to enrich health services available to students and families. This session will provide a summary of the Healthy Student Partnership including project planning, implementation, successes and challenges while highlighting opportunities for replication in your community.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Recognize why educational and community-based programs and strategies play an important role in reaching public health goals.
- Explain how to implement interventions utilizing multi-organizational partnerships to address community health concerns.
- Identify relevant youth and adolescent-focused resources to help address health issues in equitable and sustainable ways.

Your Accountable Health Journey in the Quality Payment Programt

Learning track: Value Based Care
Learning level: Beginning

***Lisa Gall**, BSN, PHN, LHIT-HP, Program Manager, Stratis Health, Bloomington MN*

***Candy Hanson**, BSN, PHN, LHIT-HP, Program Manager, Stratis Health*

The journey toward accountable health has begun: In 2017, the Center for Medicare and Medicaid Services' (CMS) Quality Payment Program started its transition year. The session will provide details on how the Merit Based Incentive Program (MIPS) is setting the stage for improving health outcomes and patient experiences as organizations select their "Pick Your Pace" option for participating in the Quality Payment Program.

OBJECTIVES

At the conclusion of this session, participants will be able to:

- Explain how components are scored in MIPs and how a positive payment adjustment for 2019 can be earned.
- Differentiate the "Pick Your Pace" options for participation in the 2017 transition year.
- Implement strategies to begin setting the stage for improving health outcomes and patient experiences in the Quality Payment Program.

2017 Health Care Homes and State Innovation Model Learning Days Event

The Minnesota Department of Health - Health Care Homes, Minnesota Department of Human Services and Minnesota Accountable Health Model State Improvement Model (SIM) Grant thank members of Learning Collaborative Work Group and planning team who contributed time and resources to plan, implement and promote the event.

The 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 (CMI) to help implement eh Minnesota Accountable Health Model.