Minnesota Department of Health – Health Care Homes is proud to host Learning Days 2019

LEARNING DAYS 2019

April 9-10, 2019

University of Minnesota Continuing Education and Conference Center
1890 Buford Avenue | St. Paul, MN 55108

MINNESOTA

WELCOME

Welcome to Learning Days! We are so pleased to have you with us for this annual event where health care homes, and behavioral health providers, public health and community partners come together to share best practice, learn from each other, and form collaborative relationships. Redefining Health | Redesigning Care reflects our continuing commitment to work together across the care continuum to improve community health and health equity. Thank you for being with us. Have a great Learning Days!

CONFERENCE HIGHLIGHTS

Hippocrates Café: Minnesota Public Radio's medical commentator, Dr. Jon Hallberg, will kick off the opening session on April 10 with a live show using professional actors and musicians to explore our conference theme of Redefining Health | Redesigning Care through story and song.

Health Care Homes Innovation Awards And Keynote: Honor recipients for the Health Care Home Innovation Awards at an after lunch dessert celebration on April 10. Draw inspiration for your journey from their stories and enjoy a keynote address on "Transformational Partnerships: The True Path to Improved Community Health" by Dr. Joneigh Khaldun, Director and Health Officer for the City of Detroit Health Department.

Wall of Fame: Back and better than ever, visit the Wall of Fame to learn about the outstanding work being done by your health care home peers and connect with people who can help you on your transformation journey.

Health Care Homes Roundtable: Stop by before the general session or during lunch for an informal conversation with the Health Care Homes Practice Improvement Specialists (formerly known as Nurse Planners). Bring your questions, share and learn from each another. Come and go as you please!

REGISTER

Register on the Minnesota Department of Health Learning Center and receive conference updates through the Health Care Homes LEARN e-news bulletin. Visit the Health Care Homes website for registration information.

LEARNING OBJECTIVES

Learning Days attendees will enhance knowledge and skills to:

1. Rethink assumptions about creating health and health equity for all Minnesotans
2. Redesign care delivery to enhance community health and restore joy in practice
3. Retool for the transition to value-based payment

EVALUATION

A survey will be sent to all registered participants after the conference. Please take 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 and accrued to your MDH Learning Center transcript. Please submit the certificate to your licensing board to obtain CEU credits. CME is not available for this event.

PRESENTATIONS AVAILABLE ONLINE

Conference presentations and handouts may be found online as available on the MDH Learning Center.

THANK YOU LEARNING DAYS PLANNING TEAM

Georgia Anderson, Minnesota Department of Health, Health Care Homes

Carol Bauer, Minnesota Department of Health, Health Care Homes

Wendy Berghorst, Minnesota Department of Health, Children and Youth with Special Health Needs

Sophie Burnevik, Minnesota Department of Human Services, Community Supports Administration, Community & Care Integration Reform Division

Alex Dahlquist, Minnesota Department of Health, Office of Statewide Health Improvement Initiatives

Chris Dobbe, Minnesota Department of Health, Health Care Homes

Dorothy Hull, Minnesota Department of Health, Health Care Homes

David Kurtzon, Minnesota Department of Health, Health Care Homes

Bonnie LaPlante, Minnesota Department of Health, Health Care Homes

Amy Michael, Minnesota Department of Health, Office of Statewide Health Improvement Initiatives

Tina Peters, Minnesota Department of Health, Health Care Homes

Rosemarie Rodriguez-Hager, Minnesota Department of Health, Health Care Homes

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

Cherylee Sherry, Minnesota Department of Health, Office of Statewide Health Improvement Initiatives

LEARNING AND TECHNICAL ASSISTANCE WORK GROUP

Carol Bauer, Minnesota Department of Health, Health Care Homes

Peter Carlson, North Memorial Medical Center

Alex Dahlquist, Minnesota Department of Health, Office of Statewide Health Improvement Initiatives

Sarah Horst, Institute for Clinical Systems Improvement

David Kurtzon, Minnesota Department of Health, Health Care Homes

Bonnie LaPlante, Minnesota Department of Health, Health Care Homes

Deb McKinley, Stratis Health

Rosemarie Rodriguez-Hager, Minnesota Department of Health, Health Care Homes

SCHEDULE-AT-A-GLANCE

TUESDAY, APRIL 9	
TIME/LOCATION	**SESSION**
Noon - 1:00 pm Upper Lobby	REGISTRATION
1:00 – 4:30 pm	**PRE-CONFERENCE WORKSHOPS W1 – W5**
42	W1 - By Invitation Behavioral Health Home Services Providers: Learning Workshop
83	W2 - Open to All Health Care Homes: Risk Stratification - A Calculated Approach to Care
155	W3 - Open to All Children and Youth with Special Health Needs: Care Coordination Quality Improvement Projects
156	W4 - Open to All Office of Statewide Health Improvement Initiatives: Patient Self Management Tools to Improve Heart Disease and Diabetes
166	W5 - By Invitation Health Care Homes Learning Communities: Strengthening Partnerships and Planning for Sustainability
2:30 – 3:00 pm	**BREAK**

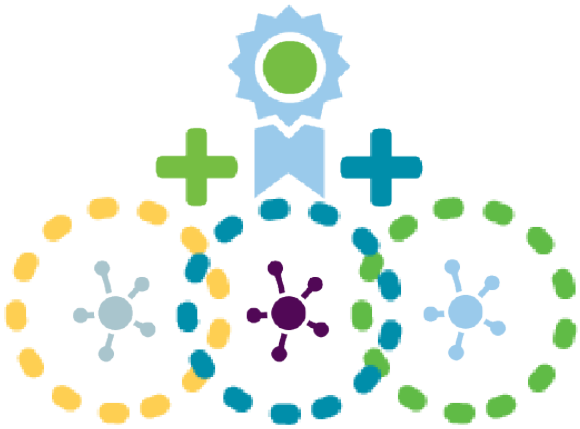
SCHEDULE-AT-A-GLANCE

WEDNESDAY, APRIL 10	
TIME/LOCATION	**WORKSHOPS**
7:30 a.m. – Noon Upper Lobby	REGISTRATION
7:30 – 8:00 am 77	Health Care Homes Roundtable – Drop In
8:00 – 9:30 am 135	**OPENING GENERAL SESSION AND HIPPOCRATES CAFÉ**
9:30 - 9:45 am Upper Lobby	**BREAK AND EXHIBITS**
9:45 – 10:45 am	**BREAKOUTS A1 – A5**
42	A1 - Building Value in Well Visits for Adolescents and Young Adults
52	A2 - A Long and Winding Road to Value Based Care
83	A3 - Innovations to Improve Access in Primary Care
155	A4 - A Closer Look at Health Disparities in Clinical Care: Social Determinants
156	A5 - Moving Beyond Grants to Sustainable CHW Models
11:00 am - Noon	**BREAKOUTS B1 – B5**
42	B1 - Whole Person Care and Joy in Practice: Approaches from a Small Independent Provider
52	B2 - Minnesota e-health Updates: Exchanging and Transforming Information for Better Health
83	B3 - Implementing Team Based Care in a Rural Primary Care Setting
155	B4 - Health Equity for Persons with Mental Illness through Tobacco Cessation
156	B5 - Redesigning Patient Navigation with IMGs Providing Colorectal Cancer Screening Options

Noon – 1:00 pm Upper Lobby	**LUNCH AND EXHIBITS**
Noon – 1:00 pm 77	Health Care Homes Roundtable – Drop In
1:00 – 2:30 pm 135	General Session: Health Care Homes Innovation Awards and Keynote Speaker
2:30 – 3:00 pm Upper Lobby	Break and Exhibits
3:00 – 4:00 pm	**BREAKOUTS C1 – C5**
42	C1 - Minnesota Health Collaborative - Tackling Mental Health
52	C2 - Piecing the QPP Categories Together to Complete the MIPS Puzzle
83	C3 - Building a Quality Improvement Culture
155	C4 - Seven Years of the Ely Community Care Team - Strategies, Results and Lessons Learned
156	C5 - Benefits of the Comprehensive Care Plan: Patient Family Perspective

PHOTOGRAPHS

Photographs will be taken throughout the conference. If you do not want your photo used, please sign a Photo Opt-out form, available at the conference registration desk.



TUESDAY, APRIL 9

Preconference Workshops
1:00 – 4:30 pm

W1 Behavioral Health Home Services Providers: Learning Workshop - By Invitation

Presenters

Chris Abelt
BHH Services Systems Navigator,
Northern Pines Mental Health Center
Brainerd, MN

Sarah Ackerman
Executive Director
Western Mental Health Center
Marshall, MN

***Kristen A. Dillon**, Ph.D.*
Research Scientist
Wilder Research
St. Paul, MN

Judy Karels
BHH Services Care Coordinator
Fairview Health Services
Minneapolis, MN

Leah Rosen
BHH Services Care Coordinator
Fairview Health Services
Minneapolis, MN

Kristina Swanberg
BHH Services Systems Navigator
Vail Place
Minneapolis, MN

Shawna Wange
Care Coordination Support Staff Specialist
Northern Pines Mental Health Center
Brainerd, MN

Description

This workshop will focus on the Behavioral Health Home (BHH) services interim evaluation findings. Wilder Research will present an overview of the findings and several BHH services providers will describe how they developed their process for tracking referrals, how they addressed challenges, and include examples of how their referral tracking process impacts BHH services delivery. The workshop will provide ample time for interactions between participants to learn, connect and network with each other.

Learning Objectives

By the end of this session, participants will be able to:

1. Summarize interim findings of the BHH services evaluation
2. Share experiences, challenges, and solutions in the provision of BHH services, with specific attention to making and tracking referrals
3. Develop/enhance relationships with fellow BHH services providers

W2 Health Care Homes: Risk Stratification - A Calculated Approach to Care - Open to All

Presenters

***Jill R. Swenson**, BAN, RN, CCM*
Lead Nurse, Ambulatory Care Management,
Sanford Health Enterprise
Fargo, ND

***Melissa Hurt**, BSN, RN*
Nurse Manager, Ambulatory Care Management
Sanford Health Enterprise
Fargo, ND

Panelists

***Savannah Aultman**, BSN, RN*
Health Care Home Coordinator
Alomere Health, Alexandria Clinic
Alexandria, MN

***Dr. Deborah Dittberner**, MD, MBA*
Chief Medical Officer
Alomere Health, Alexandria Clinic
Alexandria, MN

***Ashley Nelson**, MSN, RN*
Quality Manager
Alomere Health, Alexandria Clinic
Alexandria, MN

Facilitators

Kathleen Conboy, RN BSN, PHN
Practice Improvement Specialist
MDH Health Care Homes
St. Paul, MN

Danette Holznagel, RN, BAN, CDE, PHN, FCN
Practice Improvement Specialist
MDH Health Care Homes
St. Paul, MN

Joan Kindt, RN
Practice Improvement Specialist
MDH Health Care Homes
St. Paul, MN

Description

Risk stratification enables care teams to identify the right level of care for a distinct group of patients. Increasingly recognized as a necessity, risk stratification directs high quality care delivered at the lowest possible cost. Join this interactive workshop for a practical look at risk stratification and how to implement a calculated approach to care delivery whether you are a large system or a small independent practice. Guided peer discussion groups will enable you to network and share risk stratification approaches for targeted patient engagement efforts. Applicable for ALL care team members. Best practice risk stratification tools and resources provided.

*Participants are encouraged to bring examples to share with their peers.

Learning Objectives

By the end of this session, participants will be able to:

1. Describe how other clinics are implementing risk stratification models
2. Explore benefits and considerations when implementing risk stratification
3. Collaboratively develop a proposal to pilot in a clinic or department

W3 Children and Youth with Special Health Needs: Care Coordination Quality Improvement Projects – Open to All

Presenters

Jayson Geditz
"Coordinated Care for At Risk Kids and Their Families"
Grants Coordinator, Lakewood Health System
Staples, MN

Rhonda Buckallew
"Improved Care Coordination for Pediatric Patients with Asthma and ADHD"
Administrator, CHI St. Gabriel's Health
Little Falls, MN

***Chris Singer**, MAN, RN, CQHQ*
"Implementing NowPow to address Social Determinants of Health"
Chief Operating Officer,
West Side Community Health Services
St. Paul, MN

***Dr. Shar Valentine or Tamara Carlson**, RN*
"Advancing the Transition from Pediatric to Adult Care at Essentia Health"
Essentia Health Pediatrics
Duluth, MN

***Kristin Moquist**, APRN, CNP*
"Transition of Pediatric Patients with Sickle Cell to Adult Care"
Children's of MN Pediatrics
Minneapolis, MN

Description

Learn how five clinics have redesigned care to improve coordination of care for children with special health needs and their families. Five clinics received grants to develop and implement strategies to enhance capacity for improving care for children and youth with special health care needs. Clinics used Quality Improvement teams and PDSA cycles to do their work. They will share project goals and strategies, barriers encountered, tools developed, recommendations and future work ideas.

Learning Objectives

By the end of this session, participants will be able to:

1. Identify Quality Improvement activities that support children with special health care needs by improving coordination of care
2. Review tools and strategies to consider implementing in their own setting
3. Network and share learnings with others in MN

W4 Office of Statewide Health Improvement Initiatives: Patient Self-Management Tools to Improve Heart Disease and Diabetes - Open to All

Presenters

Sarah Sanchez
Community Impact Director
American Heart Association
Eagan, MN

***Sueling Schardin**, MPH, RD*
Community Impact Director
American Heart Association
Eagan, MN

Description

In this session, the American Heart Association (AHA), in partnership with the Minnesota Department of Health (MDH), will share information about new programs and initiatives to facilitate screening, identification and management of patients with cardio-metabolic conditions. In addition, the presenters will highlight the connection between diabetes and cardiovascular disease and offer resources for clinicians and patients. Lastly, attendees will learn how clinics and MDH can partner to enhance care coordination to prevent and manage cardiovascular disease and diabetes in high-burden populations.

Learning Objectives

By the end of this session, participants will be able to:

1. Identify AHA programs for hypertension and high cholesterol self-management and control
2. Describe a comprehensive initiative to reduce cardiovascular events among people living with type 2 diabetes
3. Work with MDH to enhance care coordination in their clinics

W5 Health Care Homes Learning Communities: Strengthening Partnerships and Planning for Sustainability – By Invitation

Presenters

***Brad Krueger**, MPH*
Research Scientist
ACET, Inc.

Description

This workshop will consist of several presentations and include opportunities to work with presenters on specific topics, including developing long lasting partnerships, establishing mutual expectations, and taking steps towards sustaining program activities. The presenters will offer insight into developing strong partnerships and strategies for sustainability. The workshop is limited to HCH Learning Community participants and will include handouts and work-time to keep audiences engaged.

Learning Objectives

By the end of this session, participants will be able to:

1. Describe steps to develop strong cross-sector partnerships
2. Share ways to plan for sustainable programs
3. Strengthen partnerships through big picture thinking and planning

WEDNESDAY, APRIL 10

Health Care Homes Roundtable

7:00 - 8:00 am

After you register, grab a cup of coffee and join the HCH Practice Improvement Specialists for an informal drop in conversation. Repeats at noon and during afternoon break.

Opening Session

8:00 – 9:30 am

Welcome: Bonnie LaPlante, Director, Health Care Homes Program, Minnesota Department of Health, St. Paul, MN. Rachel Cahoon, Research Scientist, Health Economics Program, Minnesota Department of Health, will present new research demonstrating the value of health care homes.

Hippocrates Café: Jon Hallberg, MD, Medical Director, University of Minnesota Mill City Clinic, Minneapolis, MN, and Minnesota Public Radio medical commentator, will lead a live show with professional actors and musicians to explore our theme of Redefining Health | Redesigning Care.

Breakout Sessions A1 - A5

9:45 – 10:45

A1 Building Value in Well Visits for Adolescents and Young Adults

Presenters

***Katy Schalla-Lesiak**, MSN/MPH, APRN-CPNP, PMHS*
Child Health Consultant – Child and Teen Checkups
Minnesota Department of Health
St. Paul, MN

***Shannon Neale**, MD (Family Medicine)*
Chair Family Medicine Department
Park Nicollet – Creekside
Minneapolis, MN

Description

As providers, we understand the importance of preventive health visits. But adolescents and young adults don't always see the value of going to the doctor unless they're sick. Sometimes "checking all the boxes" actually takes away from meaningful clinic visits. Partners in Minnesota - clinicians, public health, Medicaid, and youth - worked together to learn how to add value to the youth well visit without burdening clinic staff and providers. This session will explore strategies and tools for improving youth patient visits and preparing them for successful transition to adult care.

Learning Objectives

By the end of this session, participants will be able to:

1. Describe strategies for engaging youth in improving clinic visit quality and experience
2. Identify practical clinical tools to support 1:1 time with the adolescent patient, improve youth patient experience, meet preventive health quality measures, and support transition to health-savvy young adulthood.

A2 A Long and Winding Road to Value-Based Care

Presenters

Sarah Keenan, *RN*
Chief Clinical Officer and President of Integrated Care
Bluestone Physician Services
Stillwater, MN

Nate Hunkins, *MPH*
Director of Population Health
Bluestone Physician Services
Stillwater, MN

Description

Bluestone is a mid-size primary care provider that specializes in geriatric care and operates in Minnesota, Wisconsin and Florida. This presentation will describe Bluestone's path toward value-based care and cover some of the key takeaways from working with different payers, evaluating upside vs. downside risk, and participating in the Medicare Shared Shavings Program. Presenters will include insightful information about lessons learned on the path to value-based care with regard to staffing, building partnerships, and data management. There will ample time for audience members to share takeaways from their transition to value-based care.

Learning Objectives

By the end of this session, participants will be able to:

1. Describe Bluestone's path to value-based care and apply it to their own experiences
2. Differentiate and prioritize between different alternative payment arrangements within the same practice
3. Give examples of operational strategies which support the transition to value-based payment

A3 Innovations to Improve Access in Primary Care

Presenters

Jill Swenson*, BAN, RN, CCM*
Lead Ambulatory RN Care Management
Sanford Health
Fargo, ND

Melissa Hurt, *BSN, RN*
Manager, Nursing Ambulatory
Sanford Health
Fargo, ND

Hilary Odegaard, *BSN, RN*
RN Care Manager
Sanford Health
Fargo, ND

Robin Mikkelsen, *BAN, RN*
RN Care Manager
Sanford Health
Fargo, ND

Description

This group presentation by Sanford Health representatives will discuss innovations undertaken in 2018 to increase access in their primary care clinics. Learn how Sanford implemented Tyto Care, video visits, telemedicine, shared medical appointments and group visits to provide patients with improved access to patient-centered care. Explore options for improving access to care through a scenario involving a diabetic patient. Session will include handouts describing Sanford Health visit types and a Tyto Care Kit demonstration.

Learning Objectives

By the end of this session, participants will be able to:

1. Explain different visit types used by the clinical care team to manage patients that are healthy or have chronic diseases within the primary care setting
2. Describe Sanford's experiences with alternative visit types in the primary care setting, integrating and collaborating with the clinical care team, and lessons learned

A4 A Closer Look at Health Disparities in Clinical Care: Social Determinants

Presenters

***Kathie Culhane-Pera**, MD, MA*
Medical Director of Quality
West Side Community Health Services
St. Paul, MN

Description

Many patients struggle with a combination of issues including physical and mental health needs, limited English skills, acculturation, and basic needs such as food, housing and transportation. In this session, West Side will discuss their organization-wide approach to collect social determinants of health data, identify disparities in specific patient populations, and target services to address disparities. They will include results from quality improvement efforts related to aligning clinical care with identified disparities, improving clinical and operational outcomes, and developing their workforce. They will also highlight accomplishments of their Equity and Inclusion Committee, including the Equity and Inclusion dashboard.

Learning Objectives

By the end of this session, participants will be able to:

1. Discuss the importance of identifying social determinants of health in clinic populations, as social factors lead to health care disparities and impact access to care
2. Describe strategies to collect patients' social determinants of health data
3. Identify potential action steps to address gaps, improve health care delivery and reduce health disparities

A5 Moving Beyond Grants to Sustainable CHW Models

Presenters

***Megan Nieto**, BS, CHW certificate holder*
Co-Owner and Principal
CHW Solutions
St. Paul, MN

LaTrese Vanburen
Community Health Worker
CHW Solutions
St. Paul, MN

***Megan Ellingson**, BA, MHA, CHW certificate holder*
Co-Owner and Principal/Consulting Services
CHW Solutions
St. Paul, MN

***David Rak**, BA, MPH*
Co-Owner and Principal/Evaluation Services
CHW Solutions
St. Paul, MN

Description

Is it possible to continue Community Health Worker (CHW) services after grants run out? Yes! Experienced CHW's will share insights and secrets to show you how. Learn how to identify the "silent patients" in your area by teaming community outreach with standing orders. Acquire time-tested tools for managing CHWs. Discover how to bill insurance companies with detailed instructions and pitfalls to avoid. Follow up with a program evaluation, and you'll be on your way to providing CHW services in a sustainable way!

Learning Objectives

By the end of this session, participants will be able to:

1. Plan community events to reach unidentified populations
2. Successfully bill (and receive reimbursement from) insurance companies
3. Design evaluation that is easy and fun
4. Laugh along with CHWs as they share their experiences

Breakout Sessions B1-B5

11:00 am – Noon

B1 Whole Person Care and Joy in Practice: Approaches from a Small Independent Provider

Presenters

Christopher Wenner, MD *(Family Medicine)*
Physician and Care Coordinator,
Christopher J. Wenner MD, PA
Cold Spring, MN

Danette Holznagel*, RN*
Practice Improvement Specialist,
MDH Health Care Homes
St. Paul, MN

Suzanne S. Kelly*, APRN, CNP*
Nurse Coordinator, Christopher J. Wenner MD, PA
Cold Spring, MN

Description

Dr. Christopher Wenner and his colleague, Suzanne Kelly, APRN, CNP will share how their small independent practice in Central Minnesota focuses on unfettered access, strong provider-patient relationships, and patient engagement as cornerstones for family medicine while restoring joy in practice. Danette Holznagel, Practice Improvement Specialist, Health Care Homes, will moderate a discussion with the speakers and invite audience members to join in the conversation.

Learning Objectives

By the end of this session, participants will be able to:

1. Describe approaches to whole person care through the patient-provider relationship
2. Explain the mutual benefits of whole person care and joy in practice
3. Demonstrate how patient and family centered care and provider accessibility foster patient engagement

B2 Minnesota e-health Updates: Exchanging and Transforming Information for Better Health

Presenters

Anne Schloegel*, MPH*
e-Health Program Lead, Minnesota Department of Health, Office of Health Information Technology
St. Paul, MN

Karen Soderberg*, MS*
Research Scientist, Minnesota Department of Health, Office of Health Information Technology
St. Paul, MN

Melinda Hanson*, MPH*
Health Information Exchange Program Director, Minnesota Department of Health, Office of Health Information Technology
St. Paul, MN

Description

Clinics participating in health care homes and/or accountable care arrangements have a growing need for better patient information. E-Health, including health information exchange (HIE), are key tools for using and moving health information across the continuum in a timely and efficient way. This session will provide updates on Minnesota's e-Health activities and latest developments from the e-Prescribing Workgroup, Minnesota e-Health HIE Task Force, and current grant programs. Hear about the latest technical and policy advances, and how your organization can use e-health to support patient care, improve care coordination and increase patient engagement.

Learning Objectives

By the end of this session, participants will be able to:

1. Describe Minnesota's current e-Health activities, national trends, and federal initiatives
2. Explain how e-prescribing standards can support medication and prescription abuse management and improved workflows
3. Summarize the Minnesota e-Health HIE Task Force work and recommendations
4. Apply lessons learned into your organization

B3 Implementing Team-Based Care in a Rural Primary Care Setting

Presenters

***Savannah Aultman**, BSN, RN*
Health Care Home Coordinator,
Alomere Health/Alexandria Clinic
Alexandria, MN

***Deborah Dittberner**, MD*
Alomere Health/Alexandria Clinic
Alexandria, MN

Description

Representatives from Alexandria Clinic's certified health care home team will lead an interactive presentation describing their transformation from a traditional nurse/provider team to a comprehensive, interdisciplinary team across their primary care setting. RN clinicians will discuss their dynamic "three-part" role and how it empowers them to work to the top of their license. A care-coordinated patient will share via video how shared decision-making and team collaboration has vastly improved her ability to self-manage multiple chronic illnesses and maintain independence.

Learning Objectives

By the end of this session, participants will be able to:

1. Summarize the variety of members of the interdisciplinary team in a primary care setting
2. Explain how team based care can improve the care that medically complex patients receive and how this impacts overall health and well-being
3. Describe clinical examples of implementation of team-based care in a variety of settings within primary care

B4 Health Equity for Persons with Mental Illness Through Tobacco Cessation

Presenters

***Julie Plante**, RN*
Nurse Manager – Integrated Care
Vail Place
Minneapolis, MN

Description

We know smoking kills. We know that adults who live with mental illness have a higher rate of smoking than the general population. Yet we falter when confronting this devastating addiction in our clients and patients. As social workers and health care providers, our goal is to inspire healthy changes in individuals and communities. In this workshop, we will introduce tools to tackle this challenge with conviction and confidence so we can help people find their way to freedom from addiction. If not now, then when?

Learning Objectives

By the end of this session, participants will be able to:

1. Explain how helping people with mental illness to stop smoking fosters social justice and improves health equity
2. Identify barriers to smoking cessation among people with mental illness
3. Share tools to help individuals quit tobacco use for the long haul
4. Describe Vail Place's agency-wide initiative around tobacco cessation and results of their Behavioral Health Home program, Vail Care

B5 Redesigning Patient Navigation to Improve Colorectal Cancer Screening and Reduce Disparities

Presenters

***Bashir Moallin**, MD*
Sage Consultant, Minnesota Department of Health-Sage Program
St. Paul, MN

***Abdifatah Haji**, MD, MPH*
Sage Consultant, Minnesota Department of Health-Sage Program
St. Paul, MN

Description

While Minnesota's statewide average for colon cancer screening is 73 percent, Minnesota has one of the worst colon cancer screening disparities, with more than a 50-point difference in screening rates depending on country of origin. Our lowest screening rate occurs in the Somali community with 28 percent. To tackle this inequity, the Sage Program collaborated with foreign-trained immigrant physicians, known as International Medical Graduates (IMGs), and local Federally Qualified Health Centers (FQHCs) to redefine patient navigation. Through presentation, case studies and panel discussion, presenters will share lessons learned and outcomes of our Sage-IMG-FQHC efforts to redesign colorectal cancer navigation.

Learning Objectives

By the end of this session, participants will be able to:

1. Identify disparities in colorectal cancer screening in Minnesota, especially in East and West African immigrant communities
2. Describe challenges and opportunities to close the colorectal screening gap in Minnesota
3. Explain different approaches to patient navigation and obstacles to avoid when working with East and West African immigrant communities

LUNCH AND EXHIBITS
NOON – 1:00 PM

HEALTH CARE HOMES INNOVATION AWARDS AND KEYNOTE SPEAKER

1:30 – 2:30 PM

Honor recipients for the Health Care Home Innovation Awards at an after-lunch dessert celebration emceed by Veronica Svetaz, MD, Medical Director, Aqui para ti/Hennepin Health, followed by a keynote address on "Transformational Partnerships: The True Path to Improved Community Health" by Dr. Joneigh Khaldun, Director and Health Officer for the City of Detroit Health Department.

BREAK AND EXHIBITS

2:30 – 3:00 pm

BREAKOUT SESSIONS C1 – C5

3:00 – 4:00 pm

C1 Minnesota Health Collaborative – Tackling Mental Health

Presenters

***Jeyn Monkman**, MA, BSN, NE-BC*
Director, Institute for Clinical Systems Improvement
Bloomington, MN

Senka Hadzic, MPH
Clinical Systems Improvement Facilitator
Institute for Clinical Systems Improvement
Bloomington, MN

Description

The Minnesota Health Collaborative, comprised of 15 of our region's health systems and health plans, is working to improve systems for mental health in primary care. How are these organizations raising the bar for integrated behavioral health? What are common needs and themes across our community? Presenters from the Institute for Clinical Systems Improvement will share early Minnesota Health Collaborative recommendations, learnings and results.

Learning Objectives

By the end of this session, participants will be able to:

1. Identify a common framework being adopted across major Minnesota health systems to advance integrated behavioral health
2. Apply learnings and tools from early successes and challenges in Minnesota Health Collaborative efforts

C2 Piecing the Quality Payment Program Categories Together to Complete the MIPS Puzzle

Presenters

***Lisa Gall**, DNP, FNP, LHIT-HP*
Clinical Project Manager, Stratis Health
Bloomington, MN

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

Description

Ready for Year 3 of the Quality Payment Program (QPP)? Attend this session to prepare for 2019 changes in the four QPP categories. See what EHR and providers need to do to meet new Promoting Interoperability measures. Explore changes and new options in the Quality category and maximize your quality performance efforts. Discover what the Cost category will include and apply your best practices to complete improvement activities. Participants will share experiences in overcoming challenges, see how category scores count toward final performance scores, and acquire resources, including a link to the FREE Stratis Health MIPS Estimator.

Learning Objectives

By the end of this session, participants will be able to:

1. Address Quality Payment Program requirements for 2019 Performance year
2. Explain changes to Promoting Interoperability category
3. Use the Stratis Health MIPS Estimator to estimate current category performance, and plan and implement improvement strategies

C3 Building a Quality Improvement Culture

Presenters

Alyssa Palmer
Director of Quality,
Southside Community Health Services
Minneapolis, MN

Lori Wenborg
Clinic Manager,
Southside Community Health Services
Minneapolis, MN

Sandra Gonzalez
Care Coordinator,
Southside Community Health Services
Minneapolis, MN

***Pilar Sanchez**, RN*
Lead RN,
Southside Community Health Services
Minneapolis, MN

Description

Learn how a community health organization built an organizational culture based on psychological safety, engagement, and quality improvement. Hear stories about what worked, what didn't work and why. Engage in small group conversations with peers to learn about others' quality journeys. Acquire take home tools, including a quality work plan, internal clinical resource guide, new hire orientation platform, policy and procedure template, and ideas for how to have conversations with staff on what matters.

Learning Objectives

By the end of this session, participants will be able to:

1. Explain the importance of patient and staff engagement to build a culture focused on quality and psychological safety
2. Access tips and tools to build organizational support for a quality improvement culture
3. Describe how Southside developed a quality improvement culture though education and thoughtful conversations

C4 Seven Years of the Ely Community Care Team - Strategies, Results and Lessons Learned

Presenters

***Heidi Haney Favet**, BS, CHW*
Community Care Team Leader, Ely Behavioral Health Network Project Director
Essentia Health- Ely Clinic
Ely, MN

***Jenny Uhrich Swanson**, MPA*
Network Director, Ely Behavioral Health Network
Ely, MN

Description

The Community Care Team (CCT), serving Ely and surrounding communities since 2011, collaborated with health (including mental health) care, education, governmental and non-governmental social services and community members to insure that there is "no wrong door" for addressing community members' health and wellness needs. This session will describe CCT growth and development over seven years and offer insight to understand how to assess and fill gaps in care, partner and innovate with others in the community, and introduce evidence-based practices to ensure high quality care.

Learning Objectives

By the end of this session, participants will be able to:

1. Summarize strategies that helped CCT to grow and thrive for seven years
2. Describe how CCT identified and filled gaps in community services
3. Explain how CCT helped network partners leverage resources
4. Identify how a CCT can serve as the evidence-based component missing in many care coordination models

C5 Benefits of the Comprehensive Care Plan: Patient Family Perspective

Presenters

Melissa Winger
Consumer Representative
Health Care Homes Program
Minnesota Department of Health
St. Paul , MN

Description

Learn how a well-organized care plan can help patients and families navigate the health care system from the parent of a child with complex medical needs and developmental disabilities. The patient's mother will take the audience through a visual description of the clinical and community based services that her child receives, and share a care plan that includes patient centered goals, action plans, and integrated specialty care and community care plans. Along the way, she will offer practical tips on teaching the family to use the care plan.

Learning Objectives

By the end of this session, participants will be able to:

1. Explain the purpose of a care plan for complex patients
2. Create a purposeful care plan with actionable patient-centered goals
3. Educate patients and families on how to use a care plan

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