

Statewide Health Improvement Program
Multi-grantee Health Care Work Group Meeting
 May 18, 2010, 2:30-4:00 p.m.
 Allina, (Mora Conference Room, 068-Greenway Level)

MEETING MINUTES

Attendees: Courtney Jordan (Physician Consultant), Renee Gust (Hennepin County Public Health), Cathy Brunkow (Hennepin County Public Health), Mary Larwik (Neighborhood Health Care Network), Ruth Tripp (Bloomington Public Health), Megan Ellingson (MDHFS), Ron Jankowski (Freemont Community Health), Patty Bowler (MDHFS), Patty Graham (MHP)
 Phone: Rhonda Evans (BCBS), Kristin Erickson (Otter Tail County Public Health), Melissa Marshall (ICSI), Randall Warren (Health Partners)

Agenda Item	1. Welcome and Introductions
Discussion	<ul style="list-style-type: none"> Courtney Jordan, Chair of the Health Care Work Group (HCWG), convened the meeting and called for introductions.
Next Steps	<ul style="list-style-type: none"> None.
Agenda Item	2. Approval of April 20, 2010 meeting notes
Discussion	<ul style="list-style-type: none"> Meeting notes were approved with no changes.
Next Steps	<ul style="list-style-type: none"> None.
Agenda Item	3. Clinic status and ICSI update
Discussion	<p><u>ICSI</u></p> <ul style="list-style-type: none"> The first face-to-face ICSI Collaborative meeting was held on Friday, April 30, 2010, at the Northland Inn, Brooklyn Park. The first participant conference call was held today, May 18th over the noon hour. 7 organizations are participating, with potentially 3 more to join, with diversity in the types of clinics represented. The next face-to-face meeting is June 10, 2010, and will focus on aims and measures. <p><u>Hennepin County</u></p> <ul style="list-style-type: none"> Hennepin County Public Health had recruited two clinics for the multi-grantee grant, Hennepin Care East (Minneapolis) and Hennepin Care North (Brooklyn Park) that will participate in the June 10 face-to-face ICSI meeting. ICSI will have a 1-hour conference call ahead of the meeting to bring the clinics up-to-speed. Cathy Brunkow will be working with these two clinics. <p><u>Minneapolis</u></p> <ul style="list-style-type: none"> The Minneapolis Department of Health and Family Support (MDHFS) continues to work with five clinics on full guideline implementation: Freemont Community Health Services (Central Avenue Clinic, Freemont Clinic, Sheridan Clinic), Neighborhood Involvement Program/Uptown Community Clinic, and The People's Center Medical Clinic. Minneapolis is also working with several other clinics on the referral-only intervention: Southside/Green Central, AXIS Medical Center, the Phillips Neighborhood Clinic and Broadway Clinic. All five full-guideline clinics completed baseline staff/provider surveys, and four of the five full-guideline clinics have completed baseline chart audits. These baseline assessment data were available at the April 30th face-to-face meeting for clinics to start putting together their action plans. The toolkit is completed and will be brought out to clinics in the next couple of weeks. Minneapolis will be focusing on developing action plans

	<p>with clinics, and doing more assessment with them (patient waiting room surveys and staff/provider focus groups) related to the referral network.</p> <p><u>Bloomington</u></p> <ul style="list-style-type: none"> Bloomington Public Health continues to work with the two Bloomington Lake Clinics (Bloomington and Minneapolis locations) on the multi-grantee grant. They had a representative at the ICSI Collaborative and are in the process of conducting their staff/provider surveys and chart audits. Through their Bloomington SHIP grant, Bloomington Public Health is also working with Northwestern Health Sciences University which is participating in the ICSI Collaborative, as well as Southdale Internal Medicine, WIC, and SagePlus that are not in the Collaborative. <p><u>General Comments</u></p> <ul style="list-style-type: none"> The group discussed various efforts that are going on that put this work in the context of the broad public health effort to prevent obesity and tobacco use. The efforts mentioned included The Alliance, SHIP efforts generally, an MDH group Courtney is on that discusses primary prevention of cardiovascular disease (including covering legislative issues on the topic), and a new Minneapolis stimulus grant (Communities Putting Prevention to Work—CPPW) with ten additional interventions. Also, there were no cuts this year to SHIP funding. The group discussed how the clinics/systems we work with fit into these broader efforts, and that we expect to see movement on the indicators for this broad-based public health effort.
Next Steps	<ul style="list-style-type: none"> The Multi-grantee team will be working with their clinics on action plans and next steps, including participating in the second ICSI meeting with intervention clinics on June 10, 2010.
Agenda Item	4. System status update (Park Nicollet and others)
Discussion	<ul style="list-style-type: none"> Megan provided a draft Scope of Service and Budget outline to Park Nicollet to use for planning project implementation. Park Nicollet has had one or two internal meetings to start planning the project. They will be in-touch with Megan within about a week with a draft Scope to use for further discussion with the Project Team. Megan and Ellie reported that they and Kristen Godfrey met with several Allina representatives working on Allina’s Robina Project and phone navigator help desk to determine if there are ways for the project to work with Allina in the short- or long-term. Robina Care Guides assist people with chronic diseases and the phone navigation help desk is focused on connecting seniors and their caregivers with resources. The group discussed sharing the SHIP referral list when it is developed and the potential for using these models for prevention in the future. Courtney reported that she is continuing to try to get this topic on the agenda at Health Partners for their 2011 priority setting. Megan has not heard back from Fairview about any next steps.
Next Steps	<ul style="list-style-type: none"> Megan will contact Fairview again to see if they are interested in any follow-up. The Project team will meet with the Park Nicollet team to discuss the draft deliverables, work plan and budget. Multi-grantee team will report back with updates on systems at the next meeting.
Agenda Item	5. Update from reimbursement and follow-up care sub-groups
Discussion	<ul style="list-style-type: none"> The reimbursement subcommittee chaired by Carol Berg, UCare, and Sandy Lien, Medica, has not met since the last Health Care Work Group meeting. The proposed

codes for ICSI guideline-related services are going before the Administrative Uniformity Committee (AUC) on May 25th. The group discussed the possibility of creating new codes if some are needed. While there may be gaps between having codes and having all of them reimbursed, getting uniform codes is a first step toward greater reimbursement for guideline-related services.

- The Follow-up Care Sub-group met for the first time on May 4th. Several HCWG members were there and they gave the group an update on what happened at the meeting. Brooke invited a few SHIP Coordinators from Greater MN to join the sub-group by phone to get their perspective as well. The sub-group discussed the need for a resource and information clearinghouse, as well as the idea of expanding the tobacco fax referral system to physical activity and nutrition resources. The sub-group had a lot of discussion about how to triage people, the need for medical follow-up, and roles of medical providers v. others in providing regular follow-up. The sub-group decided to convene two groups based on the discussion: one to envision what an expanded fax referral system could look like; and another to move forward the discussion/decisions about what, if any, information clearinghouse to use statewide.
- Ellie requested an update on Minnesota Community Measures and their link to this work. Megan reported that she met with Jane Duncan at MN Community Measures to talk about connections, and that the SHIP ICSI Project chart audit tool was modified to using the MCM format because clinics had requested this to make it easier and more consistent for them. This tool was share back with Jane at MN Community Measures so that she could see the work and approach. Megan has also talked to Brooke about having further discussion with MDH quality staff on this topic. There was discussion about how we can measure outcomes of this work (changes in BMI, tobacco use, physical activity, nutrition) and not only outputs, and that from a primary prevention standpoint we will need to get to a model that does this, with incentives to provide care outlined in the guidelines.
- Renee asked if the Health Care Work Group was ok with operating on these high-level topics, given that the project is working with individual clinics and clinic systems to implement the guidelines at their sites. Each individual clinic is taking on different components of the guidelines based on their priorities and needs. The group responded that they wanted to work on both individual clinic levels and at higher policy levels in order to have long-term change. Incentives and reimbursement change care practices, so these are tools for broadly changing practice, as well as helping the individual clinics with which we're working. If incentives and reimbursement are in-place, clinics will figure out how to provide the services. At individual clinics we will measure change through chart audits. Getting on the radar of MN Community Measures would be a good way to create long-lasting systems change. Renee is finding that individual clinics need assistance with training/education, and developing new tools to make it work for them—help working it through at their clinic site.
- Ron commented that the way chronic disease prevention is handled clinic-to-clinic and health plan to health plan varies widely, and that more consistency, as there is in disease treatment, would lead to more provision of preventive services. SHIP will be able to take vague guidance and say “here are some standardized things you can do.” The group discussed how the ICSI guidelines provide guidance, but

	<p>treating these risk factors like a disease, and intervening preventively, is new for medical providers. Because the providers participating in this project serve a lot of public program patients, working closely with DHS will be helpful in standardizing.</p> <ul style="list-style-type: none"> • The group discussed how we will know if we are successful, and that while the project will measure provider behavior change, what are the plans for measuring changes in BMI, smoking and other risk behaviors among patients. Cathy reported that Hennepin County will be measuring baseline BMI and 12-month follow-up BMI with their clinics (non-multi-grantee clinics). MDH is not requiring SHIP reporting on BMI and risk behavior change, but on implementing systems and policy changes. MDH has short- and long-term outcomes expressed as years 1-2: document policy, system and environmental changes; years 3-10 document behavior changes; and years 10-25 document pre- and post- intervention changes using BRFSS data. Many counties are using population-base surveys like Hennepin County’s SHAPE survey to measure overall impact of their SHIP interventions (those in community, schools and worksites as well as clinics). Our role in the short-term is to make sure the ICSI guidelines are followed. • Ron suggested that we have a “healthy lifestyle tool”, similar to the PHQ9 for depression, that gives a score that can be used to guide practice as well as to measure impact of the work. Kristin discussed the questions on page 41 of the ICSI guidelines as a start for this tool, as well as an assessment tool she’s developed. Hennepin County has developed a wellness assessment tool for use at a clinic in Crystal they’re working with. The group agreed that it would like to take this on as an activity, and Renee will follow-up on it.
Next Steps	<ul style="list-style-type: none"> • Megan Ellingson will send the health plan billing and resource grids to the Health Care Work Group when they are finalized. • MDH will be convening the two groups assigned out of the Follow-up Care Sub-group, as well as the next Sub-group meeting. • Progress in the Reimbursement and Follow-up Care sub-groups will be reported back at the next Health Care Work Group meeting. • Megan will ask Brooke to speak at the next Health Care Work Group meeting about MDH’s long-term strategies and measures for chronic disease prevention. • Renee will share current “healthy lifestyle tools” with Courtney and Ron for feedback, and together they will draft a tool to bring to the next Health Care Work Group meeting for discussion.
Agenda Item	7. Next steps and future agenda items
Discussion	<ul style="list-style-type: none"> • The next meeting is June 15, 2010, 2:30-4:00 pm at UCare (Room 309).
Next Steps	<ul style="list-style-type: none"> • Future agenda items include updates on clinics and clinic systems, subcommittees on reimbursement and referral/follow-up models, MDH information on overall strategies and measures and review of a draft “healthy lifestyle” measurement tool.