

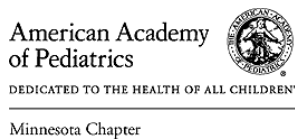


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Minnesota Health Care Home Capacity Assessment: Clinics and consumers identify their readiness for health care reform and Health Care Home implementation

June 30, 2009

A primary care collaboration with:



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Executive Summary

Health care homes, also nationally known as medical homes, are a cornerstone of the comprehensive, nation-leading reforms passed in Minnesota in 2008. Health care homes (HCH) are an innovation in primary care in which primary care providers, families and patients work in partnership to improve the health and quality of life for individuals, especially those with chronic and complex conditions. Health care homes put the patient and family at the center of their care, develop proactive approaches through care plans and offer more continuity of care through increased care coordination.

To successfully implement health care homes in Minnesota, it is vital to first understand how ready providers and patients are for this new model of primary care. This capacity assessment serves as a report on the current readiness of both primary care clinics and health care consumers for health care homes.

Between January and June 2009, health care providers, primary care clinics (family medicine, pediatrics and internal medicine), and consumers provided input to the HCH capacity assessment. A total of 707 state-contracted primary care clinics were invited to participate in the primary care survey; 373 clinics completed the survey (a 53 percent response rate); 68 percent of respondents were urban and 32% were rural clinics. Five focus groups were conducted statewide to solicit consumer input in preparation for an on-line consumer survey focusing on questions related to health care access, input on their primary care clinic and knowledge of/interest in health care homes. Over 560 consumers statewide completed the survey.

Based on this assessment, the authors conclude that a majority of responding Minnesota primary care clinics are preparing for health care home implementation. The majority (272 or 73 percent) of primary care clinics that responded to the survey self-reported that they had some of the components of HCHs already implemented in their clinic.

- More of the responding clinics that said they had already implemented some HCH components in their clinic are located in urban areas (76 percent) compared to rural areas (24 percent).
- Clinics that reported participating in the Minnesota Medical Home Learning Collaborative were more likely to have implemented some of the components of HCH in their practices.
- Potential barriers to implementation include workforce and staffing shortages and start-up costs:
 - Nearly 62 percent of the clinics indicated that workforce shortages or staff time are a possible barrier to implementing HCHs.
 - More than 70 percent of Minnesota clinics identified start-up and/or organizing costs as a possible barrier.

The assessment also found that consumers are somewhat aware of health care homes, but it is clear that more must be done to educate consumers about the concept. Generally consumers expressed satisfaction with the quality of health care they receive at their primary care clinic, but less than half were satisfied with the costs of health care.

- Over 60 percent of consumers stated that they had heard about “health care home” or “medical home” concepts.

- But when asked if they understood what is meant by the “medical home” or “health care home” concept, 38 percent of consumers expressed that they did not feel they had a solid understanding of the definitions of a health care home.
- Consumers were asked to rank the most important parts of a “health care home” to them. The most important parts of a health care home would:
 - Help them coordinate care among multiple providers (58 percent)
 - Possibly save money on health care expenses (57 percent)
 - Improve communication (57 percent)
 - However, more than 20 percent of consumers did not feel they had enough information about Health Care Home to answer the question.
- Nearly 42 percent of consumers were unsure of how a Health Care Home would impact them and their health care, while another 15 percent said a “health care home” would make no difference to them.

There is a considerable gap between clinic and consumer perspectives about current use of health care home components. The project found that the consumers and clinics have different perspectives about the current use of care plans, care coordination and involvement of patients in quality improvement efforts. This indicates that more education is needed on both sides about definitions and implementation of these HCH components.

Summary of Recommendations

Based on the assessment, we recommend a number of steps to further support the successful development of HCHs in Minnesota. For more details, please see the recommendations section on page 28.

1. Target outreach to primary care clinics that report implementation of at least half of HCH components and provide them with information on the HCH certification process. This outreach would use the assessment results to identify the specific clinics most likely to be successful in implementation so that resources can be initially focused toward those clinics.
2. Provide focused outreach with HCH resources and education to less prepared clinics, clinics that reported that they did not know about HCH components and non-responding clinics.
3. Provide information collected through the capacity assessment about desired training and education needs and methods to the HCH Resource and Education Committee and the HCH Learning Collaborative.
4. Explore ways to engage and educate consumers regarding the HCH model.
5. Provide education to consumers and clinics about opportunities at the clinic level for patient/family input in clinic service and quality improvement. Attention to clinic development and patient education on care plans is a priority.
6. Develop state and private initiatives to address health care work force shortage and retention issues because clinics report this is a barrier to HCH implementation and consumers report it as a barrier to health care access.
7. Identify sources of funding for clinics to help with practice transformation and communicate that information to clinics.
8. Pursue opportunities to provide assistance to clinics with facilitation of internal decision-making and implementation of practice transformation and with assistance in managing the necessary cultural changes.

Introduction and Background

The interest in and momentum for health care homes, or medical homes, has been building in Minnesota for the past five years. The initial Minnesota medical home project provided primary care coordination and family-centered care for children with complex/chronic conditions in 2004 as a federally funded health project.

Medical home legislation was first passed by the Minnesota legislature in 2007. The medical home legislation was identified as provider-directed care coordination for patients with complex illness in the Medicaid fee-for-service population (now called primary care coordination). This provider-directed care coordination model is patterned after other state and national health reform initiatives with proven cost-saving and quality-enhancing outcomes.

Also in 2007, Minnesota launched several initiatives to study and make recommendations related to health care reform. The Governor's Health Care Transformation Taskforce and the Legislative Commission on Health Care Access both met throughout the summer and fall of 2007. Both issued recommendations for health reform in Minnesota, including endorsements of medical homes. Those recommendations, in turn, lead to the passage in May 2008 of the state's nation-leading, comprehensive health reform law that included a variety of components aimed at improving the health of the population, the quality of care, the affordability of health care and the individual patient experience.

One of the main components of the 2008 health reform law is the health care homes initiative. Minnesota has adopted the term "health care homes" rather than "medical homes" in order to indicate a broader focus on improved health care coordination, community involvement and health promotion.

The 2008 law builds on the momentum of the health care home concept-that this is an idea with the potential to transform primary care delivery and create more patient- and family-centered care. The law allows for providers to become health care homes and for patients to go to health care homes for their care. It also represents payment reform by creating a care coordination payment for health care homes. The Minnesota Departments of Health and Human Services are collaborating to implement the various aspects of health care homes in Minnesota.

This capacity assessment had a dual purpose of both assessing clinic and consumer readiness for this reform and providing education to health care providers and consumers on the components and expectations of health care homes. Minnesota residents, as consumers of health care, were also asked to provide input on their current level of satisfaction with primary health care provided by their health care providers.

Guiding Questions

Six key questions were identified by the Minnesota Department of Health for inclusion in this assessment:

1. What are the current primary care clinic demographics in the state?
2. Are clinics ready to begin health care home implementation?

3. Which clinics are most ready?
 - a. Where are they located
 - b. What do they have in common?
4. Which clinics are least ready?
 - a. Where are they located?
 - b. What do they need to become ready?
 - c. What do they have in common?
5. Which clinics meet initial health care home standards and may be identified as most ready to move forward with health care home certification?
6. What is the consumer's understanding of and perceived need for a health care home?

To answer these questions, a project team composed of representatives from the Minnesota Department of Health, the Minnesota Chapter of the American Academy of Pediatrics Foundation (MAPF), the Minnesota Academy of Family Physicians (MAFP), the MAFP Foundation, the Minnesota Chapter of the American College of Physicians, Stratis Health and the Minnesota Department of Human Services conducted the project between December 2008 and June 2009. This public - private partnership of organizations supporting primary care providers and state agencies provided multiple methods of outreach to the stakeholders in Minnesota who could answer these questions.

Methodology

The Minnesota Department of Employee Relations provided an initial list of more than 900 primary care clinics in Minnesota to the project team. This list came from the primary care clinics that contract with the state for its employees in fiscal year 2009. After the deletion of duplicative clinic listings, closed clinics and clinics that self-identified as not providing a full spectrum of primary care services, the list included 707 clinics. These primary care clinics (family medicine, pediatrics and internal medicine) were surveyed to receive primary care provider input.

The survey period was April 16 through June 10, 2009. The project team contacted clinic managers, quality improvement managers and/or medical directors for each clinic in several ways- twice by e-mail, twice by mail, and by phone to increase survey participation rates. Respondents completed an online survey or paper survey. A copy of the survey and summary of the project is described on MDH's Health Reform Website at <http://www.health.state.mn.us/healthreform/homes/capacity.html>

Methods utilized for seeking consumer input on their readiness for health care homes in Minnesota included:

- Input from statewide consumer focus groups
- Consumer participation and responses from a web-enabled consumer survey (including fax-back and mailed-in responses)
 - There were 563 total respondents to the survey, including 384 metro consumers (68 percent), 179 non - metro consumers (32 percent)

Key consumer questions to be addressed were identified early in the planning process by the MDH planning team. Consumer focus groups were conducted statewide to identify broad areas of satisfaction and concern with health care home concepts and to provide consumer education. Five focus groups were conducted by William & Kaye, Inc. in the East Metro (Maplewood), West Metro (North Minneapolis), Duluth, Moorhead, and Marshall. The focus groups included 46 participants and were conducted between April 22 and April 29, 2009.

A web-enabled consumer survey was promoted through multiple presentations, public service announcements, and communications with organizations statewide. It was available online, and in a mail-back/fax-back version between May 1 and May 28, 2009. It included 563 respondents (687 began the survey and 82 percent of those completed the survey). Consumer input was coordinated by one of the consortium partners, the Minnesota Academy of Family Physicians Foundation under the leadership of Lynn Balfour.

Project Findings

Part I: Clinics

Primary care clinic demographics in Minnesota

Seven hundred and seven (707) primary care clinics were identified in Minnesota. The project team e-mailed all clinics with a known or recent e-mail address inviting them to participate in the health care home capacity assessment online survey. Non-responders received two electronic reminders, two mailings, and at least one phone call. Three hundred seventy-three (373) respondents completed the survey, a 53 percent response rate. Figure 1 identifies the location of the 707 primary care (family medicine, internal medicine, and pediatrics) clinics invited to participate in this survey.

Figure 1. Map of Minnesota Primary Care (Family Medicine, Internal Medicine, and Pediatrics) Clinics

Note: This map was developed using the zip code of each primary care clinic. The size of each dot represents the density of the clinics in that zip code. Therefore, the location of the dot is in the center of the zip code, not exactly where the clinic is located.

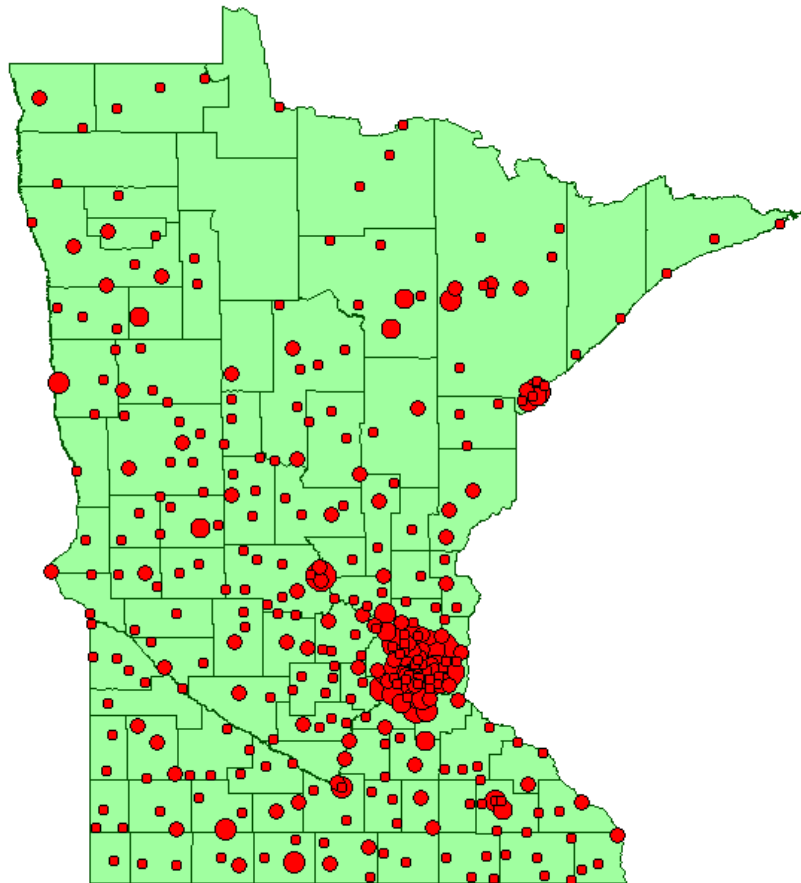
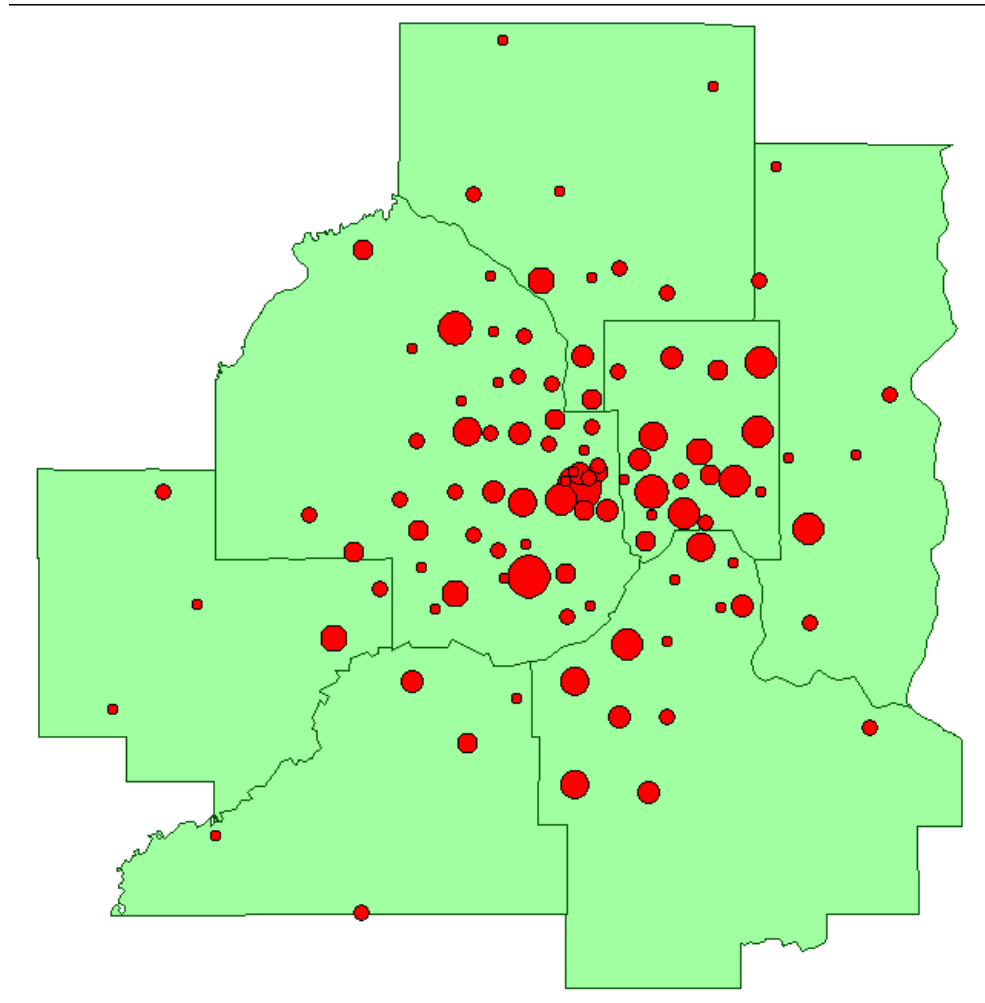


Figure 2 provides additional detail regarding the primary care clinics included in this survey that are located in the Twin Cities Metropolitan area.

Figure 2. Map of Primary Care Clinics Located In the Twin Cities Metropolitan Area

Note: This map was developed using the zip code of each primary care clinic. The size of each dot represents the density of the clinics in that zip code. Therefore, the location of the dot is the center of the zip code, not exactly where the clinic is located.



The Rural-Urban Commuting Area (RUCA) codes, version 2.0, were used to designate clinics as rural or urban (Table 1).¹ Based on zip code, clinics with a RUCA code of 1-3 were designated as urban, and clinics with a RUCA code of 4-10.6 were designated as rural.²

¹ University of Washington, WWAMI Rural Health Research Center, <http://depts.washington.edu/uwruca/>.

² University of Washington, WWAMI Rural Health Research Center, <http://depts.washington.edu/uwruca/codes.html>.

Table 1. Rural-Urban Designation (RUCA) for HCHs Survey Respondents and Non-Respondents

	Respondents		Non-Respondents	
	N	%	N	%
Urban	252	68%	162	49%
Rural	121	32%	172	52%

Slightly more than 44 percent of respondents described their clinic as a medical group component of an integrated delivery system, while more than 25 percent described their clinic as an independent medical group.

Table 2. Description of Responding Clinics by Practice Type

N	%	
166	44%	Medical group component of integrated delivery system
95	25%	Independent medical group (example: physician owned)
66	18%	Hospital-based clinic
18	5%	Federally Qualified Health Center (FQHC)
6	2%	Community Health Center or similar practice
7	2%	Academic practice
15	4%	Other

More than half of respondents had the following providers/services at their clinic:

- Family medicine (92 percent)
- Registered nurses (83 percent)
- Pediatrics (77 percent)
- Patient educators (73 percent)
- Obstetrics/Gynecology (72 percent)
- General internal medicine (71 percent)
- Medical interpreters (61 percent)
- Surgical services (60 percent)
- Designated care coordinators (57 percent)
- Pharmacists (50 percent), and
- Dieticians (50 percent).

Less than half of respondents reported having the following providers/services at their clinic:

- Med/Peds (49 percent)
- Mental health professionals (45 percent)
- Therapists (43 percent)
- Social workers (35 percent), and
- Community health workers (7 percent).

Note: For the question, “Which of the following providers/services are available at your clinic?” clinics had different interpretations of whether they should include services provided through their clinic or only services provided by employed providers. One clinic commented that it has a specialist who leases space at the clinic with whom the clinic coordinates care.

Additionally, other services may be provided at the local hospital but coordinated by the clinic. Therefore, the results from this question should be interpreted with the limitation that survey respondents may have interpreted the meaning of this question differently.

Are clinics ready to begin health care home implementation?

The majority of primary care clinics in Minnesota that responded to the survey (**73 percent**), self-identified that they have some of the components of HCHs already implemented in their clinic. Of the 12 percent of respondents who indicated they did not have some of the components of HCHs already implemented in their clinic, 72 percent reported they had considered implementing HCH concepts. A potential group of clinics to target for HCH outreach and education are the nearly 15 percent of respondents that replied that they did not know about the components for HCH.

In order to further examine whether clinics do indeed have HCH standards and criteria implemented in their clinics, it is helpful to explore specific survey questions that addressed individual aspects of health care homes. The survey included a series of questions based on the five HCH standards and criteria currently under development for HCH certification in Minnesota: access/communication; patient tracking and registry functions; care coordination; care plans; performance reporting and quality improvement (see <http://www.health.state.mn.us/healthreform/homes/capacity.html> for complete survey questions). We evaluated how many clinics met 0-25 percent, 26-50 percent, 51-75 percent or 76-100 percent of the criteria identified for each question.

Access and Communication

Clinics were asked which components of access and communication they offered to their patients:

- An on-call primary care provider (physician, nurse practitioner, or physician assistant) directly or via phone triage system 24 hours /day 7 days/week.
- Same-day appointments through a predetermined protocol.
- A protocol to determine which patients with acute care needs will be seen same-day or next day.
- After hours medical care.
- Secure e-mail for patients to communicate with the clinic/providers.
- Telemedicine for patients.
- Timely communication of test results to patients.
- A process to identify patients who are discharged from nursing home, hospital, skilled care facility and process for clinic follow-up.
- Spanish interpreter services.
- Somali interpreter services.
- Hmong interpreter services.

26 clinics (7 percent) reported having all 11 components of this question.

The percent listed below reflects the percent of these criteria the responding clinic reported was present.

Percent of Criteria Present	Clinics	
	Number	Percent
0-25%	5	1%
26-50%	86	23%
51-75%	166	45%
76-100%	116	31%

Clinics were also asked if they had a process to identify patient’s preferred method of communication. This question included four component criteria:

- Preferred language
- Communication by phone
- Communication by mail
- Communication by e-mail

23 clinics (6 percent) reported having all four components of this question.

The percent listed below reflects the percent of these criteria the responding clinic reported was present.

Percent of Criteria Present	Clinics	
	Number	Percent
0-25%	156	42%
26-50%	85	23%
51-75%	109	29%
76-100%	23	6%

Patient Tracking and Registry Functions

Clinics were asked if they have patient tracking and registry functions (electronic, searchable list of patient data to identify, track, and coordinate care) in two areas:

- A patient database or registry to manage preventive care (e.g., mammography, colonoscopy, etc.)
- A patient database or registry to manage chronic disease (e.g., diabetes, hypertension, etc.).

251 clinics (67 percent) reported having both components of this question.

The percent listed below reflects the percent of these criteria the responding clinics reported was present.

Percent of Criteria Present	Clinics	
	Number	Percent
0-25% (all were 0%)	79	21%
26-50%	43	12%
51-75%	0	0%
76-100% (all were 100%)	251	67%

Clinics were also asked if they have a fully implemented electronic health record (EHR). 323 clinics (87 percent) reported having a fully implemented EHR or were working to implement an EHR within six months.

- 253 clinics (68 percent) of the 373 clinics responding to the survey reported having a fully implemented EHR.
- 70 clinics (19 percent) reported that they were working to implement an EHR within six months.
- 50 clinics were not working to implement an EHR or responded “I don’t know” to the question.

Federal stimulus funds have been allocated to assist clinics implement EHR as a component of health care reform. Primary care clinics will be eligible for these funds based on federal guidelines. For more information visit <http://www.health.state.mn.us/e-health/hitech.html> The Minnesota Department of Health is coordinating these efforts through the E-Health Initiative <http://www.health.state.mn.us/e-health/index.html>

- Of the 70 clinics working to implement an EHR within six months, 49 (70 percent) reported that at least 30 percent of clinic patients are covered by Medicare.
- Of all responding clinics, 78 clinics (21 percent) reported that at least 30 percent of clinic patients are covered by fee-for-service Medical Assistance (MN Medicaid) or a Prepaid Medical Assistance Plan.
- Of all responding clinics, 123 clinics (33 percent) reported that at least 30 percent of clinic patients are covered by Medicare or by a Medicare Advantage plan.

Care Coordination

Clinics were asked if they have the following components of care coordination:

- Coordination of resources to help patients/their families to achieve health care goals.
- Referral of resources to help patients/their families to achieve health care goals.
- A referral tracking process for specialty referrals, admissions to hospitals, or skilled nursing facilities.
- A referral tracking process for specialty referrals, admissions to hospitals, or skilled nursing facilities.
- A protocol/process used by the clinic with the patient when it learns of emergency room use, hospitalization, or other discharge plan.
- Shared decision making with patients and/or their families.

Ninety-two (92) clinics (25 percent) reported having all six components of this question.

The percent listed below reflects the percent of criteria the responding clinic reported was present.

Percent of Criteria Present	Clinics	
	Number	Percent
0-25%	116	31%
26-50%	60	16%
51-75%	49	13%
76-100%	148	40%

Clinics were asked if they have a care coordinator, or a person who works with clinic staff, providers, patients/family and community resources to ensure that medical follow-up is provided and who communicates daily with medical providers.

- 205 clinics (55 percent) reported having a Care Coordinator or person who provides the above functions.
- When asked to describe the Care Coordinator, more than 50 percent of these Care Coordinators were a staff position with other clinic responsibilities, a staff position with only Care Coordination duties or shared with another clinic. (Respondents were able to select more than one option for this question.)

Care Plans

Clinics were asked if they develop care plans with patients who have complex or chronic care needs

223 clinics (60 percent) reported developing care plans with patients who have complex or chronic care needs.

If clinics answered “yes” to this question, they were asked a follow-up question about which of the following ten components they included in their care plans for these patients:

- Contact information
- A plan for after hours care when needed
- A plan for emergencies (acute episodes of a chronic condition)
- A plan for preventive services
- A plan for care of chronic health conditions
- Patient’s input/ideas included in the plan
- End-of-life/advance directives (when appropriate)
- Documentation about supports needed for activities of daily living (ADLs)
- Documentation of durable medical equipment (DME) needed
- Caregiver support needed.

29 clinics (8 percent) reported having all 10 components of this question.

The percent listed below reflects the percent of these criteria the respondent reported was part of their care plan at the clinics

Percent of Criteria Present	Clinics		
	Number	Percent of Total Clinics (n=373)	Percent of Applicable Clinics (n=223)
Not Applicable	150	40%	N/A
0-25%	63	17%	28%
26-50%	59	16%	27%
51-75%	20	5%	9%
76- 100%	81	22%	36%

Performance Reporting and Quality Improvement

Clinics were asked if they have a quality improvement team at the practice level.

333 clinics (89 percent) reported having a quality improvement team at the practice. More than 21 percent of these 333 clinics reported including patients and/or families as members of the quality improvement team.

Clinics were also asked if they have or use:

- Training on quality improvement methods for staff and quality improvement team members
- Learning collaborative(s) with other clinics to improve outcomes
- Standardized care guidelines or evidence-based practice guidelines
- Surveys of patients and/or their family members to measure satisfaction with care delivery
- Surveys of patients and/or their family members to measure level of their engagement in patient care
- Surveys of patients about their perception/experience of receiving care at your clinic.

184 clinics (49 percent) reported having all six components.

The percent listed below reflects the percent of criteria the respondent reported was present at their clinic.

Percent of Criteria Present	Clinics	
	Number	Percent
0-25%	12	3%
26-50%	52	14%
51-75%	44	12%
76-100%	265	71%

Clinics were asked if they regularly involve patients and/or their family in their care.

327 clinics (88 percent) responded yes, they regularly involve patients and/or their families in their care.

As to how they involve patients and families, the survey asked about six specific ways:

- Are included in decision-making about their care
- Are asked what care/treatment support they need
- Receive information about community resources (transportation, health insurance, school-based services, home nursing care)
- Are involved in planning for transitions between providers and life stages (i.e., children becoming adults, health insurance changes, etc)
- Provide feedback regarding their perception of care through systematic methods (e.g., surveys, focus groups, or interviews)
- Are involved with clinic staff in a process to review survey feedback and problem solving.

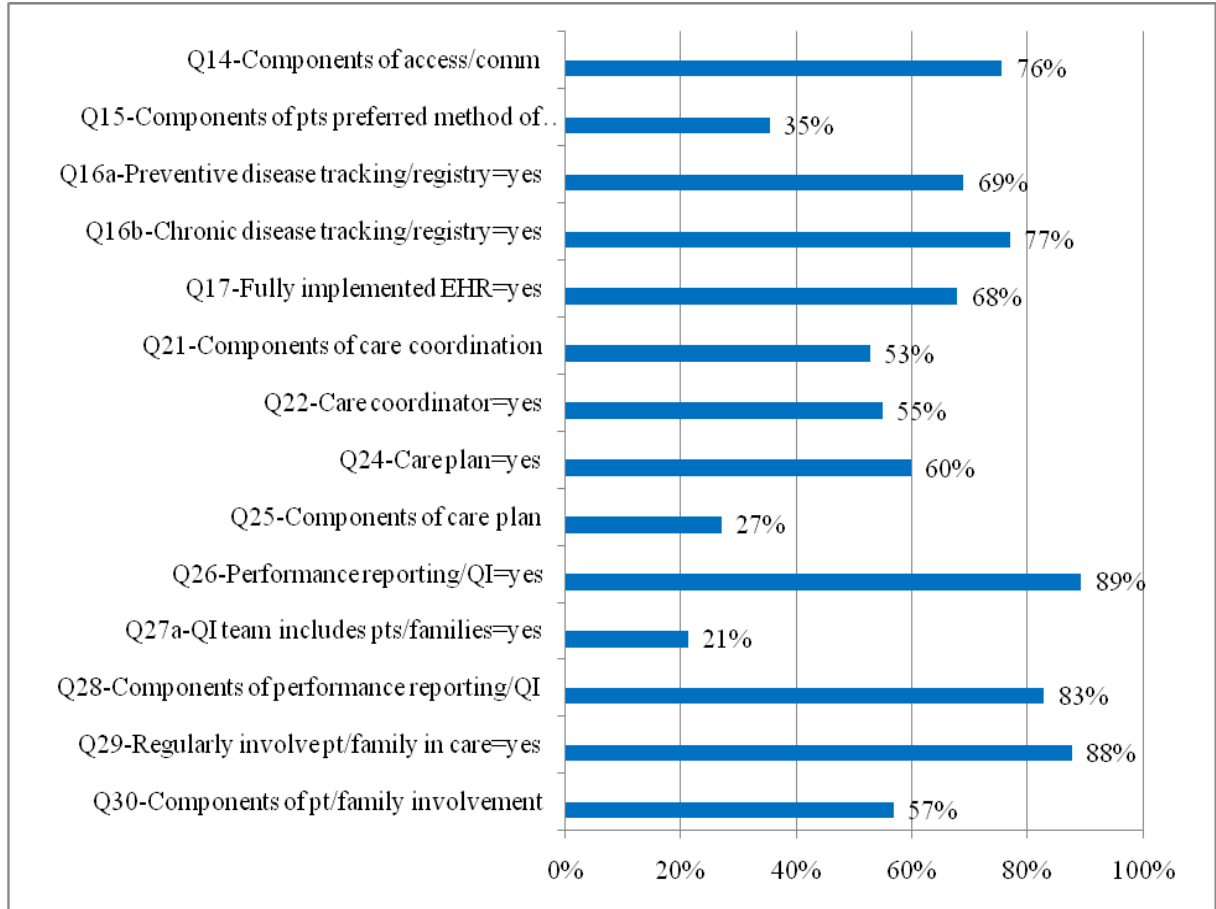
58 clinics (16 percent) reported having all six components of this question.

The percent listed below reflects the percent of criteria the respondent reported as to how patients and/or their families are involved in their care at each of these clinics

Percent of Criteria Present	Clinics		
	Number	Percent of Total Clinics (n=373)	Percent of Applicable Clinics (n=327)
Not Applicable	46	12%	N/A
0-25%	18	5%	5%
26-50%	97	26%	30%
51-75%	61	16%	19%
76-100%	151	41%	46%

Using this same methodology, the project team identified clinics who met 50 percent or more of the criteria identified for each question or responded “yes” for yes/no questions. These clinics were considered to meet the HCH criteria for the specific question. Figure 3 presents what percentage of clinics had adequately “met” the criteria for each question. In order to represent all responding clinics, the denominator for all percentages is 373, the total number of clinics that responded to the survey.

Figure 3. Clinics Meeting HCH Criteria for Each Question



Nearly 33 percent of respondents reported participating in the Minnesota Medical Home Learning Collaborative. This figure does not correspond with the known number of clinics participating and may reflect a multi-clinic response when only one of the system clinics is a Medical Home Learning Collaborative participant.

Of the 123 clinics that responded they participated in the Minnesota Medical Home Learning Collaborative, 98 percent self-reported they had already implemented some of the components of HCH in their clinic.

Clinics that are ready: Who are they? What do they have in common?

Geography

Of the 73 percent of primary care clinics in Minnesota who self-identified they had some of the components of HCH already implemented in their clinic, 76 percent are located in urban areas and 24 percent are located in rural areas. This rural/urban distribution is statistically significant compared to those clinics who reported they did not have some of the components of HCH implemented in their clinic, 57 percent of whom were urban and 43 percent of whom were rural ($p=0.0107$).^{3,4} It highlights the need to expand educational and training resources for HCH readiness into greater Minnesota.

Practice Type

The type of clinical practice or system was also related to the HCH readiness and percent of respondents who self-reported having some of the components of HCH already implemented in their practice:

- 100 percent of academic practices
- 93 percent of clinics who were part of a medical group component of integrated delivery system
- 92 percent of other types of clinics
- 84 percent of independent medical groups
- 69 percent of hospital-based clinics
- 67 percent of Federally Qualified Health Centers (FQHCs), and
- 33 percent of Community Health Centers

Patient Registries and Electronic Health Records

Clinics that self-reported implementing some of the components of HCH were more likely to have:

- A patient database or registry to manage *preventive care* (e.g. mammography, colonoscopy, etc.) than clinics who had not implemented some of the components of HCH (78 percent versus 46 percent respectively).
- A patient database or registry to manage *chronic disease* (e.g. diabetes, hypertension, etc.), than clinics who had not implemented some of the components of HCH (86 percent versus 57 percent respectively).
- An *electronic health record* (EHR), than clinics who had not implemented some of the components of HCH (74 percent versus 50 percent respectively).

³ Fisher's Exact test of significance used for cell frequency less than 30.

⁴ Clinics that responded "I don't know" were excluded from the analysis.

Patient Payer Mix

Clinics that self-reported implementing some of the components of HCH did not have a different distribution of Medicaid patients. They did, however, report serving a lower percent of Medicare patients:

- 64 percent of clinics that had implemented some HCH components reported “less than 30 percent of clinic patients are covered by Medicare” versus 41 percent of clinics that have not implemented the components of HCHs.
- 27 percent of clinics that had implemented some HCH components reported “greater than or equal to 30 percent of clinic patients are covered by Medicare” versus 46 percent of clinics that have not implemented the components of HCHs.

Clinics identified a number of possible benefits to implementing HCHs (Table 3).

Table 3. Possible Benefits to Implementing HCHs

	Yes		No		I don't know	
Improved quality through involvement of patients and families	336	90%	7	2%	30	8%
Improved overall health of the clinic population	326	87%	8	2%	39	10%
Improved patient experience	326	87%	10	3%	37	10%
Partnering more with patients and families in their care	326	87%	13	3%	34	9%
Better coordination of care and reduction in duplication or unnecessary services	316	85%	13	3%	44	12%
Supportive working environment for care teams	303	81%	13	3%	57	15%
Improved patient access to care	288	77%	23	6%	62	17%
Payment for coordinating care	284	76%	12	3%	77	21%
Improved time management for staff and clinicians	226	61%	31	8%	116	31%
Improved ratio of cost to value of care	175	47%	25	7%	173	46%
Reduced overhead costs	83	22%	149	40%	141	38%

A list of clinics most ready to move forward with HCH was provided to MDH staff.

Clinics that are less ready: Who are they? Where are they? Do they want to move forward with HCH? If so, what do they need to become ready? What do they have in common?

Clinics identified a number of possible barriers to implementing HCH (Table 4).

Table 4. Possible Barriers to Implementing HCHs

	Yes		No		I don't know	
Start-up and/or organizing costs	262	70%	43	12%	68	18%
Workforce shortages/staff time	230	62%	83	22%	60	16%
Lack of patient insurance coverage	228	61%	65	17%	80	21%
Certification process	179	48%	81	22%	113	30%
Lack of understanding about HCH	169	45%	163	44%	41	11%
Perception of HCH as a gate-keeping model	123	33%	142	38%	108	29%
Lack of infrastructure/tools (e.g. EHR)	82	22%	242	65%	49	13%
Motivation	76	20%	214	57%	83	22%
Not a strategic priority for the clinic at this time	50	13%	263	71%	60	16%

Clinics identified some key areas of training opportunities:

- Training on the basic HCH model
- Help with engaging participation by all components of clinic system
- Building on current structure
- Specific tools (e.g., registries, care plans, involving patients in quality improvement efforts)
- More definitive information from MDH
- Financial information, and
- Training via collaborative learning.

From the analysis, targeted assistance on HCH implementation is needed for clinics who indicated the least readiness to implement HCH. These clinics are more likely to be:

- In greater Minnesota
- Community Health Centers
- Federally Qualified Health Centers (FQHCs)
- Hospital-based clinics
- Clinics without a chronic disease or preventive care patient registry
- Non-responding clinics that may fit this profile.

Part II: Consumers

What is the consumer's understanding of and perceived need for HCHs?

Consumers participating in the five regional focus groups and the on-line survey provided a wealth of comments and opinions on their current access to health care, their primary care provider/clinic, and their expectations for involvement in decision-making about their health care. Consumer input was received from over 600 Minnesotans in both urban and rural areas through the survey and focus group. Several consumer themes are summarized from both the focus group and online survey.

Understanding the concepts of preventive care and primary care

Minnesota consumers appear to have a solid grounding in the broad concepts of primary and preventive care.

- Nearly 93 percent of consumers agreed or strongly agreed to the statement: “I understand what preventive health care means.”
- Almost 94 percent of consumers agreed or strongly agreed with the statement: “I understand what a primary care doctor is.”

Understanding the concept of health care homes

Many consumers have heard about the concepts of health care homes from various sources:

- Over 60 percent of consumers stated that they had heard about “health care home” or “medical home” concepts.
 - About 40 percent of consumers said they heard about the concepts from TV/radio/newspaper
 - 31 percent said from their clinic
 - 20 percent reported hearing it from a family member or friend.
- Nearly 53 percent of consumers said they understood the meaning of “health care home.”

It is clear, however, that many consumers do not understand what health care homes are or their impact on individual health care:

- Some 38 percent of consumers expressed that they did not feel they had a solid understanding of the definitions of a “health care home”.
- Another 10 percent offered no opinion
- Nearly 42 percent of consumers were unsure of how a “health care home” would impact them and their health care.
- About 15 percent said a health care home would make no difference to them.
- Nonetheless, almost 38 percent of consumers stated that they thought a “health care home” would make it easier to see other specialists.

Consumers were asked to rank the most important parts of a “health care home” to them. The top three responses:

- A health care home would help them coordinate care among multiple providers (57 percent)
- A health care home would possibly save money on health care expenses (57 percent)
- A health care home would improve communication (57 percent).

It is important to note, however, that more than 20 percent of consumers did not feel they had enough information about health care homes to answer the question.

Focus group participants were presented with a description of a health care home, and it still proved a difficult concept to understand:

- Most wondered how much it would cost and who would pay for it.
- Some of the participants assumed that since “nothing is free,” adding a care coordinator would increase the cost of health care because there would be one more person to be paid.
- Participants stated that a care coordinator should be employed by the clinic and not the insurance companies.
- They also said that a health care home coordinator could result in increased appointments and health care services resulting in more out-of-pocket costs for the consumer.

Issues with access and communication

The survey asked consumers to report if they had trouble getting health care at their current clinic. The top four reasons consumers said they could not get health care were:

- They couldn’t get an appointment when they needed one (21 percent)
- Their deductible was too high (15 percent)
- Clinic hours were not convenient (14 percent),
- The wait was too long (13 percent).

The two most common modes of communication between consumers and clinics are telephone and letter/US Mail. The survey asked consumers how their clinics communicate with them about upcoming appointments:

- By telephone (73 percent)
- By letter/US mail (20 percent)
- By e-mail (19 percent)
- Clinic does not contact them about upcoming appointments (15 percent)

The survey also asked how consumers received test results from their clinics:

- By letter/US Mail (62 percent)
- By telephone (55 percent)
- By e-mail (19 percent)

Other consumer comments on access and communication:

- Generally speaking consumers reported a positive experience at their clinic with 75 percent reporting that they felt listened to, received needed information, and felt involved in health care decisions.
- 86 percent of consumers said that their provider was easy to understand
- 73 percent felt the provider was sensitive to their values and customs.

Clinic communication directly with patients for upcoming and missed appointments appears to be very uneven:

- 41 percent of consumers reported that their clinic *did not* contact them about missed appointments, scheduling routine and preventive check-ups, or preparing for an upcoming appointment.
- About a third (33 percent) of consumers reported that their clinic *did* contact them to schedule routine and preventive check-ups
- Only 15 percent of consumers reported that their clinic *did* contact them about missed appointments.

Comments related to access and communication were issues for some consumers:

- “Unable to get time off from work during clinic hours.”
- “Long wait on the phone.”
- “Busy office, not always enough doctors available in the PM.”
- “Exam tables are too high.”
- “No appointments available for preventive care.”
- “Our primary care practitioner may not have an appointment when we need to see him during an acute illness. Sometimes we need to schedule weeks/months out for a preventive health visit with our doctor. We could see others at the practice, but chose not to.”
- “Difficulty talking over results of tests and plan of care directly with my MD.”
- “I am not usually able to get whatever question I might have answered by a nurse and then the time and inconvenience of going back and forth with a physician is frustrating. It would be nice to have an e-mail option for asking questions that can’t be answered by an RN.”
- When visiting the clinic consumers want more time with providers. Less than 10 percent of consumers reported that they felt their provider spent enough time with them.

Partnership with Providers

Consumers were asked a number of questions to explore whether or not they felt like a partner with their primary care provider. Consumers reported a strong desire to be more involved in their health care in partnership with the clinic.

- Over 87 percent said they wanted their clinic to tell them about treatment and medication options.
- Over 86 percent wanted their clinic to involve them in health care decisions.

- Over 75 percent of consumers said that their primary care clinic involved them in health care decisions, provided them with needed information, and listened carefully to their health concerns and questions.
- A majority of consumers felt that they could trust the providers at their clinic (81 percent), felt valued and respected by the clinic (74 percent), and felt listened to by their primary provider (80 percent).
- Only 23 percent of consumers reported that their primary care clinic asked how they can to improve the clinic.

Nearly universal from the focus groups was the desire to know the primary care doctor well and to have the primary care doctor know the patient well. Participants expressed greater satisfaction when seeing “a doctor that knows my health history.” Knowledge seems to equate with more hope that the outcome of the visit to the doctor will “turn out well.”

Care Coordination and Care Plan

The online survey asked consumers how their primary care clinic relates to health care systems outside of their clinic through the use of a care coordinator who manages referrals, appointments, and community services:

- Over 50 percent of consumers reported that their primary care clinic had someone on staff that coordinated appointments to other specialists.
- 49 percent reported that someone on staff coordinates follow-up appointments for them.
- Almost 45 percent reported that someone on staff assisted with coordinating access to their primary care.
- 11 percent of consumers said their clinic did not have someone on staff to help them locate resources and services in the community, while 41 percent said they were “not sure” if their clinic offered this service.

For the focus group participants, care coordination was described as the coordination of care among more than one physician. Use of a care plan was also discussed:

- Participants presumed that a care coordinator at a primary care clinic would mean a new staff member, an increase in operating expenses and end up costing them or their insurer more money.
- Most focus group participants said that they do not consider their chronic or disabling condition (or the condition of the person for whom they are the caregiver) severe enough that they need more help than they are able, themselves, to coordinate or find. The exception is the coordination of care among multiple doctors.
- Concerns focused around the timely transfer of their records from doctor to doctor. Such “needless, duplicate care” is unwelcome and requires them to often “endure” many tests and procedures that have very recently been done elsewhere. Some raised concerns about the costs in ordering duplicate tests and treatment.
- A few of the participants identified “severe depression” or “mental illness” as one area where treatment at a primary care clinic is not handled well.

- Only a few of the focus group participants mentioned having a care plan with their primary care clinic. Those with chronic conditions have taken a very active role in preparing their care plans with a primary care doctor.
- The transfer of information about tests, procedures and medications provided by specialists, etc. is often slow to happen, resulting in incomplete information being available at the time of a next visit to a doctor. Many thought the information for their care plan was in the chart and expected the physician to review the chart for their history, treatment, needs, etc.
- “Lack of continuity in health care providers and differing advice and treatment.”
- Consumers recognized the value in “...coordination of care when needing to work with multiple specialists.”

Cost and Quality of Health Care Provided by Primary Care Clinic

Consumers were asked about their level of satisfaction with the quality and cost of health care:

- A majority of consumers (79 percent) stated that they were satisfied with the quality of health care provided to them at their primary clinic.
- Less than half of consumer respondents (47 percent) were satisfied with the costs of health care.
 - “I am careful about when I go to see a health care provider because of costs. I only go when absolutely necessary and for preventative care.”
 - “Health care is too expensive and we can’t afford it.”
 - “Costs and out of pocket expenses continue to rise.”
 - “Now that I’m on a HSA, I realize everything costs. A pelvic ultrasound is costing \$700 – how can that be possible?”
 - “Too many medical appointments to get medical information.”
 - “Son with autism, hard to find good care close to home, have to travel 1½ hours to the next state. Costs gas, leave from work time and co-pay on health insurance.”

About 82 percent of the focus group participants reported being satisfied with the quality of health care at their primary clinic. Among the 18 percent who were either not satisfied or are unsure if they were satisfied, these reasons were given:

- “Doctor does not listen and absorb what is being said.”
- “The appointments are too short and rushed.”
- “Lack of communication/inconsistency.”
- “Lack of follow-up to appointment.”
- “Quality is excellent; the access is limited by insurance.”

Participants in the focus groups acknowledged that health care is costly and a few who no longer have insurance coverage due to a job loss or an inability to afford paying for insurance find the cost of care prohibitive. A few others were unaware of what their care costs and leave the financial arrangements to the insurers.

- Focus group consumers consistently and clearly communicated their strong dissatisfaction over the cost of health care. Whether it is high co-pays, high

deductibles, high cost of medications, or high premiums, consumers identified that the cost of health care is too high. Their frustration was often directed at insurers.

- “Insurance is overpriced.”
 - “We spend more than \$250/month on co-pays for medications. Premium payments are more than \$600 per month. Other co-pays are deductibles exceed \$3,000 per year.”
 - “After paying for my families coverage, co pays, and deductibles (which keep climbing), I essentially am also paying for almost all of the appointment and any testing costs out of my pocket.”
- Several consumers expressed their concerns about the cost of health care for self-employed, unemployed, and those households with single-income earners. One consumer noted the need to work three jobs for the health insurance.
 - Many expressed the frustration in choosing when to access care because of the related costs.
 - Additional suggestions shared by a few consumers is to have health care not be provided through the employer system, have insurers to cover psychiatric care, move to a single-payer health system, reduce the duplication of lab work and tests by multiple specialists, and reduce the “waste” in having to see their primary care physician for a referral to another specialist because the specialist requires a referral.

Switching to another doctor or clinic to save some money did not appeal to most focus group participants. Most participants were satisfied with their primary care doctor and did not have a reason to switch providers.

If advances in technology and medications have, in fact, helped control a medical condition or help the patient “get better,” focus group participants stated that whatever it costs to develop the technology and medication was worth it. For example, less invasive surgery is identified as one of the advances that has cut health care costs and made a difference in improved health.

Consumers offered these comments and areas of concern to them as examples of waste in the health care system:

- Duplication of tests
- Test results not shared with other specialists providing care.

Satisfaction with primary care provider and areas for improvement

Nearly 80 percent of consumers said they would recommend their primary care clinic to their family and friends. The more than 7 percent of consumers who said they would not or were not sure offered these general reasons:

- “Depends on how strong and organized a person they are; if they can fight to get what they want then yes.”
- “Don’t think it matters. All providers are basically the same. Need whole new health care system.”

Some of the reasons consumers gave for why they could not recommend their primary care clinic included:

- A shortage of doctors at their clinic
- Long waits
- High physician turnover
- They don't like their physician or his/her staff.
 - "The docs are okay, the staff is not family-centered."
 - "I am very satisfied with my individual provider, but do not like the larger clinic system."

Some consumers responded that they could not make a recommendation because they don't have a primary care clinic.

There was a wide range of responses from consumers when asked how they know their primary care provider is doing a "good job:"

- Lack of professional and courteous customer service was listed by many consumers when describing their negative experience at the clinic. Listening was clearly the most recognized ingredient for a good job.
 - "I love my primary MD, the issues at my clinic lay within the staff outside of the physicians aka management, nurses, front desk, insurance reps, etc."
- Other qualities that are valued include being respectful, caring, responsive, available, thorough, knowledgeable, asking good questions, and giving good answers.
 - "The communication is great and my health is great!"
 - "He treats me respectfully, is extremely well-informed, selects medication dosages that can be split in two or four to save money, takes time to listen and provides options for treatment."
 - "She knows me and has developed a relationship with me and shows personal investment in my health."
- Patients also measure quality by the level of involvement they are given in decisions about their care.

Consumers identified suggestions for improvement at their primary care clinic.

- "Less repetitive paper work; reduce wait times; more electronic communication."
- "If you and the doctor don't speak the same language, you have to wait to get care when someone can interpret for you. That can take a couple of days or a week to work out."
- "You have to spend more money to see your doctor to finally get a referral to a specialist. I don't understand why that happens."
- "Someone with chronic problems needs a relationship with one doctor, not shifted between clinic to clinic and seen by doctors who don't know you or your condition."
- "Sometimes hard to see who you want to because there are clinics who won't accept Medical Assistance."
- "I found a doctor that I loved, but she left the clinic and is now on her own. However, I can't see her anymore because my insurance won't pay to see her."
- "The amount paid to doctors by the insurance is too little, and we can't keep good doctors around here."

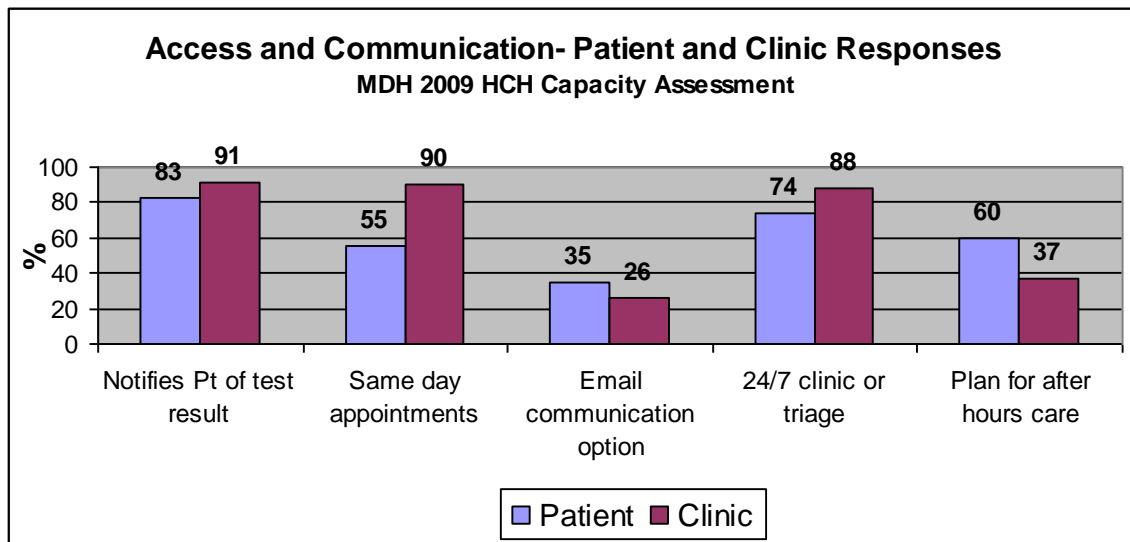
- “The doctors who are here are so busy, it’s almost impossible to get in to see one. When a new doctor comes to town, it only takes a few hours after starting the practice, and you can’t even get in to see the new doctor.”
- “When you are in a wheelchair, it’s really hard to get from the parking area into the clinic and really hard when there is snow on the ground.”
- “Better customer service.”
- “Show better personal interest and caring.”
- “Reminder of appointments.”
- “Offer online appointment scheduling.”

Part III: Gap between clinic and consumer responses

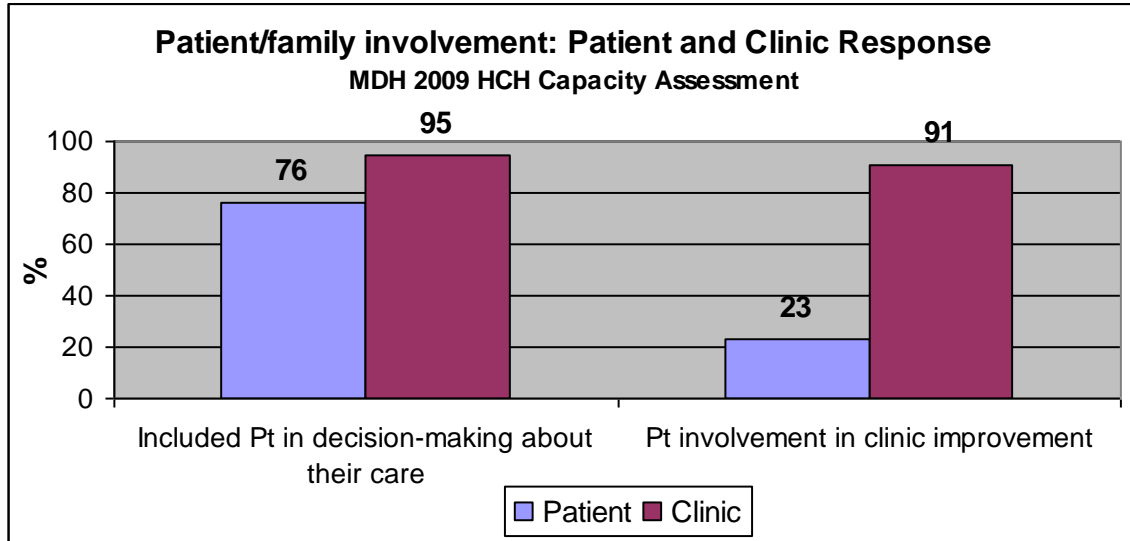
Self-reported responses of the clinics to the same questions asked of consumers were compared for common clinic access and communication methods.

- Clinics reported higher rates of notifying patients of test results, availability of same day appointments, and 24/7 clinic access or triage than were perceived by consumers.
- Consumers reported that their clinic had an e-mail communication option and provided a plan for after-hours care more frequently than clinics reported those access options.

Most notable is the patient perception and clinic practice of providing same day appointments.

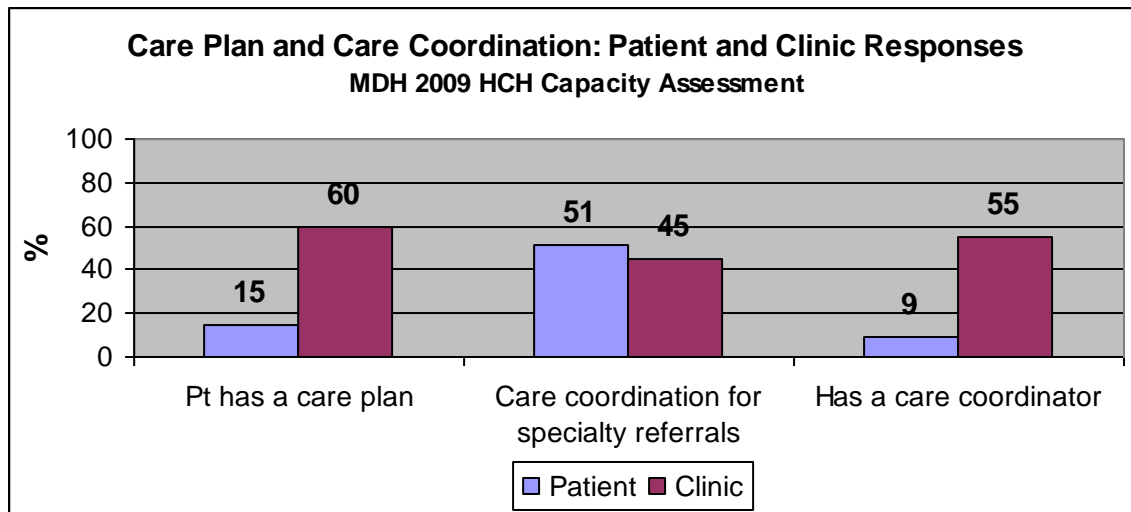


The consumer perception of care provided by their clinic compared to the responses from primary care clinics provided an interesting contrast. Consumers generally identified as less involved/included in their health care decision-making and clinic improvements than the rates reported by the clinics in the clinic survey.



Consumers and clinics were asked about a written **care plan** developed by primary care providers and patients and their families. Interestingly, there appears to a “disconnect” about care plans as reported by clinics and consumers.

- Almost 60 percent of responding consumers felt that a care plan would be helpful to them in managing their health care, but only 15 percent had a care plan and 16 percent said they were not sure if they had one.
- Yet, 60 percent of responding clinics said they have a care plan for their patients.



Conclusions and Recommendations

The information gathered in this capacity assessment has led to a number of conclusions and recommendations for consideration.

From the clinic survey it is clear that some clinics are further along in implementing components of health care homes. Those clinics could be early adopters and success stories that could influence and assist the clinics that are less ready to become health care homes.

1. **Recommendation:** Target outreach to primary care clinics that report implementation of at least half of HCH components and provide them with information on the HCH certification process. This outreach would use the assessment results to identify the specific clinics most likely to be successful in implementation so that resources can be initially focused toward those clinics.

Training and education will be key for successful implementation of health care homes. Outreach is important to the 334 non-responding clinics and 101 less prepared clinics for their decision-making process.

2. **Recommendation:** Provide focused outreach with HCH resources and education to less prepared clinics, clinics that reported that they did not know about HCH components and non-responding clinics.
3. **Recommendation:** Provide information collected through the capacity assessment about desired training and education needs and methods to the HCH Resource and Education Committee and the HCH Learning Collaborative.

While more than 60 percent of consumers said they've heard about health care home or medical home, many seemed to lack the understanding of the concept. Nearly 48 percent of consumers said they strongly disagreed, disagreed, or had no opinion when asked "I understand what is meant by a HCH or medical home."

4. **Recommendation:** Explore ways to engage and educate consumers regarding the HCH model.

An important part of the HCH model is the participation of patients in clinic quality improvement efforts. More effective communication between clinics and patients is clearly needed. There appears to be a gap between provider perceptions and patient expectations.

- *Just over 23 percent of consumers said their clinic asked them how they could improve the clinic.*
- *But more than 90 percent of clinics reported surveying patients to measure patient satisfaction with care delivery and the patient experience of receiving care at the clinic.*
- *Additionally, 41 percent of consumers reported their clinic did not contact them about missed appointments, scheduling routine and preventive check-ups or preparing for an upcoming appointment.*

- *After learning about care plans, nearly 60 percent of responding consumers believed a care plan would be helpful to them, but only 15 percent reported having such a document with their providers. As for clinics, 60 percent reported having care plans for their patients.*⁵

While only 27 percent of responding clinics met the HCH components for care plans.

Efforts to close the gap between consumers and clinics' perceptions would provide strength to engaging patients in their health care, quality improvement efforts and the overall clinic experience.

5. **Recommendation:** Provide education to consumers and clinics about opportunities at the clinic level for patient/family input in clinic service and quality improvement. Attention to clinic development and patient education on care plans is a priority.

Workforce shortage issues are clearly an underlying concern for both clinics and consumers when it comes to implementation of health care homes. Almost 62 percent of clinics indicated workforce shortages or staff time are a possible barrier to implementing HCHs. At the same time, 20 percent of consumers report not being able to get an appointment when they needed one.

6. **Recommendation:** Develop state and private initiatives to address health care workforce shortage and retention issues because clinics report this is a barrier to HCH implementation and consumers report it as a barrier to health care access.

*More than 70 percent of Minnesota clinics identified start-up and/or organizing costs as a possible barrier to HCH implementation. A national study also noted that "transforming to a patient-centered medical home costs dollars as well as time and effort, and currently available funds and reimbursement are likely to be inadequate for the transitional costs."*⁶

7. **Recommendation:** Identify sources of funding for clinics to help with practice transformation and communicate that information to clinics.

*Early analysis of results from the Patient-Centered Medical Home National Demonstration project shows that "practices working with facilitation agents reported significant improvement in their adaptive reserve – a measure of capacity for change – and were more likely to implement components of the patient-centered medical home than were self-directed practices."*⁷

8. **Recommendation:** Pursue opportunities to provide assistance to clinics with facilitation of internal decision-making and implementation of practice transformation and with assistance in managing the necessary cultural changes.

⁵ Note: The gap in consumer and clinic findings may be due to differences in defining the term "care plans." Clinics may use the term to indicate they have a plan of care for their patients, while the consumer survey defined a care plan as "a health summary that helps patients and providers communicate information about health needs. It lists the patient's chronic health conditions, medications, medical equipment that may be used and identifies doctors and other providers who work with the patient. A care plan also includes any patient preferences concerning his/her care, treatment procedures, results from medical tests (such as lab work, x-rays, etc.), and addresses any language or cultural considerations.

⁶ "Initial Lessons from the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home" was published in the May/June 2009 edition of *Annals of Family Medicine*.

⁷ "The Effect of Facilitation in Fostering Practice." Robert Graham Center in Washington, D.C., www.graham-center.org.