From Big Vision To Better Health At Lower Cost:

A Process Evaluation Of Formation And System Change At Southern Prairie Community Care

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Table Of Contents

Context & Acknowledgements

This process evaluation was first conceived of and commissioned by a group of Minnesota foundations and state leaders in 2011 as a tool to both better understand the change process required of successful, systemic redesign efforts, and as a learning vehicle to support other state and local government leaders considering redesigns of their own.

At that time, a series of state and federal legislative victories created new incentives to redesign public services. At the federal level, the Affordable Care Act had just ushered in sweeping reforms to how healthcare is understood, paid for and measured. Minnesota's receipt of a Statewide Innovation Model (SIMs) grant in 2012 jump-started even greater innovations in how health care is managed and delivered across the state, including the Accountable Communities for Health (ACH) grant program that connects human services programs and community coalitions with clinical care systems. Minnesota's State-County Results, Accountability and Service Delivery Reform Act also ushered in the state's first statewide performance measures for human service programs, creating a statutory path to focus human service payment and oversight on outcomes rather than dictated process.

Through a $400,000 learning grant to Southern Prairie Community Care, plus process evaluation support, stakeholders set out to learn from and document the process of making bold new ideas part of operational practice. This evaluation represents one of the first times state and philanthropic leaders have had the opportunity to step back, review and learn from the implemented changes legislation instigated. It was developed with the input, guidance and perspectives of Southern Prairie Community Care and state and foundation leaders with an interest in public sector redesign and system-change work. Stakeholders providing input are:

- Mary Fischer, Executive Director of Southern Prairie Community Care
- Elizabeth Cinqueonce, Senior Vice President of Community Health Improvement, Southern Prairie Community Care
- Norris Anderson, Medical Director, Southern Prairie Community Care

- Allison Barmann, Vice President of Strategy & Learning, Bush Foundation
- Chuck Johnson, Deputy Commissioner for Policy & Operations, Minnesota Department of Human Services
- Sandy Vargas, President & CEO, The Minneapolis Foundation
- Luz Frias, Vice President of Community Impact, The Minneapolis Foundation
- Lori Berg, Health Program Officer, Minnesota Philanthropy Partners

Evaluation Focus & Research Methods

The process evaluation of Southern Prairie Community Care sought to achieve three goals:
1. Document the plans, processes and perceptions surrounding development and launch of a redesign project.
2. Understand the features, challenges and opportunities latent in executing a system redesign.
3. Chart the evolution in expectations of the redesign across constituencies and time to support planning for future redesign projects.

Research in pursuit of these goals focused on three key facets:
1. Scoping and Review Conversations With Southern Prairie Staff. Stephanie Devitt attended several meetings with Southern Prairie Community Care staff and partners (Wilder Foundation, others). The conversations provided context on the meeting structures, teams and processes that shaped Southern Prairie's formation, and helped inform the structural assessment and interview guide.

2. Structural Assessment. A document review of catalogued committees, their memberships and their charters over time provided a snapshot of Southern Prairie Community Care's collaborative design process, and the structural evolution of this new cross-sector service enhancing organization.

3. In-Depth Interviews. Stephanie Devitt and Katie Eukel completed 19 phone interviews between Apr. 4 and May 30, 2015. Interviews were guided by a 20-question conversation guide, with dialogue focused on the period of time and level of involvement of the respondent. For example, only county commissioners and service directors involved in the early formation of Southern Prairie Community Care were asked in-depth questions about the formation process.

Interviews Completed	
County Commissioners (Current + Past)	7
Healthcare (Vary Ownership: System, Physician & Gov.)	5
Behavioral & Chemical Health	4
Human Services & Public Health	3
SPCC Staff & Consultants	2
Total Interviews	19

Southern Prairie Community Care
## Introduction + Description

First conceived in 2006 and launched in early 2014, Southern Prairie Community Care (Southern Prairie) is on track to become the nation's first multi-county, cross-sector partnership that threads services and sectors in joint pursuit of better health for all. The county-governed entity relies on shared payment and shared data to facilitate its connectivity, but those changes are just the jump-start for bigger, systemic change that's possible when health care, public health, social services and other sectors work together in new ways.

A Description of Southern Prairie Community Care

Southern Prairie Community Care is on the cutting edge of integrating health care and human services for improved regional population health. But it treats no patients and employs only one doctor. Instead, Southern Prairie develops, manages and deploys information technology and facilitates cross-sector prevention, population health management and care coordination to 34 health care providers, behavioral health providers, human service agencies and nonprofits across 12 counties in Southwest Minnesota. From the outset, Southern Prairie Community Care has focused its work on managing the needs of Medicaid patients, and particularly those managing chronic health conditions such as diabetes or mental health issues, creating one consistent care coordination model for the region.

While the concepts of Southern Prairie Community Care have been discussed for almost nine years, design of the new organization's work first began in early 2013 and implementation of programmatic concepts began in Jan. 2014. Southern Prairie's Integrated Health Partnerships (IHP) payment agreement with the Minnesota Department of Human Services (DHS) began in March 2014, marking the organization's first joint payment agreement and attributed patient populations. A partnership with Blue Cross and Blue Shield of Minnesota began in the spring of 2014, and provided additional seed funding to support and bolster Southern Prairie Community Care's start-up and operations.

Southern Prairie Community Care Region
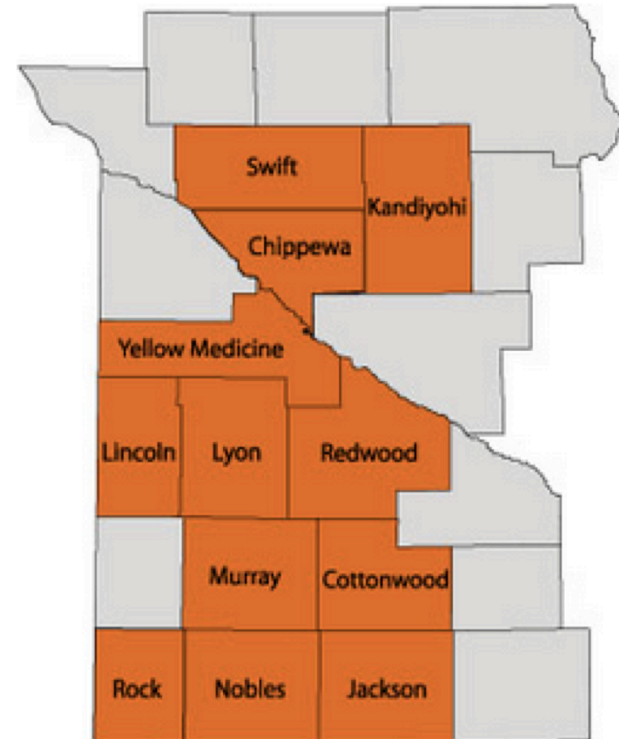
Community Care Teams

Collaboration will result in integration of community services to implement changes for patients' improved health and well-being.

Engagement

Community Support (Informal)

Core Team (Formal)

Advocate

Hospital

Patient

Clinic

Family/ Friends

Pharmacy

Mental Health

Faith Community

Human Services

Public Health

Support Groups

Home Care

Transportation

Engagement
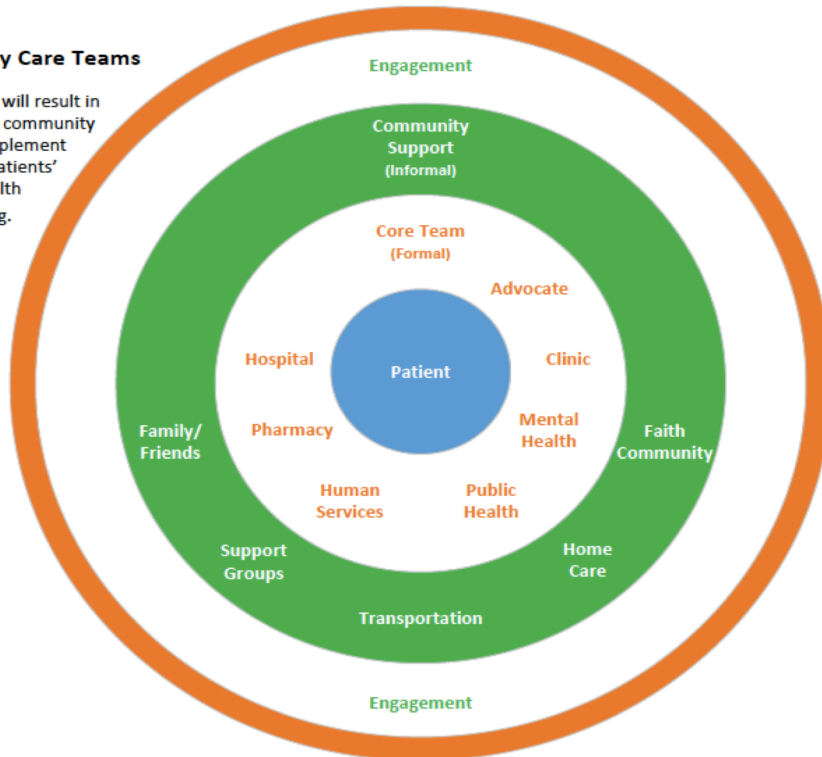
Southern Prairie Community Care leverages shared technology and shared Medicaid payment to facilitate cross-sector care coordination, as shown at left. While Southern Prairie does not provide any direct services, the organization is responsible for the health outcomes of 24,000 attributed Medicaid patients in Southwest Minnesota each year.

Better health outcomes are achieved by facilitating patient-centered care coordination across a variety of health care and human services providers – county government services, nonprofit services, clinical care and specialized hospital treatment – as well as engagement of supporting community services like transportation (e.g. rides to appointments), food assistance and others.

As a "virtual Accountable Care Organization (ACO)," Southern Prairie Community Care aims to facilitate coordination of care and health for all people of Southwest Minnesota – not just Medicaid recipients -- in the years to come. The unique organization has specific accountabilities for: shared data / information technology; shared global payment via Integrated Health Partnerships (IHP) payment arrangements with the Minnesota Department of Human Services; and shared county government oversight via a Joint Powers Board and agreement. A consistent care coordination model has been deployed across all sites, and demonstrated nearly $4 million in total healthcare cost savings in its first year.
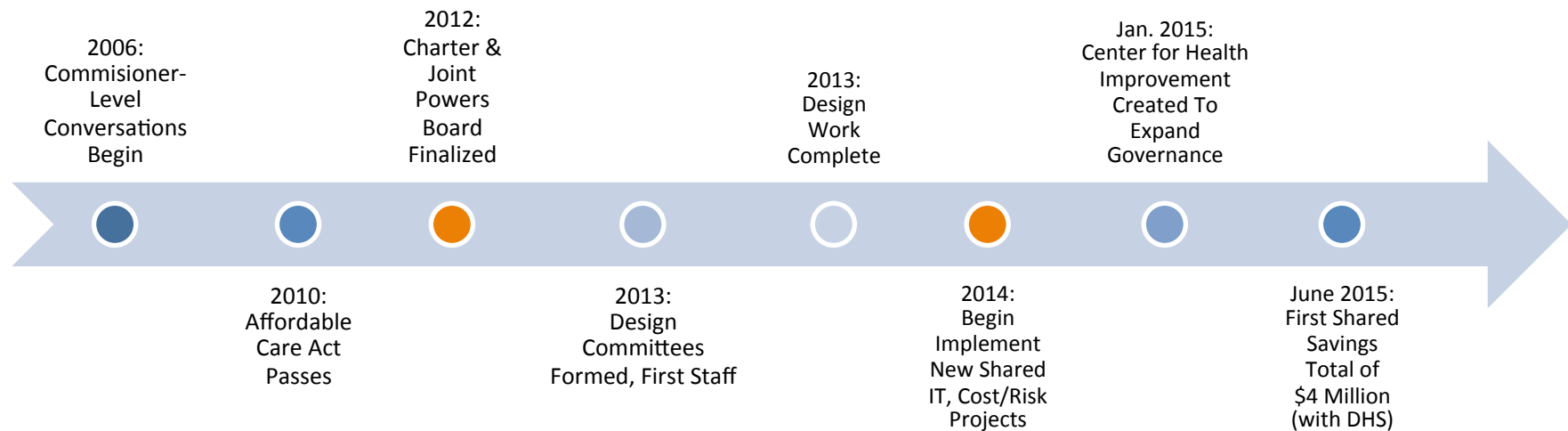
Structural Assessment

Southern Prairie Community Care had an attributed Medicaid patient population of 24,000 in 2014, its first year of operations. Between 2006 and this successful first year, several phases and iterations of design and negotiations to bridge commissioners' bold visions for reform and the day-to-day operations of health care and human services in Southwest Minnesota.

Phase 1: Vision-Setting. Leadership Coalesces Around A New Vision. In 2006, after witnessing the success of Prime West Healthcare (a consortium of counties in Western Minnesota collaborating on Medicaid coverage), county commissioners in Southwest Minnesota began exploring a similar model. The state of Minnesota placed a moratorium on county-based purchasing shortly thereafter, and the vision was set aside until Governor Dayton took office and showed an interest in pursuing new arrangements with counties. With state leaders open to new arrangements, county commissioners began meeting in earnest in 2010. A final framework for Southern Prairie Community Care was negotiated and approved by commissioners in 2012.

The organization operating today incorporates 34 healthcare, mental health, public health and human service providers, as well as the 12 county boards, working together on shared governance, shared payment and shared information technology with the aim of integrated care for the region's neediest patients.

Southern Prairie's Timeline Of Creation

2006: Commisioner-Level Conversations Begin

2010: Affordable Care Act Passes

2012: Charter & Joint Powers Board Finalized

2013: Design Committees Formed, First Staff

2013: Design Work Complete

2014: Begin Implement New Shared IT, Cost/Risk Projects

Jan. 2015: Center for Health Improvement Created To Expand Governance

June 2015: First Shared Savings Total of $4 Million (with DHS)

Phase 2: System Redesign. Designing Southern Prairie Community Care's New Model Engaged 55 Leaders Representing County Commissions Healthcare, Public Health and Human Services. From 2012 – 2013, a diverse cross-section of leaders from hospitals and clinics, public health, human services, behavioral health services and related community support services came together to design a new, shared and integrated care system for Medicaid patients. These teams negotiated Southern Prairie Community Care's redesign, including parameters of a shared information technology/case record system used across partners; a unified care model and process for building care teams across organizations and disciplines; and a shared cost savings distribution formula.

Joint Powers Board of Commissioners
Vision & Governance (2012)

Manager-Level Implementation
Design Committees (2013)

Committee 1: Services & Supports Design	Committee 2: Healthcare Home & Care Management	Committee 3: Quality Improvement & Customer Satisfaction	Committee 4: Technology, Information Exchange & Analytics

Phase 3: Redesign Roll-Out. Care Coordination Began Everywhere In 2014; Roll Out of The Health Information Exchange (HIE) Has Taken A Phased Approach. Southern Prairie Community Care launched its care coordination model across its 34 sites for 2014. Through the roll-out phase of work, Southern Prairie Community Care both road-tested the model created through its extensive design process (refining and improving as implementation got underway) and began expanding its network of relationships to include key staff and directors at the sites responsible for implementing the new care model.

The Health Information Exchange (HIE) will add analytics capabilities to Southern Prairie's proven care coordination model through shared information technology that will enable one consistent record per patient across providers. Southern Prairie is taking a phased approach to rolling out the HIE, allowing each new cohort to fully understand and integrate the technology in a thoughtful manner. As of fall 2015, Southern Prairie hired 10 project managers, each embedded at a different site, to support integration of the HIE into daily use across the network. The phased approach is enabling Southern Prairie to carefully manage implementation and the detailed standards that can accompany data roll-out, while ensuring that front-line staff incorporate new data systems into workflows across organizations.

Perspectives Engaged From Vision To Roll-Out
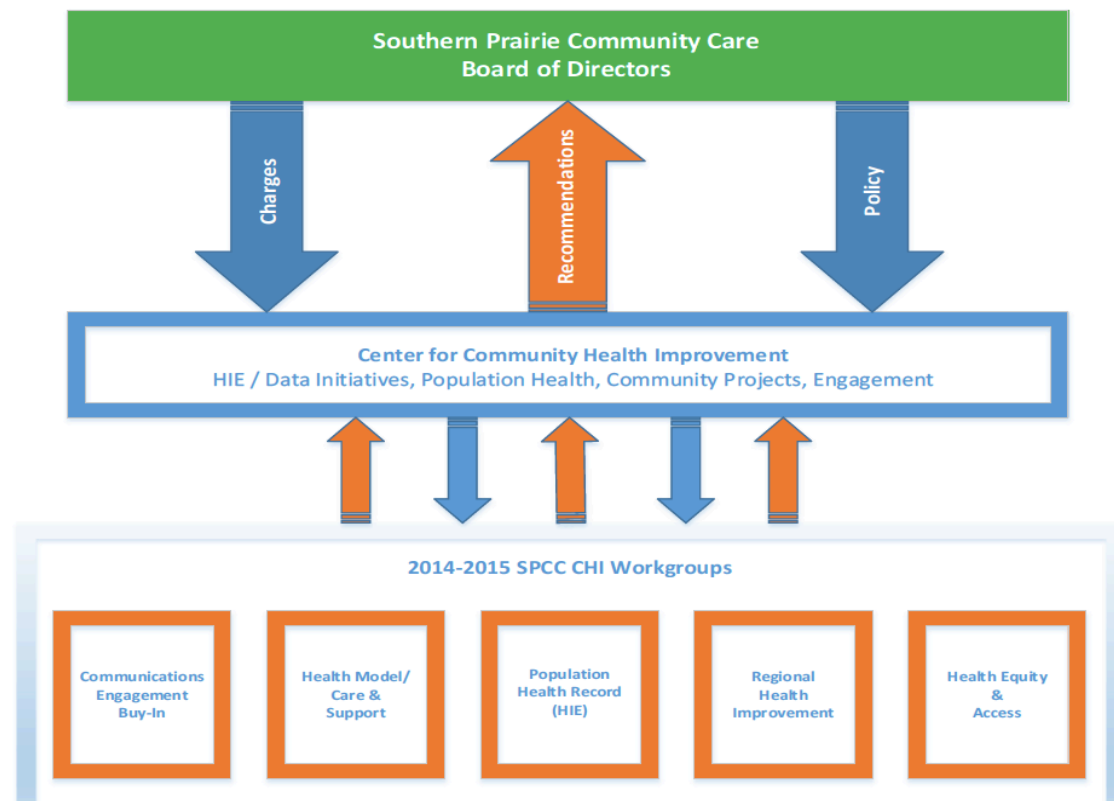

Vision
Commissioner-Led Discussions

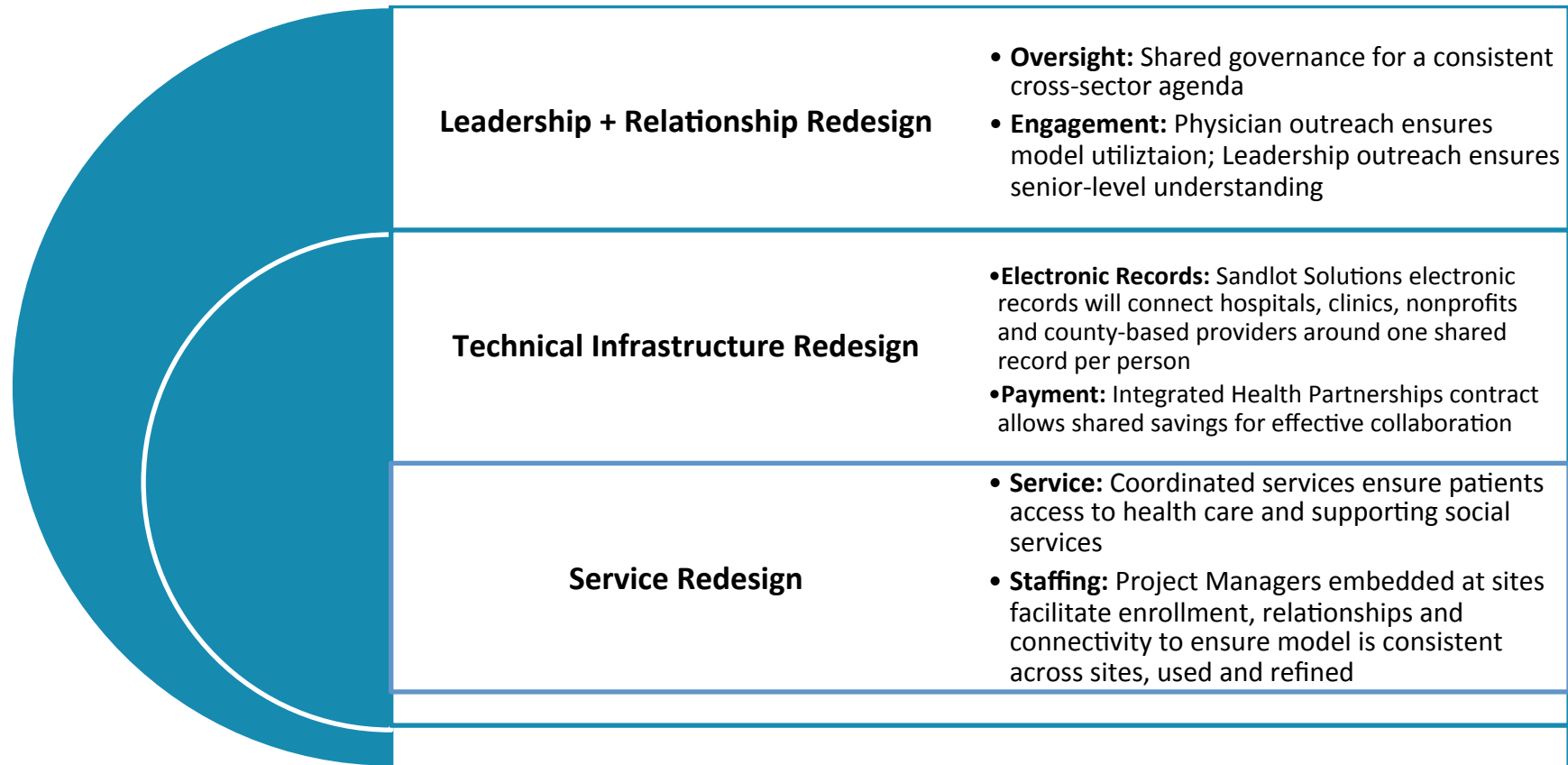**Design**
Top Managers & Administrators Co-Created A New Model

Roll-Out
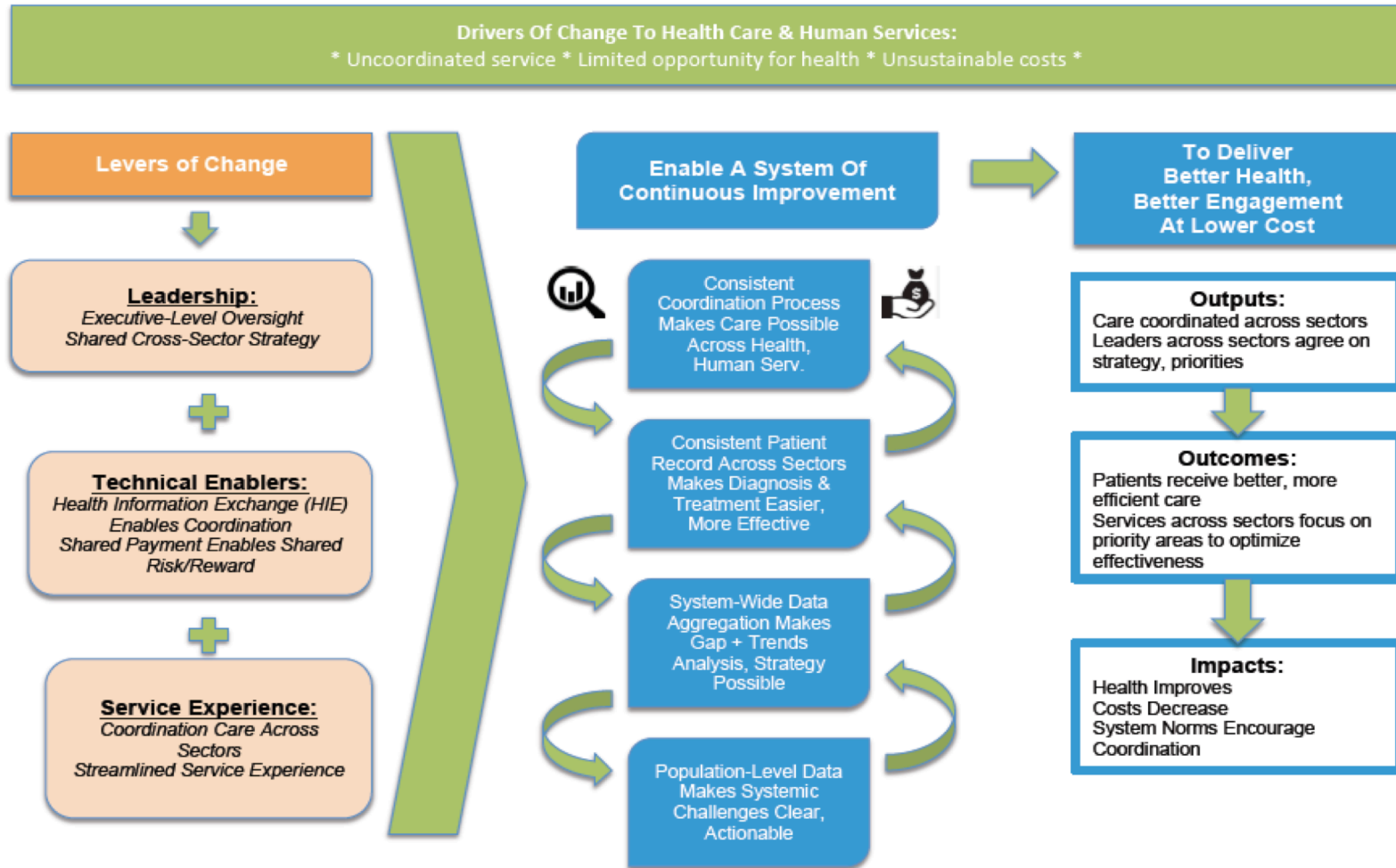Top Administrators, Managers And Staff Deployed The Design

Phase 4: Implement and Sustain System Redesign. The Center for Health Improvement (CHI) Provides Cross-Sector Governance That Enables Ongoing Engagement Of Stakeholders. This new 501c3 structure, launched in January 2015, will reinstate expanded engagement used in the design process and provide a central vehicle for health care providers, mental health, public health and human services staff to reach consensus on shaping the strategic direction for Southern Prairie Community Care's implementation. County Commissioners maintain full budget authority through their Joint Powers Board of Directors, but the CHI structure allows for a consistent and deliberate path where stakeholders across healthcare, human services, mental health and more find consensus in recommendations to the county commissioners.

Southern Prairie Community Care
Board of Directors

Charges

Recommendations

Policy

Center for Community Health Improvement
HIE / Data Initiatives, Population Health, Community Projects, Engagement

2014-2015 SPCC CHI Workgroups

| Communications Engagement Buy-In | Health Model/ Care & Support | Population Health Record (HIE) | Regional Health Improvement | Health Equity & Access |

Implementing System Redesign: Multi-Layered Changes Drive Coordination Across Sectors. Southern Prairie Community Care, as a "Virtual Accountable Care Organization," is redesigning the delivery of health care and human services for better services and better outcomes achieved through alignment. The collaborative approach also gives many providers and agencies access to technology and expertise that would otherwise be unavailable for small, rural counties and nonprofits.

Leadership + Relationship Redesign

- **Oversight:** Shared governance for a consistent cross-sector agenda
- **Engagement:** Physician outreach ensures model utiliztaion; Leadership outreach ensures senior-level understanding

Technical Infrastructure Redesign

- **Electronic Records:** Sandlot Solutions electronic records will connect hospitals, clinics, nonprofits and county-based providers around one shared record per person
- **Payment:** Integrated Health Partnerships contract allows shared savings for effective collaboration

Service Redesign

- **Service:** Coordinated services ensure patients access to health care and supporting social services
- **Staffing:** Project Managers embedded at sites facilitate enrollment, relationships and connectivity to ensure model is consistent across sites, used and refined

Implementing Redesign: Theory of Change Diagram

Drivers Of Change To Health Care & Human Services:
* Uncoordinated service * Limited opportunity for health * Unsustainable costs *

Levers of Change

Leadership:
Executive-Level Oversight
Shared Cross-Sector Strategy

Technical Enablers:
Health Information Exchange (HIE)
Enables Coordination
Shared Payment Enables Shared Risk/Reward

Service Experience:
Coordination Care Across Sectors
Streamlined Service Experience

Enable A System Of Continuous Improvement

Consistent Coordination Process Makes Care Possible Across Health, Human Serv.

Consistent Patient Record Across Sectors Makes Diagnosis & Treatment Easier, More Effective

System-Wide Data Aggregation Makes Gap + Trends Analysis, Strategy Possible

Population-Level Data Makes Systemic Challenges Clear, Actionable

To Deliver Better Health, Better Engagement At Lower Cost

Outputs:
Care coordinated across sectors
Leaders across sectors agree on strategy, priorities

Outcomes:
Patients receive better, more efficient care
Services across sectors focus on priority areas to optimize effectiveness

Impacts:
Health Improves
Costs Decrease
System Norms Encourage Coordination

Process Evaluation Findings

Findings: Factors In Formation

Southern Prairie Community Care is the nation's only multi-county, cross-sector project for sharing data, costs and resources in pursuit of better health.

- **Southwest Minnesota's history of cross-county work is seen as seeding Southern Prairie Community Care**. Commissioners across southwest Minnesota often work across counties to share oversight of high-cost services. Those interviewed pointed to this history of working relationships as an important undercurrent for Southern Prairie's formation – collaboration is the norm in Southwest Minnesota and trust runs deep, creating a fertile spot for a cross-sector collaborative of Southern Prairie's size and scope.

  - *Multi-county mental health and corrections boards facilitated relationships*. Several commissioners, staff and observers pointed to an 18-county mental health board as a venue where many Southern Prairie commissioners first worked together, and worked with other commissioners who led creation of Prime West. A multi-county corrections board in the area was also mentioned as a venue where commissioners built relationships and became comfortable working together.

  - *Southwest Health and Human Services built confidence*. The six-county shared public health and human services agency began its work just as county commissioners in the 12 counties were creating a joint powers board for Southern Prairie Community Care. Some commissioners and staff mentioned the experience of negotiating and launching Southern Prairie helped build regional confidence in the potential success of jointly administered programs. One staff member talked about the early formation of Southern Prairie as "getting the band back together."

- **County-Based purchasing was the original goal.** County commissioners – particularly in the northern half of Southern Prairie's territory – looked to Prime West as a model of how local governments could work together to provide managed care in ways that kept county Medicaid dollars in their home districts. Commissioner-level conversations about a joint venture temporarily cooled when the Pawlenty Administration placed a cap on future county-based purchasing agreements, though relationships remained intact via the mental health board.

  - *Prime West's Overlapping Healthcare Provider And Commissioner-Level Relationships Influenced Southern Prairie's Direction.* Affiliated Community Medical Centers (ACMC), the region's top independent medical practice, provides care to a majority of counties in the Southern Prairie region, as well as many counties covered by Prime West. ACMC's administrator was deeply involved in sharing ideas from Prime West with commissioners in Southern Prairie counties.

Likewise, the multi-county mental health board included leaders from many counties in the Prime West region, as well as Southern Prairie, creating a venue for building relationships and cross-pollenating ideas.

- **The Dayton Administration's leadership is seen as a key incentive during commissioners' early negotiations.** County commissioners rejuvenated their interest in pursuing a multi-county, cross-sector effort shortly after Governor Dayton signaled a willingness to support new approaches to public services early in his first term. The rejuvenated commissioners also looked beyond county-based purchasing, which had been a priority of the Pawlenty Administration, in part because of the Dayton Administration's receptiveness to bigger ideas. Commissioners and staff cited visits, support and encouragement received from the Department of Human Services as a valuable morale boost during the period when commissioners were finalizing their shared vision for Southern Prairie.

- **Regional self-determination, health improvement, keeping dollars local and cost containment were the most persuasive arguments for pursuing Southern Prairie Community Care.** Reflecting on why commissioners from 12 counties ultimately chose to pursue a shared system for managing Medicaid and social services, the desire for local control held constant across constituent groups. Secondary arguments did vary, however:

  o *Self-determination was most commonly cited as the primary expected benefit of creating Southern Prairie*. While self-determination mattered to both commissioners and direct-service staff interviewed, the reasons why self-determination mattered varied. For commissioners, the idea of self-determination was rooted in finances – Southern Prairie would allow them to keep managed care dollars in the region, rather than spending Medicaid dollars for services in the Twin Cities. For staff, self-determination was more about setting the region's own procedures for connecting human services, health care, public health and other services.

  o *Cost containment and health improvement were noted as the long-term value of Southern Prairie*. Cost containment (slowing the rate of growth) and improved health for all constituents were the most important reasons why change was seen as worthwhile to county commissioners and service providers (public health, human services). For many, these two ideas reflected two sides of the same coin; that is, better health and a greater emphasis on prevention will ultimately slow the growth in costs, too. Overall, most commissioners reported a balanced view of Southern Prairie Community Care, valuing cost-containment and regional health improvement equally. Mental health and human service providers, on the other hand, focused more on health improvement, citing the cost benefits of better health as a downstream benefit of the redesign.

- *Patient examples crystalized the vision and value of Southern Prairie for stakeholders*. Project proponents created an example client named "Charlie" to illustrate how one patient could touch health care and social services systems multiple times to deal with multiple issues -- costing time, dollars and diminishing health along the way. The illustration was primarily used in presentations to build support for the Joint Powers Board in 2011 and early in the design process (2012 – 2013), and it became a tool for stakeholders to understand how Southern Prairie would benefit its constituents / clients. Ultimately "Charlie" served as a short-hand example for why change was needed. In evaluation interviews, stakeholders referenced the "Charlies of the world" when talking about reasons for changing the delivery system in Southwest Minnesota.

Findings: Perspectives On Formation

For all of its technical and payment redesign, perhaps Southern Prairie's greatest challenge and opportunity lies in aligning the daily work of different professional fields and cultures across 34 distinct organizations. Technical changes are merely tools to facilitate this bigger shift. Throughout interviews with Southern Prairie stakeholders, distinct perspectives emerged across constituencies participating in the collaboration.

- **County Commissioners interviewed embraced their role in direction-setting**. Commissioners (current and former) interviewed viewed Southern Prairie's development as complex and complicated, but also very important. They appreciated that Minnesota is rare in allowing counties to take on localized leadership of both Medicaid and human services, and take pride in their work to innovate.

- **Behavioral health, public health and human services leaders interviewed see alignment at commissioners' direction as both logical and exciting**. For these leaders, transparency and cooperation across organizations for improved services was seen as a logical next step, particularly after the creation of Southwest Health and Human Services. Several respondents noted surprise that this culture of transparency is not as common among health care providers and provider systems.

- **Health care administrators' perspectives varied by ownership: county-owned, independent and system-owned.** Overall, health care leaders interviewed were the only group to express some hesitation toward Southern Prairie's work, citing the many similar changes that have been made since implementation of the Affordable Care Act. Health care administrators of clinics and hospitals owned by local governments were most engaged in, and supportive of, Southern Prairie's creation, while those from independent provider groups or larger systems placed more qualifications on their support, which was attributed to a perceived duplication of effort.

- o *Technology is seen as the greatest point of concern for health care administrators*. Connecting all patients with one electronic record system is a goal across the health care sector today. Some area providers interviewed voiced concern that creating a Southern Prairie-specific electronic record system with different technology than currently used by the major regional providers (St. Cloud and Sioux Falls, where specialists are housed) could make patient management difficult for follow up care of high-cost, high-need patients.

- o *Varying quality requirements are another concern*. Under the Affordable Care Act, as of Jan. 2015, physicians are paid in part based on care quality for Medicare patients. The new payment requirement has led providers to create a quality tracking and care management system for implementation in Jan. 2015, and some administrators see Southern Prairie's process as duplicating that work.

- o *All interviews were with administrators, rather than physicians*. This is important to note because administrators are most likely to connect with Southern Prairie around time-intensive start up efforts, such as getting the Health Information Exchange (HIE) off the ground. But these same leaders are less likely than physicians to see and understand how changes to services are impacting patients' lives.

- **A group of county administrators is seen as the only source of opposition to Southern Prairie's formation**. Administrators provided the only noted source of opposition to Southern Prairie's early development. Interviewees noted that administrators cited the level of risk involved – counties spent money to create a model with no evidence that it would work – as the reason for their opposition to participating in Southern Prairie. Others hinted that a loss of control was another underlying reason for some administrators' reluctance to join the collaboration. Some interviewees speculated that a select few administrators were "silently waiting for us to fail," but all believed that Southern Prairie is ultimately accepted region-wide.

- **Outside perspectives are seen as playing important roles in the formation process**. Ultimately, each piece of Southern Prairie's new model for integrating services and care across sectors was locally developed and locally chosen. However, partners and stakeholders from outside of the region were seen as playing important roles in facilitating or encouraging those choices.

- o *Outside Consultants*. The law firm Halleland Habicht, PA provided early strategy, research and facilitation to commissioners, helping to shape and guide choices about what a new cross-sector model that went beyond county-based purchasing could look like and what it would entail. The firm and its leadership commanded respect from county commissioners as a knowledgeable, neutral resource available to support their decision-making, and were seen as effective in facilitating engagement of other sectors and stakeholders early in the process. They guided the work from concept through to completion of the design phase.

- o *Department of Human Services*. Encouragement from Minnesota Department of Human Services (DHS) Commissioner Lucinda Jesson and Scott Leitz (in his role with DHS prior to MNsure), in particular, were seen as providing helpful motivation that would reinvigorate county commissioners around the work. Their attention, as well as willingness to dedicate time to work through potential scenarios with Southern Prairie representatives, helped commissioners see the meaning of Southern Prairie's work. The continued attention and support was a source of ongoing motivation for commissioners.

- o *Foundation grants*. A small grant from the Otto Bremer Foundation, as well as the larger Beyond the Bottom Line investment, was seen as helping commissioners maintain confidence in the direction of Southern Prairie. The Beyond the Bottom Line investment was seen as a significant vote of confidence in the Southern Prairie redesign.

- o *Blue Cross and Blue Shield of Minnesota*. The insurer arranged a significant partnership with Southern Prairie to support the initial Medicaid-focused project, but with a long-term goal of applying the Southern Prairie care management model to everyone in the 12-county region.

- **The Dayton Administration is respected as a supporter of redesign**. County commissioners, in particular, noted the Dayton Administration's support for redesign as an important factor influencing their decision to seriously pursue a new, joint service model through Southern Prairie. Those interviewed believed that the Governor would be a consistent supporter of counties' collaboration, ensuring county investments in roll out would be dollars well spent.

Findings: System Redesign & Early Implementation

Once county commissioners approved a joint powers agreement authorizing Southern Prairie Community Care, the deep work of designing the new care system began in earnest. As depicted earlier (p. 7), four cross sector teams – service & supports design; healthcare homes & care management; quality improvement & customer service; technology, information exchange & analytics – led design of components of Southern Prairie. Committee members were responsible for reporting back on the design process to their respective organizations, and members were all senior staff or top executives.

- **The vision was refined as planning got underway**. Several commissioners acknowledged that the vision for Southern Prairie changed and evolved "a few times" as the number of stakeholders expanded and others took the project more seriously. For example, first conversations focused exclusively on county-based purchasing, though Southern Prairie ultimately evolved to be a shared infrastructure and shared savings collaboration – a "virtual Accountable Care Organization (ACO)." Likewise, Southern Prairie began as an organization specifically designed to focus on coordinating services for Southwest Minnesota's Medicaid population. Over the past year, a partnership with Blue Cross and Blue Shield has led to the potential for growing the Southern Prairie's model to serve everyone in the 12-county region.

- **Southern Prairie's staff is seen as an important asset for the region.** Commissioners, human services staffs, behavioral health and health care leaders all recognize the top-tier talent that Southern Prairie employs.

  - *Mary Fischer's hiring is seen as key to launching Southern Prairie*. Mary's past experience working for public health and human service agencies across Southwest Minnesota, as well as her work as a hospital administrator, made her a respected and credible voice for all. From the outset, commissioners trusted her allegiances to the region (rather than one county over another), and her knowledge of the systems at play.

  - *Dr. Norris Anderson is recognized as central to engaging health care*. Leaders across sectors see that Dr. Anderson's credibility with physicians across the region and his passion for Southern Prairie's mission has allowed the new model to make impressive in-roads in engaging health care.

  - *Elizabeth Cinqueonce is respected as an asset in working through the technology start-up process.* Liz's work to organize and launch the Sandlot electronic health records system has moved the important technology work forward fast, and several see her contributions as essential to bringing the Southern Prairie vision to life.

- *Finding talented staff is seen as one of the greatest implementation challenges facing Southern Prairie.* Across stakeholder groups, interview respondents recognized that the Southern Prairie is working to create new ways of coordinating services to achieve new results, and finding staff up to that challenge is not easy. A significant proportion of staff and consultants have come from outside Southwest Minnesota due to the region's lack of qualified staff.

- **Care coordination's swift roll-out illustrated Southern Prairie's new model, but also offered lessons.** Southern Prairie Community Care's care coordination model was rolled out to all sites across sectors and partners immediately in 2014. The swift process made Southern Prairie real to every organization that had been involved in the design, helping to boost early credibility. Some partners did note that the roll-out also offered important lessons in the communications and time investments needed to help each partner learn about the model and help it fit in their own work.

- **Embedded staffs drive day-to-day coordination**. Southern Prairie staff and service leaders report the greatest enthusiasm for new care coordinator/project manager positions embedded at sites across the region. Southern Prairie employs these staff positions, but they office at health care and human service providers within the network, and are tasked with supporting implementation of the new model through collaboration with existing staff. The embedded nature of staff also helps to facilitate communication and sharing across professional cultures (healthcare provider, human services, behavioral health) that enables Southern Prairie leaders to unearth and address needs, issues or misunderstandings early.

- **Retirements and staff transitions had both positive and negative affects into implementation.** Southern Prairie has moved forward in the face of significant leadership changes early in the collaboration's implementation. Two of the most vocal county commissioner champions lost reelection or retired just before the work fully launched, and the administrator of Affiliated Community Medical Centers – the region's largest provider, and a champion for the project – retired in Jan. 2015. Other county commission seats have turned over, as well. The combined impact is seen as both positive and negative.

  - *Benefits of Staff Changes*: New county commissioners, in particular, talk about Southern Prairie as an almost foregone conclusion. Because Southern Prairie has been in existence and supported for as long they have served on the boards, it's accepted as a normal part of governing. It's a sharp contrast from the perspectives of commissioners who were involved with the project from the beginning. Those commissioners talked more about the effort required to settle on a direction for Southern Prairie, and characterize the work as more hard-won and valuable than most programs or projects.

- *Challenges of Staff Change:* Losing institutional knowledge of Southern Prairie's vision and design, as well as knowledge of the organization, trust and relationships of key champions, was seen as a real challenge for Southern Prairie. In addition to losing great minds and champions, the turnover had significant time costs, as Southern Prairie staff dedicated time to bringing new organizational leaders up to speed on the vision for the work and the needs of partner organizations.

- **Technology change (namely the Health Information Exchange / HIE) is the most-anticipated feature of Southern Prairie for many, but has been more time-consuming than those interviewed expected**. Across interviews, but especially among behavioral health and human services staff, Southern Prairie's electronic records system is seen as the tool that, once fully connected, will unlock the potential of the new model. Stakeholders interviewed have been surprised by the time and level of detail involved in creating the electronic system. For many service staff, in particular, getting the HIE operational will unlock the full potential of collaboration across sectors and systems.

- **Engaging the medical community has proven different and more difficult than what commissioners and service leaders expected**. Human services and behavioral health staff, in particular, observed that health care providers' approach collaboration in more reserved way than is typical of local governments and nonprofits. The differences in approach were not expected, and highlighted the differences in professional cultures for some respondents. Some human services, public and mental health respondents observed that the time-intensive work of engaging physicians, administrators and others in the model has required significantly more than what was initially expected, but the time invested has been well spent.

- **Engaging patients for Southern Prairie enrollment has amplified the need for community outreach capacity, too**. Early on, Southern Prairie leaders believed that their attributed population (2,000) was automatically enrolled in the project for their Medicaid reimbursement. Learning that Southern Prairie was accountable for enrolling its patients added a need for swift outreach capacity that respondents see as ultimately good for the organization, but in the immediate term caused project leaders to take time and resources away from building up technical infrastructure and other aspects of the project.

- **The Center for Community Health Improvement was created as vehicle for non-commissioners to engage and advise on strategy and operations**. Staff created the new nonprofit entity as a governance strategy to sustain the community engagement and transparency consistently moving forward. The new nonprofit entity will sustain cross-sector governance and engagement that had been managed by design committees prior to Southern Prairie's launch. The Center's committees are comprised of stakeholders from human services, health care administration, behavioral health and public health, as well as physicians, and are tasked with making organizational policy and strategy recommendations to the Joint Powers Board of county commissioners.

The work of the Center will focus through five standing work groups:

o   Regional health improvement. This workgroup guides overall strategy for Southern Prairie Community Care, developing a baseline understanding of the region's health status, strengths and weaknesses, prioritizing areas for improvement and measuring and communicating on progress.

o   Communications, engagement & buy-in. One group is now specifically focused on the people-side of change, helping peers, providers and patients understand the value of Southern Prairie Community Care and how they can best engage with the new coordinating model.

o   Health care model care & support. Leaders across sectors specifically focus on how Southern Prairie's integrated, evidence-based and locally-driven model is achieving its goals in care and support, and work together to address or remove barriers to successful implementation.

o   Population health record. Southern Prairie Community Care's data aggregation capacity makes population health management – with population health defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group – possible across the 12 county region as a whole. The workgroup guides the creation of Southern Prairie's health information exchange (HIE), which will provide the technology backbone for a comprehensive population health strategy.

o   Health equity & access. People of color and those of limited means experience poorer health outcomes in Southwest Minnesota, and across the state and nation. The committee works to better understand the unique dynamics and barriers to health faced by communities of color in the 12-county region (where all future population growth is expected to come from communities of color), and facilitates culturally-appropriate strategies in response.

Findings: Expectations & Lessons of Change

One year into implementation – and after several years of negotiation and design – Southern Prairie Community Care's leaders and stakeholders have learned valuable lessons.

- **Setting clear expectations for change has been challenging**. Stakeholders, from commissioners to service managers, reported having few clear expectations for how implementation of Southern Prairie might unfold when implementation began in 2014. Several reported the "build it as you fly it" phenomenon as being an expected part of undertaking such a large-scale change effort. One year in, norms for how Southern Prairie will create its new system have emerged and expectations are becoming more concrete, though still varied.

    - *Timing expectations*. Most stakeholders reported being surprised by the time – both calendar and staff time – needed to develop and execute Southern Prairie's electronic record system.

    - *Technical expectations*. Ultimately, all stakeholders held high hopes for the role a unified record system can play in facilitating collaboration and streamlining services in the region. Still, few have a clear sense of when to expect a fully operational electronic record system. Expectations ranged from having test cases complete within the next six months, to expectations that the full system could be live by then.

    - *Service expectations*. All stakeholders shared a vision for seamless services across Southwest Minnesota's Medicaid patients, from human services and behavioral health to the primary care system. Commissioners and human services staffs, in particular, believed that embedded care coordinators at sites across the region have quickly made great strides in making the Southern Prairie model real for staffs.

    - *Collaboration expectations*. County commissioners, behavioral health, public health and human services staffs all see the collaboration possible through shared records as improving their work and the outcomes they can generate for clients. Health care administrators also see significant value in collaboration with local services to support patients' local needs, but balance that enthusiasm with an equally strong need to collaborate with major regional health care providers and specialists in Sioux Falls and St. Cloud.

- **Expectations of success vary for what Southern Prairie might achieve even in six months.** For example, one human service director would like to see Southern Prairie "*seed enough teams to get a measure of impact based on success. SPCC-wide, we want to see 200 to 250 models in action*" by Oct./Nov. 2015. For a county commissioner, on the other hand, success would include *"all counties participating in Sandlot (the IT solution) and entering the information."* A healthcare administrator noted *"On a scale of 0 to 100, we're at about a 10 right now. In 6 months, I hope we're at '40 to 50.' I'd like to see us enrolling patients and sharing information. If I was to guess, we'd have 50 people enrolled by then. Maybe 100."*

- **Communications is seen as key for building support and sustaining implementation**. From the outset, communications and engagement with the full gamut of Southern Prairie stakeholders has been essential to creating and launching the new cross-sector collaboration, as well as informing the public and patients of changes underway.

  o *Open communication among commissioners enabled negotiation around the vision*. Several commissioners observed that negotiating the terms for Southern Prairie Community Care's creation came down to clear conversations. Commissioners were forthright with each other about what they could and could not support based on the needs of their respective counties. Each county had one delegate to the collective project, and those delegates benefited from having the trust and support of their local colleagues to negotiate on behalf of the county, as well.

  o *Human services leaders played an important role in making the case for change*. Beyond commissioner negotiations, human services staff reported spending significant time building and sharing a case for why change was important, providing commissioners with public support for their efforts and leading staff through the changes.

  o *Ongoing communication remains essential through implementation*. Staff is investing in ongoing communications to keep stakeholders and the public aware of the change underway and engaged in the process of building Southern Prairie Community Care. Efforts include regular update calls and meetings with stakeholders. Partner-organizations appreciate the updates, though some lament that conversations are so technical that "if you miss one meeting, it's hard to catch up."

- **Trust and economics are seen as the lynchpins of success**. When asked what other redesigns should ensure they "get right" on a redesign, trust and economics consistently emerged as priorities.

  o *Trust among commissioners and across the network.* All commissioners observed that a project of Southern Prairie Community Care's size and scope would not be possible without their long history of trust and collaboration. From the multi-county mental health board, corrections board and others, county commissioners and key staffs were accustomed to working together at a smaller scale. The experiences built the trust needed to have long, hard and honest conversations necessary in negotiating a system of Southern Prairie's size and scope.

  o *Economic model and strategy toward sustainability are especially important in the eyes of health care administrators and county commissioners.* All recognize that redesigns like Southern Prairie Community Care are new innovations that lack precise road maps. Still, having a clearly articulated case for the cost of inaction, coupled with a clear plan and check points for how economics of the new system will be evaluated and managed, are seen as key to protecting the long term success of redesign projects. The focus on economic sustainability was most prominent among health care administrators. For commissioners, economic sustainability mattered, but was viewed within the larger context of poor health's costs in Medicaid spending, human services, behavioral health and other county-funded services.

- **Ultimately, respondents see Southern Prairie as Southwest Minnesota's best path to improving health coordinating services and lowering costs.** In the immediate, interviewees of all perspectives look to benchmarks such as decreased emergency room visits, better care coordination and better collaboration across services. Pilot projects in diabetes care and mental health treatment are viewed as valuable test-cases in collaboration that, coupled with embedded staff at site across the region, will seed examples of success and in-roads across professional cultures to spread positive change fast and effectively. Yet these implementation strategies are also seen as simply a path to the end-goal: better health and lower costs achieved through more coordinated, locally-led health care and social services.

Preliminary Cost Outcomes

Southern Prairie Community Care is working closely with the Minnesota Department of Human Services (DHS) through three streams of innovation funding:

1. *Accountable Communities for Health*: A diabetes prevention project underway will "road test" the Southern Prairie approach to collaboration and care, identifying patients who are Type 2 diabetic or pre-diabetic, and engaging them in community-based solutions to help them manage the disease or prevent it from taking hold.
2. *Health Information Exchange (HIE):* Southern Prairie's integrated database, via Sandlot Solutions, will serve as Southwest Minnesota's HIE for connecting patient records across the region.
3. *Integrated Health Partnerships:* Southern Prairie has a shared-savings payment agreement with DHS – a new model of Total Cost of Care payment that allows for limited risk on behalf of providers, as well as shared savings incentives for providers that succeed in lowering treatment costs.

The Beyond the Bottom Line investment in Southern Prairie Community Care was made in connection with DHS' first Integrated Health Partnership contract to the new organization, and allowed Southern Prairie the resources to implement redesigned connections across health care and social services to support early implementation. The investment was a success.

Year 1: Integrated Health Partnership Financial Results

Attributed Population: **24,000** Medicaid recipients across 12 counties in Southwest Minnesota

Total 2014 Cost Avoidance: **$4 million** less was spent to treat these patients than models predicted

Average Cost Avoidance: **$167** per attributed patient in the first year

Southern Prairie's Result: **$1.55 million** will be redistributed to members and reinvested in further system improvements

Foundation Investment ROI: **$3.88 to $1.** For every dollar foundations invested in Southern Prairie's start-up, $3.88 is now available to Southern Prairie Community Care to support additional system improvements that will further improve care, improve health and lower costs in Southwest Minnesota. When accounting for the dollars saved by the Department of Human Services, the return on investment is $10 to $1.

Analysis

Beyond the perspectives and opinions shared by Southern Prairie Community Care, it's equally important to note what was not said. Analysis of what's missing offers a glimpse into the factors often taken for granted – or at least the factors that may not be as top-of-mind – as organizations, regions and cultures work with each other to manage shared change.

Context Of Change

- **In The Early Years Of Southern Prairie Community Care, Change Was Inevitable**. In 2006, when commissioners started holding conversations about a joint county-based purchasing project, then-Governor Pawlenty made county-based purchasing available to several counties. The Association of Minnesota Counties (AMC), in partnership with state leaders, dedicated time and resources to talking with county commissioners about collaboration and changing the nature of services. State deficits and a partisan divide in the legislature created budget pressures that turned attention toward redesigned services. In this environment, county commissioners in Southwest Minnesota and across the state were talking about _how_ to change, not _whether_ to change.

- **Static Language Of Government And Healthcare Is Attributed To Southern Prairie's New Way Of Working.** Language shapes culture, and a new, shared operating culture will be necessary for Southern Prairie Community Care's cross-organization, coordinated approach to take root. However, many respondents used the language of traditional government and healthcare work – words like "administer" and "model" – to describe work underway. This language implies a "set-it-and-forget-it" approach to structuring the work differently, a phenomenon not unique among public sector redesigns. Ultimately, implementing data-driven patient management will require new approaches that can adapt to patient and system needs.

- **Inequity Is An Important Factor In Future Health For The Region, Yet Race Was Not Mentioned In Interviews.** A full 100 percent of Southwest Minnesota's population growth between 2010 and 2040 will come from communities of color. The Center for Health Improvement has a committee dedicated to understanding and addressing health equity in the covered region. However, conversations about redesign of a future health and social services system for health improvement (and why redesign is necessary) didn't draw out mentions of culture or race. The reasons why race wasn't mentioned could be many, but merit further investigation.

Process of Change

- **Change Is Often A Phased Process; Yet The Redesign Process Is Largely Undefined Beyond The Vision And Technical Enablers**. Although interviewees highlighted excitement over potential turning points – the implementation of the HIE, cost-savings at the year one mark, etc. – it was clear that the framework for understanding how complex change initiatives become reality was intuitive or unclear for many associated with Southern Prairie. Organizations in the business of change often have established frameworks for helping their constituencies understand the different periods of work in a change process. For example, advocates often use a four-phased process – entering a community/engaging with a community, building support, passing policy and then implementing policy – to understand the different phases of policy change. Venture capitalists make investments in different phases of business development – from angel investing and seed-stage funding, to start-up/early-stage, formative and late-stage funding – as well. A similar framework for the redesign process will provide government leaders and staff with a clear path for planning multi-layered engagement across an evolving structure. The general phases identified in this evaluation are a first step toward that end.

- **Managing Systemic Change and Managing Programmatic Change Require Different Skills**. Programmatic change – from implementing a specific regulation or program to navigating the new initiatives of new administrations – is core to the work of public administrators in state and local governments across Minnesota, and in health care, as well. Most public sector and health care leaders are highly skilled in managing through this type of change. Systemic change – including transitioning or transforming leadership structures – is new for many. Large-scale transformation efforts, such as the shared governance and cross-sector implementation of Southern Prairie, require significant time and financial resources dedicated to informing and engaging people at all levels of multiple organizations, over-and-above the technical changes (data, payment) that spark a drive for change. Leaders in Southwest Minnesota are on the forefront of navigating change to align organizations of this magnitude. Their governance model – both the Joint Powers Board and the Center for Health Improvement's board of directors – can offer important lessons for others pursuing cross-sector shared funding and shared-power operating models.

Conclusions: Key Lessons For Redesign

1. **Southwest Minnesota's History Of Collaboration Provided A Solid Foundation For Southern Prairie Community Care.** The pre-existing relationships that commissioners built through joint powers boards in mental health, corrections and public health created ties of trust among the Southern Prairie Community Care commissioners before the idea of a health and social services redesign ever came to be. Likewise, relationships with commissioners in the Prime West area gave many confidence that they, too, could undertake an effort of this size and scope. The region's rural nature, with only 500,000 people across the 12 counties, made collaboration part of the operating culture in Southwest Minnesota, before and beyond Southern Prairie.

2. **Encouragement From State Leaders And New Laws Gave Commissioners Confidence To Redesign.** The statewide policy environment, from Dayton's support of change to Pawlenty's county-based purchasing agreements, was key to starting the conversations about concepts that became Southern Prairie Community Care. Outside support in the form of encouragement – visits and encouragement from DHS, grants from foundations, etc. – boosted the sense of confidence among county commissioners and may have also helped deter those who otherwise might have walked away. Outside support in the form of staffing and facilitation provided commissioners with trusted, neutral information and a clear path to reaching consensus on what a shared vision for Southern Prairie Community Care could be.

3. **Locally-Driven Alignment Is Essential.** While external leaders played an important role in helping county commissioners muster the courage for transformational change, the final decision was ultimately and completely local. Across interviews, county commissioners clearly spent significant time working out differences together in private, and feel ownership in the success of Southern Prairie. Likewise, key staff members are proud of the roles they have played in encouraging and supporting commissioners' decision to move forward with the redesign. At all levels and in every county, Southern Prairie Community Care's stakeholders are invested in the redesign.

4. **Redesigning Services Across Sectors Requires A Phased Approach Anchored By Aligned Oversight.** Aligning 34 organizations across 12 counties to implement one model is no small task. Southern Prairie Community Care has done so through a deliberate approach to engaging leaders and stakeholders:

   - Phase 1: Vision Alignment. County commissioners' aligned vision for better care and better services at lower cost anchored early discussions of Southern Prairie Community Care. Commissioners led the conversations, but stakeholders across sectors were engaged early and often in discussions.

- Phase 2: System Design. Agencies responsible for delivering on Southern Prairie's vision led the process and brought cross-sector perspectives to the design of care coordination, payment, governance and technology/HIE models. The cross-sector perspectives helped ensure the ultimate redesign would resonate and work for all partners, and deepened the buy-in and engagement of those with staff responsible for day-to-day implementation.

- Phase 3: Redesign Roll-Out. Southern Prairie has been intentional in rolling out components of its model piece by piece – first rolling out the care coordination model across sites, then taking a phased approach to implementing new technology – to ensure each component of the model is fully understood and embraced by staff and management of each partner-organization. While the roll-out moves focus to the staff level, engagement stretches across the full system with lessons and updates continually connected back to commissioners and top managers for ongoing strategic management.

- Phase 4: Implementing and Sustaining System Redesign. The Center for Health Improvement provides a consistent, sustainable structure for Southern Prairie Community Care's partners have an organized, neutral vehicle to combine expertise and develop shared strategy and policy recommendations to the Joint Powers Board of county commissioners. New operating procedures are becoming standardized and new norms of operation are taking hold.

5. **Support for Southern Prairie Is Consistent, But Enthusiasm For Implementation Varies By Sector – Government, Social Service Nonprofit and Healthcare.** Among government and social service nonprofits, as well as mental health providers, many of Southern Prairie's most distinct features – shared data, shared measures and a system for coordination – are very new and exciting. For healthcare providers, the ideas of Southern Prairie are appreciated, but balanced with the challenge of managing Southern Prairie norms with the changes already underway due to the Affordable Care Act, Minnesota's healthcare homes, and others.

6. **New Technology Is Enabling Coordination To Degrees Previously Unimaginable; Engaging Front-Line Staff Will Be Key To Maximizing Its Impact**. From county commissioners to front-line managers, all stakeholders see the Sandlot technology solution as essential to delivering on Southern Prairie's promise. But consistent data entry and data use will be essential to achieving technology's promise. Southern Prairie's decision to embed staff at sites across partners will help ensure consistent, two-way communication between Southern Prairie and partner-managers in terms built on true understanding of both the existing program and Southern Prairie's needs.

7. **Staff Responsible For Bridging Cultures Have Played An Essential Role In Enabling Implementation.** Southern Prairie created the medical director position, held by Dr. Norris Anderson, specifically to lead the engagement of physicians in executing on the care coordination model. Given the independent nature of physicians' work, Dr. Anderson has been an essential partner in supporting patient enrollment and model refinement. As technology has rolled out, Southern Prairie has employed a project manager on-site at each site implementing the HIE. Project managers provide Southern Prairie with a daily presence at sites implementing the new technology, and work as ambassadors for the model to support implementation as part of each site's daily work.

8. **Hopes Are High And Confidence Is Strong.** Southern Prairie's stakeholders understand they are in unknown territory, and they are excited to be leading the way. And it's important to note that interviews were complete just before DHS announced Southern Prairie's $4 million savings in year one – a validation of the work that surely boosted confidence across the partnership.

Recommendations

Southern Prairie Community Care's process of formation and early implementation offers several essential lessons for all sectors interested in supporting the redesign of public services for better outcomes at sustainable costs. From local government and state leaders, to academics, health care providers, nonprofits and foundations, three key lessons stand out for consideration:

1. **Define, Plan And Manage For Phases Of Change In Redesign**. Building an operational plan for the execution of a redesign is part of gaining the approval needed to move forward with any new endeavor, but only a small part of the work. Additionally, future redesigns should consider a companion stakeholder communications and engagement plan (and dedicated staff or resources) to help ensure smooth transitions and a sustained commitment to the vision.

   - Create A Phased Plan To Manage From Vision To Execution. Future redesigns can learn from Southern Prairie Community Care's phased approach to rolling out its technology model, as well as its phased engagement of stakeholders – starting with top executive alignment and moving down to implementation – in planning large-scale transformation efforts.

   - Plan For Variance In Governance, Skills And Champions With Each Phase Of Change. Aligning commissioners first and foremost remains essential. Throughout Southern Prairie's design and development, champion advocates for the project emerged at every level (commissioners, top administrators, and supporting service leaders), and the phases of engagement (from Joint Powers Board to design committees to the Center for Community Health Improvement) have offered clear paths for stakeholders to remain engaged in decision-making. Maintaining an evolving governance structure of this nature, all while keeping commissioners informed and preparing for future changes, requires significant time and favors soft skills in communications, engagement and negotiations over the technical expertise typically favored in healthcare, public administration and related fields.

   - Set Process and People Benchmarks, In Addition To Technical Goals. While Southern Prairie did not have specific phased goals for engaging people, implied goals and strategic processes emerged through this process evaluation. Future efforts would be well-served by creating deliberate goals and benchmarks for stakeholder and public engagement at each phase of the change process. Benchmarks could consider awareness, internalization and adoption of the redesign's new ideas and approaches across key audiences: commissioners, top managers and administrators, middle managers and front-line staff, patients and their support networks, and physicians and independent professionals, to name a few.

- **Allow Sufficient Capacity To Build Trust And Sustain Communications**. Communications and engagement is time-intensive work – particularly when striving for shared understanding across organizations. For example, Southern Prairie currently has 11 staff (Dr. Anderson and 10 project managers) dedicated to facilitating understanding across organizations. When exploring the early concept of Southern Prairie, commissioners hired a consultant to facilitate their communications, strategy and research, and to help manage stakeholder engagement in the early governance. Southern Prairie Community Care has succeeded in implementing its model because leaders have committed the time and capacity needed to facilitate open dialogue, communication and trust throughout the process.

2. **Create A "Best Practices" Approach For The Redesign Process That Gives End-Users And All Cultures An Active Role In Designing Future Systems**. Transforming the way public services are delivered – whether education, human services, healthcare or transportation – is a significant policy and management undertaking that has historically lived within the confines of state and local governments, and too often failing to engage county commissioners and top executives in the process. Yet, despite these significant considerations, the best redesigns must go beyond engaging governing leaders to also engage the public -- and particularly communities of color and those traditionally excluded from the systems in redesign -- in designing and implementing new approaches to delivering services. Philanthropic and state leaders can support public officials by convening a team to develop a new "Best Practices" approach to the redesign process that gives the public, and particularly communities of color, an active voice in both the design and implementation of redesigned systems. Steps to creating a "Best Practices" approach could include:

   - **Convene A Broad, Credible Work Group To Guide Approach Development**. Bring stakeholders from local government (county commissioners, city council members), service delivery (human services, healthcare), and low income communities and communities of color, as well as statewide leaders in government, business and philanthropy, to develop guiding principles and a "Best Practices" approach for redesign in Minnesota.

   - **Execute An Engaging Process To Feed Broader Public Input And Lessons Of Redesign Into The Process**. Activities like learning sessions, evaluation presentations, social media outreach, and other engagement strategies can ensure that a diversity of perspectives contributes to shaping the future of how public services are designed and delivered. These audiences can also be engaged for distribution of the final "Best Practices" approach.

- Establish A Redesign Process "Owner" In State Government. Create a position or small office within state government – perhaps within the Minnesota Department of Human Rights or piloted within the Minnesota Department of Human Services – charged with shepherding the "Best Practices" across administrations and deploying process tools and technical assistance to local governments working on redesigns across Minnesota.

3. **Build A Pipeline Of Leadership To Enable Big Changes And Tomorrow's Services**. Leading significant changes, like what Southern Prairie is undertaking, requires significant aptitude in negotiation, policy-setting, communications and community engagement just to get work to a place where traditional program administration can resume under a new model. These skills have not historically been required of government staff to the same degree required in redesign, a challenge compounded by the fact that many state and local government leaders and staff will retire in the coming years. Supporters aiming to encourage future redesigns of Southern Prairie Community Care's scope may consider talent and skill pipeline ideas for state and local governments, such as:

- Building Skills And Leadership Among Current And Future Public Leaders. Creating training programs, technical and adaptive leadership skills, technical assistance, or project-based leadership development programs can help ensure the next generation public leaders are empowered to successfully drive change.

- Developing Networks, Venues Or Vehicles To Facilitate Honest Learning Across Redesign Projects. No change process is perfect, yet many public administrators work within the confines of perfection or secrecy on a daily basis. Creating a safe, neutral space – whether a network, conference or other gathering and connecting strategy – for key staff managing redesigns to learn from each other and establish best practices could be a powerful accelerant, helping to speed success of projects underway and expand leaders willingness to redesign.

4. **Create An Environment That Enables Effective Redesigns**. Rethinking whole systems and changing the bureaucratic structures that govern public services is, at least in part, a political (not partisan) process. Through strategic engagement of community, business, nonprofit and foundations, and state and local government leaders, Minnesota has the capacity to elevate redesign as a vehicle to improve services, close economic and racial disparities, and sustain the state's first-class quality of life. Some strategies to create an environment that supports redesign and holds change harmless from the trappings of partisanship could include:

- Defining The Case For Change And The Vision For Minnesota's Future. Articulate the value of improved services through research (economic, management and demographic, among others), case studies and other tools to illustrate policy's impact. Redesigns enabled by legislation passed four years ago are just beginning to bear fruit, creating a unique opportunity to fully catalog the opportunities, challenges, costs and benefits of such transformational change.

- Applauding and Supporting Signs of Success Statewide And Across Sectors. Conferences, learning events, awards and elevated communications are some strategies available to highlight redesign's successes to leaders and the public at large. The Bush Foundation sponsors the Humphrey School of Public Affairs' local government innovation awards, providing one example of such applause.

- Creating A Shared Strategy To Sustain Leadership-Level Attention Through The Changes Of Politics. The Dayton Administration will draw to a close in 2018, when a new administration will assume leadership of state agencies and potentially set a new course. Legislative and county commission seats will turn over in the interim. The constant churn innate to politics can make significant, transformative redesigns particularly difficult to achieve and sustain to a degree that will achieve real cost savings – unless other sectors pick up the mantle of redesign and facilitate consistency across political administrations. Whether a targeted outreach and communications campaign, a convened partnership of leaders advocating redesign, a focused grant program or another strategy altogether, creating one consistent strategy to engage and inform leaders across sectors could be a powerful tool to sustain positive momentum of changes underway and keep redesign above the fray of politics.

Quotes

Factors In Formation

"Credit really needs to go to Norm Holmen, who has really stuck with the project and the process. He had the relationships with DHS. Knowing that the good work is recognized by DHS is important for us, too." **County Commissioner**

"Meetings started six years ago, now. We kept the relationships together and we kept meeting. We were able to become really practical really quickly because of the relationships built over the course of the conversation and the trust gathered through the process." **Human Services Administrator**

"*Starting out, this was really the rejuvenation of a board that was originally about coming up with our own version of Prime West. We hired a consultant (Halleland) and probably morphed four times in five years. We were really trying to figure out the best configuration of what we were going to be for where we were going… It feels like this part of the state, we trust each other more. Sometimes there isn't a lot of trust between boards. It gets hairy when there's a lot of taxpayer money invested. No one wants to be responsible for doing wrong with it."* **County Commissioner**

"Get the counties building trust early. This isn't a turf battle. Serving the region is first. Dollars are second." **County Commissioner**

"This region has a history of working together to deliver services. SPCC is taking that culture to the next level." **County Commissioner**

"*County commissioners are money people; they have to make sure that they don't overspend what their tax base allows. They hear from sheriffs, welfare directors, corrections departments that there's a lot of people who are engaged in those systems who have significant health problems. The coordination of care amongst providers, of all different types – it's poorly coordinated and that costs counties lots of money."* **Mental Health Provider**

"Of the 12 counties [in Southern Prairie], six are already part of Southwest Health & Human Services. In the north, five of the counties share a public health district and several others are working together on behavioral health. This region has a history of working together to deliver services. SPCC is taking that culture to the next level." **County Commissioner**

"There have been a couple iterations of what "it" is [e.g. Southern Prairie]. We know where the high costs are for counties. It's in healthcare and it's in human services. Our challenge was: how can we create the groundwork to connect with that new model? Commissioners understood that risk and believed it was worthwhile." **Human Services Administrator**

Formation Process

"I think our strengths in the process has been our ability to let commissioners redesign the redesign. Scott Leitz did a lot of work. He did a lot of work, not sure if we were going to move or not. We had to be open with each other about what the variance in the model could be." **Human Services Administrator**

"The counties aren't the center of the universe here (with SPCC). County contracts are gold, though. Those contracts are something that gets the attention of providers and others in the area, so we have that lever for influence." **Human Services Administrator**

"*Our next challenge once everyone agreed to the vision was to look at the conceptual model and make it real. Mary [Fischer, executive director] was at Lincoln-Lyon-Murray …… She had been in county government and she had been a hospital administrator, so she knows how all sides work. She had the ear of commissioners, which is also really important."* **Human Services Administrator**

"I'd heard about this [idea], and I was invited to a meeting at least two years ago if not longer. At that meeting was Keith Halleland. I happened to know these people. They talked about a rural ACO model that incorporated government services. I come into this meeting – what was cool for me was I started listening to these guys and thought, "Hey, I know this stuff." It was an opportunity to be the smartest guy in the room. …About six or eight months after that, they started to get some traction and become SPCC. From the standpoint of actual SPCC, I've been involved since the beginning." **Mental Health Provider**

"The challenge for us was selling the concept to people who weren't directly involved. We know how to manage transactions and the existing model. In this context, SPCC is a conceptual framework. It's not tangible. How do you sell a concept without a product? It's really hard for the public system to get past this…… Once the cost estimates were in place, we crossed a big hump. We could show them that by carving out 2 percent, 4 percent of a drop in costs, here's what care could look like. One statistic everyone comes back to – 50 percent of the prescriptions in the area went unfilled. That really stuck with people." **Human Services Administrator**

"There are so many organizations working to change the way we practice. HCAP, MDH, DHS, health reform. It seems like everyone has a different way they want us to change. The value of SPCC will be getting some ownership of how we change." **Healthcare Administrator**

"County administrators were the early skeptics. They pushed back hard. It's too much risk for them. Laying out the case for a lack of local control and the financial costs helped us get over the hump." **Human Services Administrator**

"There was a huge learning curve for us in terms of understanding, and I'm not even completely there now, how the medical community looks at things, how the health plans work with...that's a huge curve for us to learn. In public programs, transparency is just expected. You have a contract that's public – anyone can request a copy of that. Companies are sometimes quiet about this, and the medical community is deeply competitive. The idea that you'd work with a hospital/clinics cooperatively has been an uphill climb. There's an underlying question of whether you're giving your opponent a leg up. The counties are neutral in this; we're not here to take over the medical community. We want to be the link to make it work better." **Mental Health Provider**

"*There was lots of anxiety about moving forward. It's a daunting challenge. We got it, and then oh no we don't got it. It's an awfully big project and very innovative – you can't just find people who've been doing this. It's been a demand in terms of time commitment from people, but many have stepped up – human service directors, commissioners have really stepped up and pulled in outside expertise….So we get some outstanding people who step up and want to help with it. We've been able to get some pretty good people."* **Public Health Administrator**

"To move past the challenges, we had to sit down one-on-one with each member of the county board, human services directors, have staff meetings and the like. We really had to put a lot of face time." **Human Services Administrator**

"Another key thing for us overcoming challenges was the example "Charlie." It was our example patient who presents to all of us in different ways. And we're all paying to give him services, and the county is paying for it all. That example patient was really our conscience for a long time, and still is." **Human Services Administrator**

Early Implementation & Signs of Success

"Care coordination process: it's brand new for us. We started off a little slow -- trying to understand the concept, the model, the role, what they're doing, etc. ……SPCC put together a great training for care coordinators; that provided some clarification and direction for our staff, helped us figure out how to promote the service in house, help the staff understand the service they're provided." **Mental Health Provider**

"Every meeting is something new. We have a physician on staff to get buy-in from doctors. All hospitals, nursing homes, mental health providers. That buy-in is critical. People were skeptical but it grew. DHS grant gave credibility with the health partnerships. In mental health, providers rarely connect with physicians. We didn't realize the lack of communication within the system. The costs keep going up, but the outcomes don't." **County Commissioner**

"Previous administrators didn't work together. Conversations started in the 1990s, and it provided a vehicle for people to work together. Integration coordinators are having an impact now. [One staff member has] done coordination work for 12-15 years and

never had a physician call back. Now, she's getting her calls returned, which is amazing. It's becoming easier to connect people across time." **Staff**

"HIE implementation is another success. Operational aspects are essential to making it work. I see greater understanding and provider challenges. Understanding what's going on with a patient across silos is key to integration, and the HIE is important for that. [We want everyone to] appreciate the perspective each group brings to supporting health overall. People are appreciating different skills, perspectives and the like. People are starting to appreciate the different skills and perspectives of others." **Staff**

"With anything new, there's always learning curves. I think for this, they have been good at starting a project and rolling it out. If it doesn't look like it's going to go, they're willing to take a step back. Our partners may not get this, so we need to spend one-on-one time educating and getting feedback. They wanted to roll this out right away, but that doesn't always fit with our timeframe. They've been very good at taking steps back, but we need to communicate more with partners and do a slower implementation than originally planned." **Mental Health Provider**

Expectations & Lessons Of Change

"We're also finding out that these things [changing systems] are hard to do everywhere; we're optimistic knuckleheads, but we're going to do it anyway. Tremendous opportunity here, and we have the right people at the table." **Mental Health Provider**

"Having good staff is what has allowed us to excel. Getting buy-in and seeing everyone else start to get it now is great. We have provider groups help us with design because they know what's best. We have doctors, human services staff involved and weighing in on "how can we make it better?" Also, having the trust factor across counties has been key." **County Commissioner**

"I think DHS' investment in us has been a big turning point. Lots happened after they gave SPCC a vote of confidence. It brought more players on board. Lots fell into place. And I think the general value proposition of Southern Prairie is really good and important. Better health outcomes, quicker and more efficient service and more cost effective service. That matters." **County Commissioner**

"Pulling stakeholders together and how they interrelate. Getting staff to manage the process. Next, the nonprofits' roll out of the program and services will be key. SPCC is really an opportunity to exchange information. It's important, but it's not always easy. Every group that's come on board has been hard. Technology is a lot of work, and we lack a lot of the technical resources to make it work. Right now we have six IT people. Public health or mental health, they have zero. None use the same software. It seems simple at first, but you dig in and getting this technology off the ground is really a lot of work." **Healthcare Administrator**

"I do think we underestimated the amount of foundational work that would need to happen. People have so little time for collaboration. The challenges are in carving out time. It's also a big technology component. Much less about technology itself, and more about getting agreement on the policy, information sharing and consistent implementation that is important." **Staff**

"Rolling out to a whole population requires a lot of advance communications. A lack of communication and education is something I would put more time into [if we had it to do over]. We need to present everyone with an opportunity to succeed together so they can jump on board. " **Healthcare Administrator**

"Success is really three things: 1) convergence of staff / case managers; 2) participation in an ACO; 3) Better understanding of the savings possible and what's available through the Medicaid dollars. Right now we have a lot of money going to the St. Cloud region. Our goal is to partner within the region so we can keep cardiologists in the area; keep specialists in the area and all of the dollars those specialists command." **Healthcare Administrator**

"One year from now, I'm hoping that they'll have some data showing some bending or slowing down of Medicaid expense growth across the entire region. A reduction in total cost of care. Hope to see an operational HIE that will lead us in directions and identity things we don't even know exist. Opportunities we don't even know exist." **Mental Health Provider**

"I think we, at a county perspective, were fairly naive about how the medical community operated. We banged our heads for a while, assuming they operated like us. That's faulty thinking on our part. ….The concept of how we like to share our good ideas and brag about it; we assumed other people did that too. That's clearly a mistake. We have a big meeting and bring providers in to educate them. You need to go to them, rather than make them come to us. We needed to go to them, talk to them in their environment and what we could do for them in that setting. It took us a while to learn. We might have gotten there quicker if we'd known." **Human Services / Public Health Administrator**

"[Looking back] communication and education is something I would put more time into. We need something to incentivize others to participate (doctors, MA patients, etc.). We need to present everyone with an opportunity to succeed together so they can jump on board." **Healthcare Administrator**

"For customers/consumers, we want one place to call home from a healthcare standpoint. Mary's presentation on the Charlies of the world gets to the heart of this. We need to have reliability, simplicity and we need to get there sooner for people. Transportation is another big deal. We need to keep people in the system to deliver the care that's expected." **Human Services Administrator**

"Truly improved health outcomes will happen only when we recognize value of paraprofessionals to help people improve their health. More time with your doctor won't improve overall population health outcomes, if we can do more preventative outcomes, that's what it's going to take to move us. We all need to sing across that sheet of music." **Mental Health Provider**

Recommendations For Others

"One of the best efforts for me, as a commissioner, has been the county health board association that we participate in through [Minnesota Department of Health]. There's one commissioner from each county that attends, as well as staff, and it gives us a chance to talk with state staff and the commissioner a few times a year about what's going on at the ground level. I would love to see DHS take a similar approach to helping all of the counties wrestling with how to do services differently." **County Commissioner**

"Have a financial sustainability plan beyond shared savings. Have a partner that helps you develop. Costs are more than the savings [at first]. Seek out specialized expertise. Staffing for the work is a real challenge. You need expertise to keep moving. Skills and ability must be available." **Staff**

"Getting the information system in place. People keep saying "when" because it's the tangible thing they know to look for. We need to have it be more focused. It's a tangible product from that point of view. We underestimated the complexity of technology. Another thing to consider: think about how stuck in a routine and boxy counties can be. Concentrate on where it counts to change a system."
Human Services Administrator

"Certainly trust. We have 12 counties working together. Some counties are not part of the group, they voted to opt out. This was a group committed to doing a better job from the get-go." **County Commissioner**

"Get the counties building trust early. This isn't a turf battle. Serving the region is first. Dollars are second. At the end of the day, I believe in it." **County Commissioner**

"The biggest thing to get right is buy-in and representation from wide groups. My commissioner convinced me to get involved. Buy-in and agreeing to the same thing is key." **Healthcare Administrator**

"Think about how stuck in a routine and boxy counties can be. Concentrate on where it counts to change a system." **Human Services Administrator**

"Advice for DHS: Keep up with the vision. Can't lag on contracting, etc. Counties want it to go faster. It takes time and people who are successful in the system don't stay long. DHS's staff changes hurt us; we had to regroup and build new relationships. But in the end we're made it through." **Human Services Administrator**

"I think ongoing communication and feedback is really important – the flexibility to adapt as you move along is important. Look at avenues for everyone around the table, and how you can work together. Be flexible to one another's needs." **Mental Health Provider**

"Take the plunge. Business as usual is not sustainable. It's not going to work. We cannot keep doing what we're doing; the healthcare system in this country is broken. It's ripe with inefficiencies and bad outcomes. We spend almost double per capita on healthcare in this country compared to other western countries, and we're about 17th in health outcomes. We don't have the best healthcare system in the world. Government can play an important facilitative role, but if I was going to recommend county governments looking at this, they have to be willing to resist the temptation to regulate. Just champion it, be a cheerleader, invest a little bit of money to get it off the ground, and get out of the way." **Mental Health Provider**

"Commissioner Jesson and HHS; they've been amazing to work with. Very early on, when we looked at county based purchasing, they've worked hard to assist us and do some creative things on their part. I've been really impressed with their work." **Human Services Administrator**