

# **Older Adults Community Consortium: Final Report of Findings and Recommendations**

Minnesota Department of Human Services  
Aging and Adult Services Division

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Minnesota Department of **Human Services**

## **Legislative Report**

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## **I. Executive Summary**

The Older Adult Services Community Consortiums (Consortium) grant program was conceived in the fall of 2007 and was developed through the 2008 Legislative Session to encourage projects that were large-scale, vertically and horizontally integrated and flexible to meet local conditions. The Minnesota Departments of Human Service (DHS), Health (MDH), Transportation (MnDOT), and the Housing Finance Agency (MHFA) were involved in the development of the proposal.

Two projects were selected for funding. They were the Carondelet Village Consortium (CVC) and the Northern Consortium (NC). The Carondelet Village Consortium is a partnership between the Sisters of St. Joseph Carondelet-St. Paul Province and Presbyterian Homes and Services. The Northern Consortium (NC), now consists of Northern Pines Medical Center – Aurora; Virginia Regional Medical Center hospitals and nursing facilities; and two additional nursing facilities – St. Raphael’s Health and Rehabilitation Center, Eveleth and St. Michael’s Health and Rehabilitation Center, Virginia. Both involved expansion of care coordination and better integration of Long Term Services and Supports (LTSS) which includes home and community-based and facility- based services for Older Minnesotans.

Environmental factors such as the broader efforts within health and long-term care system reform that occurred over the life of the projects directly affected them. The development of Accountable Care Organization and expansion of health care homes required the consortium projects to continuously readjust their initial plans and benchmarks. These factors made it difficult to build the stable and lasting internal and external relationships necessary to make large-scale collaborations like these work.

However, the Consortium project permitted CVC and NC to test practices and processes that align with other larger health care initiatives and to position them to take a leading role in these efforts. They were able to pursue better integrated, more comprehensive care coordination for a broader range of clients and more types of care transitions.

Several intermediate recommendations from this project have already been incorporated into current statute. These recommendations include extending the Consortium preference for MDH and MnDOT grants and the Commissioner of Health’s ability to waive rule and statute were added to the Community Service/Community Services Development (CS/SD) grant program. Additionally, fully funding CS/SD provides adequate resources to fund similar projects in the future while Minnesota grant making policy permits contracting for up to five years.

All of the projects and their component parts could be supported through CS/SD with these changes. The Community Consortium legislation has provided an important opportunity to test new models of service delivery in a rapidly changing health care and long term care environment.

## II. Legislation

This report is submitted to the legislature pursuant to Laws of Minnesota 2008, chapter 338, section 3, as amended by Laws of Minnesota 2012, chapter 216, article 9, section 34.

Laws of Minnesota 2008, chapter 338, section. 3, subdivision 1. **Establishment.** (a) The commissioner of human services, in cooperation with the commissioners of health and housing finance, shall develop and implement, beginning July 1, 2009, a three-year demonstration project for older adult services community consortiums. An older adult services community consortium may consist of health care and social service providers, county agencies, health plan companies, and other community stakeholders within a demonstration site that have established a process for joint decision making. Demonstration sites may include a portion of a county, an entire county, or multiple counties.

(b) Each community consortium seeking to participate as a demonstration site must submit an application to the commissioner. The application must include: (1) a description of the entities participating in the consortium, the scope of collaboration, and the process to be used for joint-decision making; (2) the methods by which the consortium plans to achieve the goals specified in subdivision 2; (3) a description of the proposed demonstration site; and (4) other information the commissioner determines to be necessary to evaluate proposals. (c) The commissioner of human services shall establish a process to review and consider applicants. The commissioner shall designate up to three community consortiums as demonstration projects. (d) Each community consortium selected to participate shall establish a local group to assist in planning, designing, implementing, and evaluating the coordinated service delivery system within the demonstration site. Planning for each consortium shall build upon current planning processes developed by county gaps analyses and Elder Care Development Partnerships under Minnesota Statutes, section 256B.0917.

Subd. 2. **Goals.** The community consortium demonstration projects are intended to accelerate the development of community based services to fill in gaps identified within communities by using a pool of funds and providing flexibility in the use and distribution of these funds within each demonstration site. These projects must be designed to: (1) ensure consumer access to a continuum of older adult services; (2) create an adequate supply of affordable home-based alternatives to care for persons currently using nursing facilities or likely to need nursing facility services in the future; (3) establish and achieve measurable performance targets for care delivered throughout the continuum of care; and (4) support the management of chronic and complex conditions through greater coordination of all services needed by older adults.

Subd. 3. **Priority for other grants.** The commissioner of health shall give priority to community consortiums selected under subdivision 1 when awarding technology-related grants, if the consortiums are using technology as a part of their proposal. To the extent that the commissioner

of the Minnesota Housing Finance Agency funds projects to create or preserve affordable housing options for older adults, the commissioner shall give priority to financially feasible projects proposed or supported by community consortiums selected under subdivision 1. The commissioner of transportation shall give priority to community consortiums selected under subdivision 1 when distributing transportation-related funds to create transportation options for older adults.

**Subd. 4. Federal approval.** The commissioner of human services may request any federal approvals or waivers necessary to implement the community consortiums under the medical assistance program and include medical assistance funding as specified in subdivision 7 in the community consortium account.

**Subd. 5. State waivers.** The commissioner of health may waive applicable state laws and rules on a time-limited basis if the commissioner of health determines that a participating consortium requires a waiver in order to achieve demonstration project goals.

**Subd. 6. Quality measures.** (a) Community consortiums participating in the demonstration project shall report information to the commissioner of human services necessary to evaluate the demonstration project, in the form and manner specified by the commissioner. The information collected by the commissioner must include both process and outcome measures, including, but not limited to, measures related to enrollee satisfaction, service delivery, service coordination, service access, use of technology, individual outcomes, and costs. (b) Participating consortiums shall identify state policies that limit the extent to which project goals can be achieved and recommend necessary changes to the appropriate state agencies.

**Subd. 7. Community consortium financing.** (a) The commissioner of health shall reserve ten percent of any funds appropriated for the biennium ending June 30, 2011, for the nursing home moratorium exception process under Minnesota Statutes, section 144A.073, for distribution to qualifying projects that are part of a community consortium. (b) Notwithstanding Minnesota Statutes, section 256B.434, subdivision 4, paragraph (d), the nursing facility performance incentive payments shall be reduced by ten percent for the biennium ending June 30, 2011. This shall be a onetime reduction. (c) Base level funding for community service grants under Minnesota Statutes, section 256B.0917, subdivision 13, and community services development grants under Minnesota Statutes, section 256.9754, shall be reduced by ten percent for the biennium ending June 30, 2011. These shall be onetime reductions. (d) An amount equal to the state share of the reductions in paragraphs (b) and (c) is appropriated from the general fund to the commissioner of human services for distribution to qualifying projects that are part of a community consortium under this section, to be available until expended.

**Subd. 8. Evaluation and report.** The commissioner of human services, in cooperation with the commissioners of health and housing finance, shall evaluate the demonstration project, and report preliminary findings and recommendations to the legislature by November 15, 2011, on

whether the demonstration project should be continued and whether the number of demonstration project sites increased. The final report of findings and recommendations shall be delivered to the legislature by January 15, 2015. The preliminary and final evaluation and report must include: (1) a comparison of the performance of demonstration sites relative to nonconsortium communities on the quality measures specified in subdivision 5; (2) an assessment of the extent to which the demonstration project can be successfully expanded to other parts of the state; (3) legislative changes necessary to improve the effectiveness of the demonstration project and to expand the projects to other parts of the state; and (4) any actions taken by the commissioner of health under subdivision 5. The commissioner of human services may withhold up to \$50,000 of the funding provided to each participating community consortium under this section to fund the evaluation and report.

### **III. Introduction**

The Consortium framework was conceived in the fall of 2007 and was developed through the 2008 Legislative Session. It was intended to encourage projects that were large-scale, vertically and horizontally integrated and flexible as needed to meet local conditions. The involvement of the Minnesota Departments of Human Service (DHS), Health (MDH), Transportation (MnDOT), and the Housing Finance Agency (MHFA) in the development of the proposal indicated the breadth of the conceptual basis of the proposal.

These departments administer a number of grant programs intended to meet the challenge of the coming “Age Wave:”

- Community Service and Community Services Development (CS/SD) grants fund a variety of systems change projects that involve health care, community-based service and other long-term care providers.
- Nursing Facility Performance Improvement (NF PIPP) grants provide incentives for nursing facilities (NF) to change how they provide services within the facility and in their communities.
- Nursing Facility Moratorium Exception grants permit necessary capital improvements.
- MHFA provides financing incentives for subsidized housing projects.
- MnDOT administers grants to address the transportation needs of Older Minnesotans.

There have been previous efforts to coordinate these programs, but they have been limited by a variety of statutory and administrative constraints.

## **IV. Background**

The Long-Term Care Imperative, a collaborative of LeadingAge Minnesota (formerly Aging Services of Minnesota) and Care Providers of Minnesota, proposed to the Governor and the Legislature that a portion of these State grant programs, programs with similar ends but differing application processes, project requirements and timelines, be coordinated to make application simpler and to achieve project synergies. This would further the over-arching goal of increasing the supply of home and community-based services for Older Minnesotans and changing the long-term care system to better meet the challenges of increasing demand and finite resources. DHS and the other departments provided technical assistance in drafting the bill and to the selected Consortiums to ensure the success of the projects.

The funding sources for the Consortium projects were authorized in the 2010/2011 Biennial budget. They were: 10% of NFPI grants, 10% of CS/SD grants, and 10% of Nursing Facility Moratorium Exception grants. All selected projects were also made eligible for a preference for MnDOT grants including Elderly Persons and Persons with Disabilities (5310), Job Access and Reverse Commute (JARC) and New Freedom, and for MDH Electronic Health grants.

The statute also gave the Commissioner of Health the authority to waive both rule and statute for consortium projects. The legislature made budget reductions during the 2009 session that reduced the amount of CS/SD grants and did not include funding for Moratorium Exceptions, but other than funding reductions, the intent of the 2008 Consortium legislation remained unchanged.

The Consortium grants were intended to change Minnesota's long-term care supports and service delivery system in a more comprehensive way, increase its capacity to help people age 65 and older stay in their own homes and communities longer and demonstrate the utility and replicability of each Consortium's approach. The grants were directed to programs that serve individuals 65 years of age or older who are at risk of nursing home placement and "spending down" for Medical Assistance.

Most older adults prefer to have the supports that they need to remain independent provided in their own homes. In most cases this is the best alternative in terms of cost, whether the supports are directly paid for by the consumer, their families, or by other third-party payers. The State supports market-based solutions that increase consumer choice, promote the most integrated alternatives, and minimize the impact of expensive service delivery options on publicly funded programs both in the short and long-term. System development must aim to maximize the use of safe and effective lower cost service options in consumers' own homes.

The State has a broad role in providing care and services to older Minnesotans through Medical Assistance (Medicaid) and its waivers, the Alternative Care (AC) program and Group Residential Housing (GRH) program. In addition, the DHS Aging and Adult Services Division

(AASD) works in partnership with the Minnesota Board on Aging (MBA) in administering programs funded by the Older Americans Act (OAA). The Consortium grant program explicitly added MDH and MnDOT grants that have been designated to serve older Minnesotans as additional potential resources.

Consortium projects were required to serve low and moderate-income persons by providing services through and paid by the Elderly Waiver, AC, other public programs as appropriate (for example, Older Americans Act, Community Services Block Grant, Food Support, etc.) and using other sliding fees scales for persons who are not quite eligible for those programs.

Each Consortium project was also required to support families and other informal caregivers, strengthen the long-term care system, better coordinate with the health care system, integrate consumer services and maximize the use of limited funding resources. This work requires collaboration among long-term care stakeholders, the health care system and communities and re-imagining both relationships and services.

Changing the long-term care system also involves identifying state and federal policies that may be barriers to the creation and support of this re-imagined home and community-based service system. The Consortium grant program directed that policy barriers and a mechanism to resolve them, if possible, be identified.

## **V. Findings**

### **a. Process Description**

DHS used the extended time between the formulation and legislation of the Consortium policy in 2007-2008 and selection of projects in 2009 to:

- Publicize the Consortium concepts to interested potential applicants and state policy staff not directly involved developing the statute;
- Solicit public comment on the development of the Request for Proposals (RFP) for projects that were broader in scope than previously attempted; and
- Provide sufficient time for the extensive preliminary work necessary to:
  - develop professional and financial relationships,
  - assemble the necessary expertise, and
  - develop and write a complex application.

DHS changed the typical RFP process at the recommendation of stakeholders to include an informational session about the legal requirements of RFPs, how those requirements shape the selection process and the specific requirements of the Consortium statute. It also provided external parties an opportunity to make suggestions about the content and timing of the RFP.

These suggestions led to a five month period between the publication of the RFP and the deadline for applications. It included a preliminary applicant conference that was held immediately after the initial publication of the RFP in November 2008 to provide an overview and explanation of this large, complex RFP. In March 2009 a second applicant conference provided additional clarification as groups prepared to complete applications. The RFP required applicants to articulate what the goals, activities, and location of the project were, and how the applicant proposed to meet the legislatively mandated evaluation requirements. The RFP also required evidence of joint governance and concrete financial commitments from all partners.

As the RFP was developed, it became clear the MFHA financing options were not suitable for inclusion.

The principal deliverable of each Consortium grant was a demonstration of the measurable impact of its activities in its chosen location compared to a similar location without Consortium-related activity. The measurement include persons served, individual outcomes, level of service access, service delivery including units of service, service coordination, customer satisfaction and measures related to the appropriate use of technology. Applicants could include additional measures as appropriate to the goals of its Consortium project.

Given the broad range of possible Consortium projects and locations, precise definition of the deliverables beyond these broad directives was the responsibility of the applicant. The aptness of the measures selected and their relation to the Consortium's activities, as well as the degree that these measures were quantifiable and comparable, was a central element of the Consortium RFP evaluation.

Each Responder was asked to:

1. Articulate the challenge or opportunity that the Consortium intended to address. This challenge needed to be tied to clearly identified, objective information. The challenge or opportunity needed to be directly related to the proposed measures used to demonstrate the impact of Consortium activities.
2. Describe the Consortium's activities. These activities needed to be relevant to the challenge or opportunity the Consortium intended to address and also generate data to help measure the impact of the activities of the Consortium. The activities also should generate process measures which are important elements for understanding both the Consortium's demonstration and how structural or corporate relationships and changes to those relationships affect the ability of the Consortium's model to be replicated. The activities themselves and process measures are used as deliverables.
3. Describe both the outcome and the process measures proposed to be used by the Consortium to measure the impact of its activities.

The responder was also required to demonstrate an understanding of how the activities could be measured and compared to a comparable non-consortium site, and how the Consortium functions and processes could be understood and reproduced. Applications were assessed based upon the Consortium's understanding of the measures it proposed and the relevance of those measures to its activities.

DHS contracted with an outside evaluator separately for an evaluation. The project evaluation was developed as part of a larger evaluation that included other reform initiatives from the 2009 Legislative session including: NF PIPP strategies and evaluation of the Return to Community initiative. This full evaluation is still in process due to subsequent legislative changes.

#### **b. RFP Evaluation**

Nine applications were received; two were non-responsive because they failed to meet the minimum requirements to be reviewed. No application adequately addressed the evaluation component of the RFP. The RFP could not be overly prescriptive so that the applicants had the ability to innovate. It was also a function of the challenge of designing both a project and its evaluation. The applicants also had difficulties clearly articulating the goals of projects which made it more difficult to outline methods of measuring their impact. This created added difficulties in designing an evaluation since the measures used were not intrinsic to each project.

The legislative evaluation requirements were met by using or modifying tools to capture information about participants and the goals of each project. The evaluation process evolved in negotiations and through implementation. Evaluators from the University of Minnesota and University of Indiana assisted in more clearly articulating the projects' activities and measuring the impacts of the activities on participants and comparing those to similar non-project areas as possible.

No application included a Nursing Facility Moratorium Exception request.

The review committee recommended the selection of two applications to enter negotiations. They were:

- The Carondelet Village Consortium (CVC), principally a partnership between the Sisters of St. Joseph Carondelet-St. Paul Province and Presbyterian Homes and Services, and
- The Northern Consortium (NC), which now consists of Northern Pines Medical Center – Aurora; Virginia Regional Medical Center hospitals and nursing facilities; and two additional nursing facilities – St. Raphael's Health and Rehabilitation Center, Eveleth and St. Michael's Health and Rehabilitation Center, Virginia.

The two Consortiums had previously existing business relationships among their members and had been engaged in substantive discussions that involved significant joint capital commitments or combined operations. The grant provided an opportunity to expand both the range and scope of their previous work. Both Consortium groups were actively pursuing systems change initiatives in their areas and were motivated by clear strategic visions that correlated with the goals of the grant.

Both projects took considerably longer than anticipated to begin. The CVC contract was not completed until December 2009, five months after initial negotiations began. The NC contract was not completed until May 2010 and involved changes both in the lead partner and service area. In both cases, the challenges lay in the actual implementation of a complex project that involved financial integration and administrative reorganization.

Both projects participated in business process mapping exercises with DHS staff to help clarify project goals, define work processes and firm up timelines. Even with pre-existing working relationships and lengthy contract negotiations, the Consortiums needed additional time during initial implementation to develop a solid plan. The strengths of each Consortium have been their ability to constructively adjust to the almost continuous changes to health care and long-term care that have been occurring as uncontrolled external variables over the term of the project.

**c. Projects**

**i. Carondelet Village Consortium**

Carondelet Village Consortium (CVC) is a collaborative that serves individuals 65 years and older in the Highland Park, Macalester/Groveland, West 7th, Summit Hill, Summit University and Union Park neighborhoods of St. Paul (and the corresponding zip code areas). It built and operates Carondelet Village in Highland Park. Carondelet Village includes a full continuum of care and services including market rate and subsidized senior housing, assisted living and memory care units, and a skilled nursing facility. It opened in November 2011. The construction process was simplified by the Commissioner of MDH waiving the mileage limit to move “lay away” beds to a different nursing facility. CVC supports seamless continuity of care through improved care coordination and promote meaningful engagement for older Twin Cities’ residents by fostering connections and building on community social capital. CVC entered into partnerships with Jewish Family Services, the Metropolitan Area Agency on Aging, Inc. and three Living at Home Network programs to offer expanded services to older adults in its target area.

The heart of the initiative is a holistic care management and coordination model that integrates long-term care and primary healthcare services in a better way improving outcomes associated

with standard case management. Key aspects of the model include: earlier connection with and assessment of elders in the community; elder engagement for active community involvement, preventative health activities, and well-informed self-care; early and ongoing support by a nurse practitioner, improved medication management; use of the latest technology to assist with transportation, referrals, and the management of care records; and stronger collaboration between social services and health staff.

CVC enrolled approximately 120 clients. Half of the participants were UCare and Medica Minnesota Senior Health Options (MSHO) enrollees who live in residences scattered across the Twin Cities Metro area. These clients are eligible for services under both Medicare and Medicaid (dual-eligible clients). The other clients were enrolled within the neighborhoods served by CVC (often self-referred). Presbyterian Homes has used the CVC model to develop Optage Home and Community Services (Optage).

Participants are evaluated using the Live Well at Home Rapid Screen© (Rapid Screen) tool and level of need is determined based upon ADL needs and chronic conditions, psychosocial needs and professional judgment. Higher need individuals (classified as Level II or Level III) receive more frequent routine contact. Those identified as at lower risk (Level I) are contacted at least once each quarter.

The Rapid Screen and other assessments are used to match clients with the appropriate intervention including: chronic disease self-management and evidence-based health promotion classes, a social engagement program based on participant's strengths, access to volunteers, care transitions management and transportation review. Each client reviews his or her assessment and plan as part of the interdisciplinary team within 30 days to validate the level of need and to ensure appropriate assessments and interventions are in place. Clients are routinely reassessed to evaluate the efficacy of their plans and physical changes. CVC also coordinates an enrichment calendar of classes, programs and activities offered by partnering organizations.

Optage is certified as a Minnesota Health Care Home and is currently an internal service to Presbyterian Homes. It provides integrated service delivery within the organization by serving clients directly in their homes and targeting seniors returning to Minnesota from other parts of the country who need to establish primary care relationships. It is a comprehensive primary care service, which operates on fifteen Presbyterian Homes' campuses. CVC's final consortium project report of June 30, 2012 indicated it was providing primary care services to 365 patients. The majority of these were covered by Medicare Prime (Medicare fee for service). The others were covered by UCare, Blue Cross Blue Shield, Humana, and United Health Care. The non-MSHO contracts were fee for service. Optage continues provide services and served 556 persons in November 2014.

**ii. Northern Consortium**

The Northern Consortium (NC) includes Northern Pines Medical Center, Aurora and Virginia Regional Medical Center, two medical centers (both part of the Essentia system) and their associated nursing facilities (NF) and two Benedictine Health System NFs—St. Raphael’s in Eveleth, MN, and St. Michael’s in Virginia, MN. One element of the project was to set up a new organizational structure to combine the ownership and administration of the nursing facilities administratively. A second was to provide care coordination services to appropriate clients when discharged from one of the consortium facilities or those identified through the two medical centers’ Health Care Homes (HCH). The Arrowhead Area Agency on Aging was an active participant providing technical assistance and training.

NC originally targeted clients who were patients at the clinics’ Health Care Home and lived within a 30 mile radius of Virginia, Aurora or Eveleth. The targeting criteria were: 65 years or older, and having one or more of the following conditions: depression, diabetes and hypertension. Targeted clients also have had an emergency room visit, hospitalization or nursing facility stay within the past three years. In 2011, the targeting criteria were broadened to include any client who would benefit from care coordination regardless of diagnosis. Despite this change, the consortium continued to face challenges in finding and enrolling clients who would benefit from care coordination. In 2013, NC incorporated behavioral health care coordination services into its program and began contracting with the Range Mental Health Center in Virginia to provide on-site behavioral health care coordination services.

Clients who met the target criteria were invited to receive care coordination services. The care coordination helps clients remain in their homes and decrease emergency visits, hospital admissions and transfers to skilled nursing facilities. The consortium’s care coordinators and HCH registered nurses worked in collaboration, doing a series of assessments beginning with the Live Well at Home Rapid Screen© tool, care planning and identifying services to assist clients remain at home. After the client’s needs were assessed, the NC interdisciplinary care coordination/health care home team created and implemented individual care plans that used other organizations to provide home and community-based services including: meals, chores, transportation, education, transitional support and companionship. It also coordinates behavioral health services as needed and provided on-going monitoring and intervention when necessary.

NC’s tracking and assessment systems, in addition to the Rapid Screen, include the Health Care Home Complexity Tier tool and the Community Planning tool. Other tools available on Web Referral may also be used including the Brief Interview of Mental Status, Activities of Daily Living/Instrumental Activities of Daily Living and the Geriatric Depression Scale. The Health Care Home and Consortium coordinators use Essentia’s Electronic Health Record (EHR), Epic, to track clients and exchange information. The NC partners used the secure Revation voice-over internet protocol tool for HIPAA-compliant conference calling, chat and document exchange.

Hiring and retaining a program manager/HCBS coordinator provided another significant challenge. Four persons served in this core program role over the course of the grant. This led to spending significant resources on recruiting and retraining, taking time for each new program manager time to make connections with internal and external providers and become aware of relevant area services. Lack of a program manager also left the primary grant direction to individuals in Essentia and BHS who had other significant responsibilities. The turnover was a manifestation of the challenges of hiring and retaining skilled workers in non-metropolitan areas.

Essentia fully implemented as usual practice those care coordination elements developed through the grant as part its becoming an Accountable Care Organizations/Health Care Home (ACO/HCH). Because of the payment mix for patients in the NC area, the majority of Essentia patients in need of those services received them through the ACO/HCH. Given Essentia's reimbursement mix, the number of individuals that need those services paid for through the grant has been small. In February 2014, there were approximately 30 clients enrolled in NC's care coordination services. At the end of September 2014, 16 clients were enrolled in the consortium's care coordination services.

Changing the ownership and management of the four NFs proved to be very difficult. The changes in the original partnership reduced the number of entities involved. However, the Virginia Regional Medical Center hospital and nursing facility were operated by the City of Virginia and changing their management structure required a change in the City of Virginia's charter. This significantly delayed the process. The delay required a statutory change and contract amendment to permit a two year extension of the project. BHS and Essentia continue to make progress toward a single ownership/management structure, but could not guarantee completion of the process before the end of the amended grant. This caused the early termination of the grant 12/31/14. Both parties agree that the progress that has been made to date is due in large part to the focus provided by the grant work.

The NC partners actively investigated re-purposing unexpended grant funds to further the use of health information exchange options, Epic (Essentia's Electronic Health Record system), and MDI Achieve and PointClickCare (EHRs used by NFs to improve care transition and information exchange between clinic, hospital, NF and home). While significant progress was made to expand upon a successful MN e-Health Connectivity Grant for a point to point connection between Alina Health Systems and BHS, the work was not begun because it could not be completed before the end of the grant.

#### **d. Conclusions**

The Consortium projects must be viewed against the backdrop of broader efforts at health and long-term care system reform that occurred over the life of the contracts. The development of

Accountable Care Organizations, the creation of ACOs, and expansion of HCHs required the consortium projects to readjust their initial plans and benchmarks. These changes created incentives for health care organizations to provide more care coordination and opportunities for horizontal and vertical integration of health care systems. In addition, the DHS had several parallel initiatives to move more long-term care services to the community, including the Return to Community Initiative. Health care organizations were facing intense competition and undergoing organizational restructuring.

These environmental factors made it difficult to build the stable and lasting internal and external relationships necessary to make large-scale collaborations like these work. It was also difficult to start a new program or set of services for older adults without being viewed as a competitor.

The Consortium grants have had a significant impact on the larger business and service practice of the various grant partners. Presbyterian Homes' initiation of Optage as a system-wide service based on the expansion of the CVC care coordination model to additional locations was not anticipated in its application or during the first year of the grant.

Essentia expanded the integration of its consortium practice with the Ely clinic. The number of persons served to date is relatively small but growing. Assessing the projects' performance using their own internal metrics indicates positive results. Those changes cannot be attributed solely to the impact of the grants. While there currently is insufficient information to compare their performance outcomes to non-consortium sites, the grant advanced the integration of care coordination and its expansion into health care delivery more completely than otherwise possible.

The Consortium project permitted CVC and NC to test practices and processes that align with other larger health care initiatives and to position them to take a leading role in these efforts. They were able to pursue better integrated, more comprehensive care coordination for a broader range of clients and more types of care transitions. Changes in Medicare reimbursement policy that create disincentives for avoidable hospital readmission have also led to the addition of new partners and to a larger pool of program participants.

The Commissioner of Health, using the authority provided in the Consortium statute, waived Minnesota Statutes chapter 144A.073, subd. 3c, in February 2010 permitting Presbyterian Homes and Services to move 45 lay-away beds from two other projects to Carondelet Village to build the NF portion of the project. Neither project has requested additional waivers.

The legislation directed that Consortium projects be given a preference for certain MnDOT and MDH grants. Coordinating the timing of and defining the preference for grants across Departments has been an on-going challenge because of the diffuse nature of the grant making process.

Both CVC and NC did work to expand the use of EHR and other electronic tools into home and community-based services. That work has provided valuable insights into the complex interactions between changes in health care service delivery, integration of Long Term Services and Supports which include HCBS and NF care, and changes in financial incentives and relationships. It has also led to potentially valuable opportunities to use the additional resources the statutory preference for MDH grants might provide.

Both projects collaborated willingly and constructively with DHS staff and their other partners. They have expanded the scope of their work to meet the significant changes in State and Federal health care policy over the grant period. Large scale, long term projects are intrinsically more difficult to implement, and projects of this magnitude require greater overall grants management and monitoring to ensure return on investment. They also require dedicated project managers for the grantees. Keeping an institutional focus on additional, exploratory, long-term systems change work is a particular challenge in a rapidly changing internal and external environment.

#### **IV. Recommendations**

In 2013 the Reform 2020 initiative provided the opportunity to act on the recommendations made the November 2011 Preliminary Findings and Recommendations Report to the Legislature.

Minnesota Statutes chapters 256.9754 and 256B.097 were amended to extend the Consortium preference for MDH and MnDOT grants and the Commissioner of Health's ability to waive rule and statute were added to the Community Service/Community Services Development (CS/SD) grant program. These additions will permit the most useful Consortium tools to be available going forward.

Fully funding CS/SD provides adequate resources to fund similar projects in the future and Minnesota grant making policy permits contracting for up to five years. All of the projects and their component parts could be supported through CS/SD with these changes.

The Community Consortium legislation has provided an important opportunity to test new models of service delivery in a rapidly changing health care and long term care environment.