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Health Care Homes: Annual Report on Implementation

Minnesota Department of Health

Minnesota Department of Human Services

Report to the Minnesota Legislature 2012- 2013

January 2014

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HCH | Health Care Homes

Minnesota Department of **Human Services**

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Executive Summary

Health care homes are foundational to Minnesota's efforts to achieve the triple aim of improving the health of Minnesotans, improving the patient experience, and reducing the cost of health care. Health Care Homes, known nationally as Patient Centered Medical Homes, require a fundamental redesign in the practice of primary care towards prevention and management of chronic disease, and serve as a foundational element of health reform in Minnesota. Authorized by Minnesota's 2008 health reform law, the health care homes initiative is jointly administered by the Minnesota Department of Health and the Minnesota Department of Human Services.[1] This legislative report highlights progress towards meeting these goals in 2012 and 2013.

HCH Implementation Progress

- As of December 31, 2013 there are 322 certified HCHs, representing 43% of Minnesota clinics, and serving 3.33 million people.
- Approximately 353,000 Minnesota health care program participants received care in a HCH.
- One hundred percent of certified health care homes applied for recertification.
- Sixty-four percent of certified clinics/health systems are submitting claims for care coordination payments for Minnesota health care programs, a 15% increase over 2012.
- An Alzheimer's HCH learning collaborative curriculum was implemented as required by the 2011 Minnesota State Legislature.[2]
- A community care team pilot designed to improve coordination between clinics, local public health, and community providers was tested in three communities. The important learnings from these pilots will serve as the foundation for the 15Accountable Communities for Health that will be established through Minnesota's State Innovation Model Grant.
- The HCH program provided face to face learning collaborative activities to 1,984 participants.
- Additionally, in 2013, the University of Minnesota conducted a legislatively mandated evaluation of the HCH program, which showed that HCHs tend to serve a more diverse population than non-HCH clinics, and that certified HCHs that were part of the evaluation had higher scores than non-certified primary care clinics on a number of quality measures and had overall lower Medicaid expenditures that non-HCH clinics. For more information on the evaluation, including detailed findings, you can read the full report at: (URL).[3]

[1] http://www.health.state.mn.us/healthreform/homes/
[2] MN Statutes 62U.15 Section 4, Subdivision 2. Alzheimer's Legislation.
[3] Evaluation report link

Continued Work to Address Challenges

- Minnesota lacks a multi-payer "critical mass" supporting a common payment methodology, which has challenged the implementation of care coordination payments.
- While there is significant transformation activity throughout the State and the HCH's clinics are on track towards their goals, there are barriers to transformation due to the large number of initiatives being implemented, limited resources and challenges with effective interoperable electronic health records. These barriers especially challenge rural clinics and communities.
- Many patients continue to move through the health care system as passive recipients of care, rather than as central members of the health care team. Health care homes and communities are asking for consumer engagement materials in various forms of media and information regarding health care homes that would foster consumer engagement**.**

Goals in 2014:

- Continue on course to certify HCH's, address elements of the payment methodology, and seek opportunities to develop consumer engagement media sources.
- Pursue integration of behavioral health with health care for adults with serious mental illness and children with serious emotional disturbance via the health home program.
- Actively participate in the implementation of the State Innovation Model Grant through rapid expansion of HCH's, practice transformation strategies and implementation of Accountable Communities for Health.

The creation of the HCH initiative has well-positioned Minnesota to respond to the quickly changing health care marketplace the state currently faces. The HCH model with its focus on whole person disease management and patient-centered care is serving as the primary driver for focusing primary care on prevention and management of chronic disease. HCH has created the foundation for additional health care reforms that drive integration in the health care system and importantly, integration of health care with behavioral, community, social service, and public health systems.

Introduction

The health care home (HCH) model offers an innovative, team approach to primary care in which providers, families and patients work in partnership to improve the health and quality of life for individuals, especially those with chronic and complex conditions. HCH put patients and families at the center of their care, develop proactive approaches through care plans and offer more continuity of care through increased care coordination between providers and community resources.

While the term "medical home" is more common, Minnesota's legislature specifically chose to name this transformation of primary care "HCH" as a way to acknowledge a move away from a purely medical model of health care; instead, the legislature wanted to focus on linking primary care with preventive and community services. Minnesota's initiative showcases a redesign of both care delivery and payment through several components:

- **Statewide system of provider certification** with practice transformation supported by multiple interactions with providers, including a statewide learning collaborative.
- **Multi-payer payment system** with reimbursement stratified by patient complexity.
- **Emphasis on evaluation and outcomes measurement** with an expectation of budget neutrality and provider recertification based on outcomes.
- **Focus on patient- and family-centered care**, with consumers involved in both certification site visits and quality improvement efforts.

Minnesota's HCH initiative is a cornerstone of the state's 2008 health reform law[4]. This law includes components focused on

- Population health
- Market transparency and enhanced quality and cost information
- Care redesign and payment reform

These components, along with supporting activities in consumer engagement, e-health, quality measurement and reporting, administrative simplification and others, work together to create a comprehensive approach to health reform that aims to fulfill goals based on the Institute for Healthcare Improvement's (IHI) "Triple Aim: to *simultaneously* improve the health of the population, the patient experience of care and the affordability of health care by reducing per capita costs."

HCH both build on and benefit from other state and federal health reform and are well aligned with the state's other 2008 and 2010 health reforms. For example:

[4] MN Statute 256B.0751 - 256B.0753

- In 2014 DHS is planning for the Medicaid Health Homes application through a combination of strategies that emphasize coordinated care services for people with severe mental health conditions.
- HCH are the primary care foundation to building successful accountable care organizations (ACOs).
- The HCH program is centrally involved in other integration projects such as the implementation of the Alzheimer's HCH.
- The state's application and receipt of the Centers for Medicare & Medicaid Innovation (CMMI) State Innovation Model (SIM) grant to expand accountable care organizations and implement Accountable Communities for Health (ACH) builds on the community care team pilot designed to improve coordination between community partners.

The Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS) are jointly responsible for the development and implementation of Minnesota's HCH initiative, with the input of a broad range of public and private stakeholders. As required by statute, this report is an annual report from the MDH and DHS Commissioners on the implementation and administration of the HCH model.

Program Development Updates

Health Care Home Certification

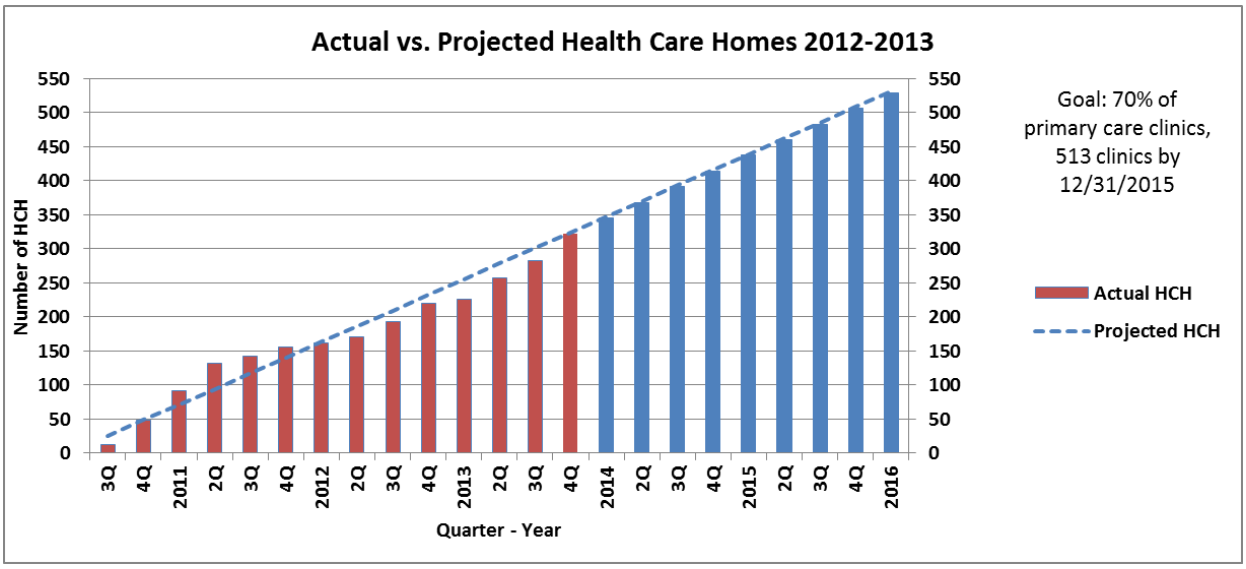
The standards for certification as a HCH were created to allow flexibility and the opportunity to achieve needed outcomes without being overly prescriptive. The goal is to enhance primary care without burdening providers. For information on the development of certification standards and the certification process, please see the December 2009 Health Care Homes Legislative Report.[5] The five certification standards are:

- Access and communication;
- Participant registry and tracking participant care activity;
- Care coordination;
- Care planning; and
- Performance reporting and quality improvement.

The HCH Community Certification Committee reviews all recommendations for certification. This committee is comprised of primary care physicians, physician assistants, nurse practitioners, RNs, quality experts, payers and consumer representatives. This committee makes final recommendations for certification to the Commissioner of Health. MDH certifies clinics throughout the year with site visits scheduled at the convenience of the applicant. Staff continues to address the barriers to rapid statewide transformation and to support the achievement of certification goals. The enclosed maps show the distribution of HCH statewide in 2011, 2012, and 2013. [6]

[5] http://www.health.state.mn.us/healthreform/homes/HCHLegReport.pdf.
[6] HCH Maps: Appendix C

Health Care Home Certification Progress



The HCH certification goal is to certify 23 clinics per quarter or 92 per year. At the beginning of 2012, 155 HCH clinics were certified; an additional 65 clinics were certified during the year, representing an average of 16 clinics certified per quarter. In 2013, MDH certified an additional 102 clinics, ending the year with a total of 322 certified clinics. This represents an average of 25 clinics certified per quarter for 2013, reaching the cumulative goal for 2013.

At the end of 2013, there are approximately 90 clinics receiving capacity-building assistance, and 16 of these clinics have submitted a letter of intent to become a HCH. Particular attention this past year has been directed at capacity building and certification for Federally Qualified Health Centers (FQHC) and safety net clinics.

For 2014, capacity building activities will continue with a focus on

- Certification of clinics with higher proportions of patients with chronic and complex conditions, including children with special health needs.
- Working with the Tribal leaders and community mental health centers.
- Targeting in regions of the state where there are currently fewer certified HCH as noted in the chart below.

2013 Minnesota Health Care Homes by Region and 2010 Population[7]

Region	Clinics	Certified Health Care Homes	Clinics to Reach 70% Goal	% Region's Clinics Certified	% Counties with One or More Certified Clinics	Clinics per 100,000 People	Certified Clinics per 100,000 People	2010 Population
Metro	334	191	233	57 %	100 %	11.72	6.70	2,849,567
Northeast	62	14	43	23 %	43 %	19.01	4.29	326,225
Northwest	42	8	29	19 %	38 %	20.83	3.97	201,618
Central	90	50	63	56 %	79 %	12.34	6.86	729,084
South Central	57	10	40	18 %	36 %	19.57	3.43	291,253
West Central	36	6	25	17 %	50 %	19.03	3.17	189,184
Southeast	50	16	35	32 %	64 %	10.11	3.23	494,684
Southwest	64	19	45	30 %	56 %	28.79	8.55	222,310
Total MN	**735**	**314**	**513**			13.86	5.92	5,303,925
Border States		8						
Total		**322**						

*****64% of counties in Minnesota have a certified HCH***

Access to a HCH continues to vary across the state. All regions of the state have increased the number of certified HCH in 2013. The variation between regions ranges from 57% of clinics certified in the metro area to 17 % certified in the west central region.

- In 2013, the metropolitan region, with the highest percentage of certified clinics, increased to 57% of clinics certified. This is an increase from 39% to 57%, representing 6.7 clinics certified per 100,000 people.
- The northeast part of Minnesota has increased the number of certified clinics to 22%, representing a growth from 2.15 clinics to 4.29 certified clinics per 100,000.
- The northwest also has demonstrated an increase in certified HCH clinics. In 2012, 15% of the primary care clinics were certified, increasing to 19% in 2013, representing a growth from 2.15 certified clinics in 2012 to 3.97 certified clinics per 100,000 in 2013.
- During the last two years, the west central region of Minnesota had the smallest number and percentage of certified HCH clinics, at 16.7%. In 2013 the percentage of HCH has increased in the west central region, this region still has just 3.17 clinics per 100,000 people.
- In 2013 the southwest region has 8.55 certified clinics per 100,000 people compared to 3.35 per 100,000 people in 2012. This increase occurred due to the certification of seven clinics in the region in areas where a lower number of people live.

[7] Appendix A: Health Care Home County / Clinic Report

Demographic Data for Certified Health Care Homes

Minnesota Health Care Homes Organizations Certified by Type*

% Total of Certified HCH Organizations

Year	Federally Qualified Health Center (FQHC)	Hospital Based Clinics	Independent Medical Group	Integrated Medical Group	Other
2012	5 (13%)	4 (11%)	12 (32%)	16 (42%)	1 (3%)
2013	10 (20%)	5 (10%)	18 (36%)	16 (32%)	1 (2%)

There are some significant changes in the types of clinic organizations that were certified in 2013 compared to 2012. Five additional FQHC organizations were certified which results in 62% of eligible FQHC's with certified clinics in their organizations. Of the remaining six FQHC organizations, five are seeking HCH certification and one is seeking National Committee for Quality Assurance Medical Home certification as part of a Health Resources and Services Administration grant program. Substantial increases in the overall number of certified independent medical groups were achieved. While the integrated medical groups remained constant, the overall number of certified clinics has increased.

Of the 220 certified clinics in 2012, 15 clinics (7%) were designated as critical access sites and 19 clinics (9%) were designated as rural health clinics. In 2013, 322 clinics are certified. Sixteen clinics were designated as critical access sites (5%) and 20 clinics (6%) were designated as rural health clinics.

Critical Access and Rural Health Clinic Designation

	Certified Clinics	Critical Access Hospital Based Clinic - [8]	Rural Health Clinics[9]
2012	220	15 (7%)	19 (9%)
2013	322	16 (5%)	20 (6%)

Applicants Apply for HCH Certification

As individual clinicians	By Clinic Where Every Clinician is Certified	By Integrated Medical Group Every Clinician in Each Clinic is Certified
18%	68%	14%

Percentages & Number of Practice Types for Certified Primary Care Providers

Year	**Family Physicians**	**Internal Medicine Physicians**	**Pediatricians**	**Nurse Practitioners & Certified Nurse Midwives**	**Physician Assistants**	**Other**
2012 N= 2,353	1036	447	282	306	188	94
%	(44%)	(19%)	(12%)	(13%)	(8%)	(4%)

[8] http://www.health.state.mn.us/divs/orhpc/flex/mnhospitals.html
[9] http://www.health.state.mn.us/divs/orhpc/funding/grants/pdf/rhc.pdf

Year	Family Physicians	Internal Medicine Physicians	Pediatricians	Nurse Practitioners & Certified Nurse Midwives	Physician Assistants	Other
2013 N=3,429	1547	589	436	473	307	77
%	(45%)	(17%)	(13%)	(14%)	(9%)	(2%)

HCH have increased the number of unique certified clinician's from 2,353 in 2012 to 3,429 clinicians in 2013. Certified clinicians by practice type are listed in the chart above. A number of specialty clinics have achieved HCH certification because they also provide comprehensive primary care services for their patients. These specialties include geriatricians, women's health, pediatrics and HIV.

Demographic Characteristics of Patients Cared for in Certified Clinics

Age Year	< 18	18-64	> 65
2011	24 %	60 %	16 %
2012	23 %	61 %	16 %
2013	25 %	59 %	16 %

For patients cared for in certified clinics, 25% are less than 18 years old, 59% are 18-64 years old and 16% are 65 years and older. Compared to the statewide population, there are 2.4 % more people over age 65 that are cared for in a HCH.[10]

Primary Language of Patients Care for in Certified Clinics

Primary Language	2011	2012	2013
Average % of English Speaking	84%	84%	86%
Average % of Non-English Speaking	16%	16%	13%

Although the overall average percentage of non-English speaking patients has decreased over the past year, the number of clinics with a greater than 20% non-English speaking patient population has increased from 32 clinics in 2012 to 58 clinics in 2013.

Certification Process Improvements

Over the past two years the HCH team has made considerable improvements to the certification process under the guidance of the HCH Certification Committee, a community advisory committee. One hundred percent of the certified clinics have maintained certification and have applied for recertification. The HCH team achieved this high rate in part by reducing documentation burden and listening to feedback from clinics.

[10] http://www.demography.state.mn.us/Census2010/

Capacity Building

At the end of 2012, there were 75 clinics from 42 separate organizations in the process of pursuing HCH certification with a letter of intent or assistance with capacity building. At the end of 2013, there are approximately 90 clinics receiving capacity-building assistance to help prepare them for the certification process and 16 of these clinics have submitted a letter of intent.

The HCH team has directed particular attention this past year to capacity building and certification for FQHCs and rural/urban clinics. A continued focus of the HCH program is to build capacity throughout the state and to certify HCH in every county to transform primary care. The team identified development of this infrastructure through community partnerships as a key strategic priority for 2012; this continued to be a focus in 2013. The HCH team developed initiatives that promoted these community partnerships to support implementation of HCH including:

- The HCH nurse community outreach activities include educating community partners including Local Public Health, Statewide Heath Improvement Program community leaders, Maternal Child Health coordinators, the MN Rural Health Association, and interested parties throughout the state about quality improvement initiatives and patient- and family-centered care models.

- A capacity-building goal of assisting the Federally Qualified Health Centers (FQHCs) to meet the criteria and timeline established by the HRSA grant to become a certified HCH. Sixty one percent of FQHCs met certification requirements.

- In 2010 MDH aligned the work of the Minnesota Children and Youth with Special Health Needs (CYSHN) program with the HCH initiative in order to capitalize on existing resources and to contribute to the medical home goals to advance the six national core outcomes for Children and Youth with Special Health Needs. Ongoing collaboration supports capacity building for health care homes and patient and family centered care for families.

Learning Collaborative

A HCH statewide learning collaborative is required by Minnesota Statute §256B.0751. This learning collaborative provides an opportunity for HCH to exchange information and enhance understanding related to quality improvement and best practices.

The learning collaborative was designed to:

- Prepare clinics and clinicians for certification and implementation of health care home standards.
- Engage system and clinic level leadership in quality improvement, practice-level transformation, system delivery redesign and the Institute for Health Improvement's Triple Aim objectives (improving patient health and patient experience while lowering cost of care) in support of HCH certification.
- Build leadership capacity and support transformational change in certified HCH to sustain patient-centered care through a team approach.
- Engage patients and families, clinicians and other stakeholders in the learning collaborative as drivers of change and quality improvement.

The Institute for Clinical Systems Improvement[11] (ICSI) was awarded the contract by MDH to design and initiate a learning collaborative model for eighteen months through July of 2012. The learning collaborative was delivered in two phases. Thirty-eight clinic teams participated during the first phase targeted at preparing primary care clinics for certification. Five regional groups, consisting of 65 certified clinic teams, participated in the second phase, which focused on preparation for recertification. Participants reported that the HCH regional learning collaborative was well structured and implemented. This first effort at a regional statewide learning collaborative yielded many lessons:

- Regional approaches, while considered convenient, may not be the best shared-learning approach. Larger systems want to learn from larger systems and smaller clinics from each other. A one-size approach to learning did not meet clinics' learning needs.
- Busy clinic teams and providers had difficulty engaging in virtual learning environments which resulted in lack of participation.
- Virtual sessions and half-day learning sessions were not as effective as whole-day learning collaborative for clinic staffing and scheduling.
- HCH teams wanted to participate in varied focused training with additional flexibility and credit for other types of learning.
- The HCH learning collaborative needed to focus more time on those clinics either not certified or newly certified as they have significantly different learning needs than clinics seeking recertification.

[11] https://www.icsi.org/

Clinics overall embraced the learning collaborative concepts. Face-to-face learning was highly valued, objectives were met, speakers were knowledgeable, individual sessions were rated highly for learning and the combination of didactic, experiential, patient- and family-centered approaches and implementation techniques were valued by participants.

MDH and DHS revisited the contracting process and recommended that a multi-modality approach to the learning collaborative be implemented for the next eighteen months and then reevaluated. MDH began facilitating learning collaborative activities internally in July of 2012, building on the experiences of the ICSI work. An added goal was to provide more direct connection with the HCH certification and capacity-building activities and provide more flexibility for clinics. MDH enlisted external contractors as resources and facilitators.

In spring 2012 stakeholders were asked for input on HCH learning needs, and clinics were surveyed to determine future priority topics and goals for the curriculum. A learning assessment survey was completed in September of 2012. This data was used to guide the development of learning collaborative format and content. Many organizations indicated learning needs around transitional care, early identification of Alzheimer's and children's mental health issues, coordination with community resources and full implementation of team-based care and care coordination processes. This learning assessment informed the learning collaborative topics selected for the 2012/2013 activities. The assessment will be repeated in early 2014 to determine new learning needs and where clinics had greatest improvements overall and will inform ongoing learning collaborative next steps

Significant learning collaborative activity and participation from clinics and health systems across the states occurred in 2012/2013.

Learning Collaborative Face to Face sessions Attendance	Participants
Health of the HCH Multi-stakeholder Dinner and Dialogue, February 2012	115
Spring 2012 Pre-Conference Workshops and Learning Collaborative Day, February 2012	335
Primary Care & Community Integration Conference, March 2012	140
Fall 2012 Learning Collaborative Learning Day, November2012	257
Spring 2013 Pre-Conference Workshops and Learning Collaborative Day, May 2013	328
Elements of Cultural Competency, May 2013	75
Care Coordination for Persons with Complex Needs, i.e., Dementia. May 2013.	102

Learning Collaborative Face to Face sessions Attendance	Participants
Fall 2013 Post-Conference Workshops and Learning day, November 2013	360
Community Transformation Grant Prevention Regional Workshops, September 2013	37
Benchmarking Training, March Quarterly Meeting	60
Patient Experience: From CG:CAHPS Visit to PCMH: Issues and Implications for MN Health Care Homes , March 2013 Quarterly Meeting	60
August Quarterly Meeting, DHS Payment Methodology Update	115
Total Participants	1,984

Learning Capacity Building

The MDH HCH team has implemented a variety of educational techniques to reach both clinics that are certified and not yet certified. Modeled after the ICSI Phase I curriculum, MDH implemented an Introduction to HCH webinar series for those clinics early in the transformation journey. One hundred and ten participants attended one or more of the sessions.

Evaluation surveys indicate that participation was hindered by time away from clinic. MDH held a technical certification/recertification seminar in November of 2013 and will continue to hold technical training sessions in 2014 to meet the needs of clinics seeking certification and recertification. In addition, several intensive time-phased learning community grants have been awarded to organizations to implement focused learning activities for HCH teams on topics such as patient- and family-centered care, obesity reduction, care coordination and practice management.

To meet its legislative requirements the HCH team is collaborating with the Community Transformation Grant (CTG) funded by the Centers for Disease Control (CDC) and implemented by MDH. The goal of this partnership is to provide education about chronic disease prevention to grantee clinics and HCH and to advance the goals of improved health of all Minnesotans. The CTG curriculum has been incorporated in the HCH learning collaborative. Each learning day features sessions and workshops about preventive measures.

To meet requests for virtual topic-based learning, monthly webinars were again implemented in spring of 2013. Topics addressed and number of registrations for each follow:

Learning Collaborative Virtual (webinar) Sessions Attendance	**Registrations**
Pediatric Asthma Quality Measures	60
SBIRT Implementation in Clinics	42
Care Coordination Toolkit- MAPCP	52
Quality Improvement in Primary Care	96

Learning Collaborative Virtual (webinar) Sessions Attendance	Registrations
MN Health Care Homes Patient Experience Survey: Implications of Moving from CG-CAHPS Visit to PCMH, July,2013	89
Introduction to Health Care Homes Webinar Series: Session One – The Business Case for Health Care Homes and Overview of Legislation and Standards, July, 2013	63
Introduction to Health Care Homes Webinar Series: Session Two – Patient- and Family-Centered Care, August, 2013	49
Introduction to Health Care Homes Webinar Series: Session Three Change Management and Creating an Action Plan, September, 2013	47
Introduction to Health Care Homes Webinar Series: Session Four - Quality Improvement & Culture Change, October, 2013	40
Organizational Tips to Improve Your Quality Measures, September, 2013	96
Making Connections – Introducing a Toolkit to Assist in Working with Patients with Complex Needs, August, 2013	127
Integrating Substance Misuse Screening and Intervention into Primary Care, July, 2013	42
Concepts of Co-Management Reflections from a Primary Care Journey to Improvement Asthma Care for Pediatrics Population, July, 2013	60
Total:	**863**

An initiative of the Medicare Multi-payer Advanced Primary Care Provider (MAPCP) Demonstration Project, the HCH Care Coordination Toolkit for Working with Persons with Complex Needs and Older Adults has been developed to assist HCH and primary care clinics in assessing patients with complex needs.[12] The goal of the toolkit is to offer an array of resources and tools that effectively guide seniors with complex functional support needs in addition to their medical issues. During implementation of the toolkit, staff held a webinar and a workshop to introduce the toolkit to HCH team members. They plan a formal evaluation of usefulness and additional topics for 2014.

Challenges

The HCH team was challenged by the increasing numbers of certified clinics and clinics in transformation. Growing numbers put a strain on MDH available meeting space resources and necessitated external contracts to provide facilities. Existing tracking and registration systems at

[12] http://www.health.state.mn.us/healthreform/homes/collaborative/carecoordtoolkit.html. Health Care Home Care Coordination: Toolkit for Working with Persons with Complex Needs and Older Adults

MDH do not provide adequate support for this volume and type of activity. A team is investigating options for providing a comprehensive tracking system for learning management. The variety of organizations now seeking certification and their needs to attend learning collaborative sessions at convenient times provides the unique challenge of differentiating level of information provided. Attendees of learning collaborative events have indicated the need for both advanced topic areas and foundational skill building.

Strategies to address this are:

- Offering on-demand webinars in both introductory and advanced levels
- Providing on-demand learning modules
- Giving new or early transforming clinics tracks or specific sessions during learning days
- Adapting the "Introduction to HCH" series for different audiences

Next Steps

The HCH Learning Collaborative Advisory Workgroup continues to advise MDH in learning collaborative activities. Advisory committee members include HCH clinic team members, quality stakeholders, consumers and payers. The group held three advisory meetings and several activity specific planning meetings during 2013. The committee will expand in 2014 to include broader community partners such as behavioral and mental health, social services, hospitals and others to meet the needs of the State Innovation Model (SIM) grant.
Future Learning Collaborative activities will build on core topics for HCH; patient and family centered care, care coordination, population management, community integration, prevention and behavioral/mental health integration, among others. The learning assessment survey will be re-administered to those initial respondents and a second assessment will be distributed to determine focus of 2014 topics. SIM activities will be held jointly when appropriate and will include a combined face-to-face learning day in September of 2014.

MDH has issued a contract the Wilder Research Foundation to design evaluation tools and data collection methods to track learning methods, participation and learning outcomes.

Alzheimer's Legislative Learning Collaborative Requirements

Alzheimer's disease and related dementias are a major public health issue and will continue to affect the health and well-being of a growing segment of the population. An estimated 5.4 million Americans are affected by Alzheimer's disease and other dementias. Many of those patients will be cared for in a HCH. Legislation passed in 2011 directs the Commissioner of Health to develop a HCH learning collaborative curriculum that includes screening and education on best practices regarding identification and management of Alzheimer's and other dementia patients for providers, clinics, care coordinators, clinic administrators, patient partners and families and community resources including public health.[13]

[13] MN Statutes.Section62U.15 Alzheimer's Disease: Prevalence and Screening

The goals established for this activity are to develop a learning collaborative curriculum and accompanying tools to support implementation of care coordination for HCH in 2012 through 2014. The learning collaborative curriculum is based on the following:

- Clinics complete a baseline assessment of their current status for coordinating care for dementia patients; progress is measured year to year and clinics are provided with feedback
- Providers, team members, community supports and patients and family members are active teachers at each session
- Learning modules are grounded in evidence-based guidelines, tools and expert documentation to support learning
- Caregiver support and care coordination elements are included in each teaching module.
- Active evaluation of the learning methods and learning of participants is integrated into future planning

The HCH team collaborated with members of the ACT on Alzheimer's Early Identification Committee (formally known as Prepare Minnesota for Alzheimer's 2020 – PMA 2020) to develop the initial draft of the HCH learning collaborative curriculum for patients with dementia. The team also developed an Alzheimer's HCH standards document with a cross walk between the HCH standards and the best practices treatment, care coordination and care giver supports to help HCH understand how to integrate care coordination of people with dementia into the systems of the HCH. Team members developed the longitudinal high-level curriculum from the PMA 2020 curriculum outline. The goal of this curriculum is to address main components in the first three learning collaborative sessions and then re-evaluate.[14]

Learning Collaborative: Alzheimer's

The first learning collaborative session, "Implementing the HCH for Patients with Alzheimer's: Early Identification, Care Coordination and Care Giver Support," was included in the HCH's Learning Day in November 2012, and provided an introduction to the topic. One hundred sixty-seven HCH team members participated in the session. Evaluations from participants were positive. Learning assessment of clinics showed a deficit in identification in primary care clinics.

In May 2013, 130 HCH team members attended a workshop entitled "Care Coordination for Persons with Complex Needs," which built on the previous learning day topic. A major component of this workshop was a presentation on Alzheimer's disease and other dementias. A behavioral health workshop was conducted in the November, 2013 learning days will focus on management of early stages of dementia disease in primary care.

[14] http://www.health.state.mn.us/divs/hpcd/alzheimer/documents/AlzheimerReport2013.pdf

Next Steps

The HCH program is collaborating with the DHS Aging and Adult Services Division in the development of the Alzheimer's/dementia-competent HCH that will be implemented in pilot sites in the next year. The experience gained from these pilots will also inform development of future learning collaborative activities. The HCH team will clarify goals and topics for learning in 2014 with the learning assessment survey. They plan webinars on early identification of Alzheimer's for clinicians and resources for care coordination, as well as a workshop at the 2014 learning day.

Health Disparities: Advancing Health Equity

In 2012, the Public Health and Prevention Work group of the Governor's Health Reform Task Force received a National Academy for State Health Policy technical assistance grant to explore opportunities to decrease health disparities and advance health equity through the Affordable Care Act (ACA). The state team developed a comprehensive learning plan with one key element focused on education of certified HCH.

In May 2012, 65 participants from HCH participated in a workshop which focused on the following key elements of cultural competency:

- Increasing understanding of cultural competency.
- Improving health outcomes for racial and ethnic minorities in HCH.
- Understanding how race, ethnicity and language data is collected and used to foster integration of patients and families' values and preference into care delivery/planning.
- Understanding the HealthPartners EBAN Experience. The EBAN Experience is a team-based collaborative that focuses on improving health disparities through community dialogue, experiential education and quality improvement projects.

Throughout 2013 a focus on health equity was implemented through activities in the HCH learning collaborative and through certification of a significant number of FQHC's and safety net clinics throughout the State. In addition, MDH evaluated the ability to include race, language or ethnicity data in the benchmarking data but current data was considered too inaccurate to be used for evaluation or benchmarking at this time. This continues to be a barrier to identifying disparities in the quality data that would allow HCH to target those specific disparities.

In early winter 2013 MDH implemented an initiative to advance health equity in preparation for a MDH report to the legislature. MDH programs were asked to lead a conversation about race and racism and focus on what current efforts or future recommendations partners working with MDH could make to advance health equity. In November 2013, 48 representatives from certified HCH that have significant minority populations met to discuss this important topic. There was an enthusiastic discussion with the following high level themes:

- Clinics recognize that this is an important initiative and key to improving quality for all populations of people receiving care in their clinics. There are clinics that are well ahead of others and have useful information to share with other clinics where there are considerable training needs.
- There are opportunities for the state's HCH team to work with certified clinics to ensure that
    - They are meeting the standards for collection of race, language and ethnicity data.
    - The clinic quality teams are representative of their communities.
    - Certified HCH's are developing, through care coordination, community partnerships.
- Availability of accurate quality improvement data that includes race, language and ethnicity in the statewide quality measures is essential to effective quality improvement strategies to address disparities.
- Participants also identified that patients and families need information on what is primary care, and how consumers can work with their primary care providers, and work within the overall health system.
- Participants shared that clinics have concerns on how to work with special populations such as the homeless, immigrant families and refugees.
- There are support systems that need to be enhanced such as interpreter services, housing, transportation, mental health services, technology support and training the health care workforce to include minorities.

Next steps:

The HCH team will to continue to actively address health disparities in its ongoing work with state and community partners in the HCH learning collaborative, measurement and evaluation activities and also through the Advancing Health Equity initiative strategies.

Community Partnerships

Capacity building in the context of the HCH program supports clinics to transform into certified HCH. It requires a variety of community partnerships and focused facilitation resources to support clinics to make significant changes that result in lasting improvements to their quality goals. Development of this infrastructure was identified as a key strategic priority for 2012 and continued through 2013. The HCH team has developed a number of initiatives that promote these community partnerships to support implementation of HCH.

Senior LinkAge Line® Receive Referrals from Hospitals and Certified Health Care Homes

The 2012 legislative session created statutory language[15] intended to create closer working partnerships between the Senior LinkAge Line®, hospitals and certified HCH. The HCH team and Senior LinkAge line worked together to develop a referral process through which individuals referred to the Senior LinkAge Line® will receive long-term care options counseling and decision support, which helps individuals make informed choices about long-term care options and health benefits.

Minnesota Board on Aging Integrated Systems Grant

Through its Integrated Services Grants funded through Community Service/Community Services Development grants[16], the Minnesota Board on Aging is working closely with HCH by

- Supporting the delivery of memory care consultation and intensive individual/family counseling to people with dementia and their family caregivers.
- Increasing the dementia capability of the aging services network, MinnesotaHelp Network™ and HCH
- Increasing statewide availability of risk management interventions and community supports.
- Facilitating partnerships between the Area Agencies on Aging (AAA) and HCH and hospitals to connect high-risk older adults to community resources.

Pediatric Health Care Transitions Grant

This one-year pilot project, initiated in January of 2012, involved a collaboration between the HCH Initiative, the National HealthCare Transition Center (NHCTC), Family Voices of Minnesota and three selected pediatric clinics certified as a HCH (or in process to become certified). This project sought to develop a model of successful health care transition to adult care for youth with special health care needs and their families by testing strategies, tools and materials supplied by the National Health Care Transition Center.[17] MDH provided grants to three HCH and Family Voices. The project required engagement of youth with special health

[15] MN Statute 256.975 Subdivision 7 (13)

[16] www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_143304

[17] http://www.medicalhomeinfo.org

care needs and their families along with the experience of pediatric providers to test and implement health care transition tools, strategies and a transition model and policy that could be disseminated statewide and nationally. In 2013, the 18-month Transitions in Health Care grant was awarded to Family Voices of Minnesota.

Safety Net Primary Care Transformation Grant

In the spring of 2011, MDH requested proposals for the purpose of providing expert support and technical assistance to safety net providers, FQHCs, community clinics, and rural health clinics to facilitate their becoming certified HCH. These clinics serve the patients who are most vulnerable to poor health outcomes and increased costs. It is the goal of this activity to provide expert facilitation for safety net providers to help them transform their practice to meet HCH standards and become certified HCH and to move towards improving quality results.

The contract was awarded to Halleland Habicht Consulting LLC. Throughout 2012, four safety net clinics received intensive project support, including a gap analysis and assistance with implementation of their HCH team. The consultant participated in team meetings, provided tools for process improvements, information and resources to the health team and support for quality improvement activities.

Key Learning from the Safety Net Transformation Grant Participants & Consultant

- Leadership support is needed not only for certification activity, but, more importantly, to ensure that the transformation required to meet the core concepts of the patient-centered HCH is actively occurring.
- The transformation process requires a culture change for most providers and staff members. Time and support is needed to get all members of the HCH team engaged.
- Many clinics struggle with information technology even if they have an electronic health record. Most are not using the electronic health record to its fullest potential and much of that is due to limited expertise or limited resources.
- Almost everyone focuses on the certification application when, in reality, the certification application itself is a small part of becoming certified. The real test is whether or not there is tangible evidence that the core concepts are being met.
- There is a misunderstanding as to how the HCH and care coordination fit with the day-to-day workflow, and thus there is a tendency to begin by designing two different workflow processes. Clinics benefit from more emphasis on the core principles of the HCH as a systems integrated delivery model.
- Having a good plan for communication and clinic-wide ownership for the process can ease staff transitions.
- Using a practice facilitator who works directly with clinics that are experiencing challenges with their practice transformation is an effective strategy to support clinics in moving forward more quickly with their work. Both the practice facilitator and the clinics experienced this benefit.

During this year for the four practices who participated in the grant, two practices became certified, one submitted their application to certify in 2013 and the fourth has placed their work on hold due to implementation of their electronic health record.[18]

Community Care Team Grant Pilot

Background

One of the primary principles of HCH is the delivery of patient- and family-centered care. Care that is patient-centered is holistic and recognizes that a person's health is determined by physical, psychosocial, and environmental factors. In alignment with patient- and family-centered care, Minnesota's HCH recertification standards require primary care practices to "identify and work with community-based organizations and public health resources such as disability and aging services, social services, transportation services, school-based services, and home health care services to facilitate the availability of appropriate resources for participants." The intent of the rule is that certified providers and clinics take a proactive approach to planning and partnering with community resources to ensure that their patients have access to needed resources and services. This is especially important in managing chronic and complex conditions and diseases in a cost efficient manner.

However, most healthcare systems do not partner effectively with community resources, and there are few existing population-based processes for collaboration, leading to under-utilization of community services and fragmentation of care. Successful self-management support involves effective partnerships with community service organizations that will lead to improved quality and costs with an emphasis on prevention.

The national strategy led by the Center for Medicaid and Medicare Innovation (CMMI) is moving in this direction. Many national grant opportunities reflect a desire for new leadership structures that align with integration with primary care, behavioral health, local public health and community prevention. There are several community care team initiatives in states such as Oregon, Vermont, North Carolina, Maine, New York State, and Alabama. In some states, such as North Carolina and Vermont, researchers are already seeing improvements related to quality and cost goals.

Community Care Team Structure

The central idea of a community care team is a locally defined leadership structure that includes, health professionals, local public health staff and community members. Partners in the community care team meet on a regular basis to establish trusting relationships and break down barriers to allow them to coordinate health-related activities, plan for evidence-based prevention and care, coordinate care, develop measurement and evaluation of activities and focus on targeted health goals established by the community's needs.

Community care teams are flexible depending on the size of the primary care clinic, the number and types of hospitals and overall population size. Some specifics:

[18] http://www.health.state.mn.us/healthreform/homes/background/safetynetpctgreport.pdf

- There is local implementation leadership support in the form of a hired community specialist.
- Community care teams have linked compensation between community and health care partners, do evaluation together and are responsible for the outcomes of a population.
- There is a service delivery team that implements direct service coordination between primary care clinics and community team members with a focus on transition processes.
- Direct service teams build on existing community resources and reflect the needs in the community assessment, such as behavioral health staff, community health workers, "trusted referral broker," local public health, care coordinators, educators and social services roles.
- There is a service delivery team that implements direct service coordination between primary care clinics and community team members with a focus on transition processes.

Selecting Community Care Teams

In 2011, MDH released a grant solicitation for primary care clinics and community partnerships or organizations with community engagement strategies to test the concept of community care teams.

The goal for the program was to design, document and implement a community care team that addresses community priorities, coordinates care manages transitions (especially between hospital and home), use of resources effectively and that engages in collaborative activities with certified HCH.

MDH awarded grants to the following providers and communities:[19]

- Essentia Health Services Ely Clinic and Community
- HCMC, Brooklyn Park and Brooklyn Center Clinics and Community
- Rochester Mayo, Employee & Community Health Clinic and Community

Each pilot Community Care Team developed a different approach to implementation.

- Essentia: Initially planned to focus on pediatric mental health, soon extended to the broader population with community-based partnerships.
- HCMC: Focus on developing its community care team leadership structure in a diverse population in the two Minneapolis suburbs. They completed a population and community assessment and focused on diabetes prevention and community/parish linkages.
- Mayo: Studied the strengths-based, wrap-around team approach, focusing on the development of the core team structures for the senior population.

[19] Minnesota Department of Health. Request for proposals: Health Care Homes: Community Care Team grants. http://www.health.state.mn.us/healthreform/rfp/hchcareteams.pdf. Published April 2011.

Lessons Learned from Community Care Teams Pilot

- There was significant need in each community to build trust between primary care clinics and community members. Partnership and focus on community needs encouraged a new relationship for these groups.
- Using an incremental approach for member composition, governance and work plan components helped the teams move forward at an acceptable pace.
- Leveraging existing partnerships in the community and starting with a team leader with social capital and knowledge of the community is key.
- The care coordinator is a pivotal member of the community care team with their health knowledge to assist patients in identifying and understanding better self-management of their disease.
- A strengths-based approach is effective for engaging patients in self-management, goal setting and problem solving.
- Development of a mechanism to provide secure, electronic communication between members of the community care team is essential.
- A sustainable finance methodology will be essential to support community care teams.

Next Steps for Community Care Teams and Strengthening Community Partnerships:

There was tremendous learning by the community partners that participated in the community care team pilots. Team members were highly engaged and committed to the success of building the community care team. Each of the community care team pilot teams met their goals to learn how to implement a community care team that includes community members and community providers, to identity care coordination methods in their communities, and to develop a sustainability plan with recommendations for the future. Significant sharing in presentations across the State has since occurred and one community care team published four articles about new strengths based care coordination methods.

A HCH serves as the central point for coordinating health care services around the patient's needs and preferences. It also coordinates care between all of the health care team members, including the patient, family members, other caregivers, specialists, other health care services (public and private) and nonclinical community services. Addressing non-medical issues (e.g., social support) with strong linkages to community partners for effective care coordination is critical to improving health outcomes, yet expanding a patient's circle of support can be challenging. There are challenges yet to address:

- There is a lack of integrated case management or coordination in the community that leads to fragmented care and the risk of duplication of care coordination or case management in the community.

- Most healthcare delivery systems do not partner effectively with the available community services, leading to under-utilization of existing services and fragmentation of care. A number of barriers exist to older adults or complex patients using community-based services including lack of awareness, reluctance and affordability.[20]
- There are limited existing community-based processes for direct collaboration between health care delivery systems, community service providers and prevention services.
- The cultural change necessary for provider organizations to make alliances with community and consumer groups can be difficult to conceive, develop and maintain on their own. Coalition politics require time, experience and training to develop. [21]
- There are communities, especially rural communities, without adequate resources for behavioral health, adequate referral mechanisms, adequate knowledge of community resources and a lack of relationships with community partners.

Payment mechanisms are not in place for sustainable community partnerships between primary care and mental health. Building new models and systems to enhance sustainable community partnerships such as those proposed in the SIM grant are the next steps to improving the health of a community. Improving communication and team work with community partners including behavioral health, local public health and social services, is essential to extending the coordination and support to improve outcomes in a sustainable manner for patients and families in HCH.

Over the next three years, the State Innovation Model Grant builds on the foundational work of the Community Care Team pilot by establishing up to 15 Accountable Communities for Health (ACH) across the state, along with working to enhance community partnerships, a focus on community supported patient centered coordinated care and secure data exchange for care coordination.

[20] Vanderboom, et.al.

[21] Anthony L. Schlaff, MD, MPH, Community Groups to Promote Health Care Reform, American Journal of Public Health | May 2005, Vol 95, No. 5

Consumer Awareness and Engagement

In a HCH, patients and families are part of the care team and actively partner with their providers in making health care decisions. As HCH become more prevalent in Minnesota, it is important that consumers/patients gain a broader understanding of this approach to care. Consumers have already become involved in the HCH initiative in various ways. The Consumer Family Council, made up of patients and family members, advises the state on HCH implementation and provides patient representation for broader work groups. Consumers have also served as site visit evaluators or on the quality improvement teams in certified HCH and consumers participate on advisory / quality teams in certified HCH's

The HCH team is working to expand consumer understanding and engagement by:

- **Consumer messaging and communications.**

  In collaboration with consumers, MDH and its marketing partners at Tuneheim and Associates, a marketing consultant vendor retained through a competitive contract process, developed targeted messages about HCH for consumers, as well as an overall communications and media plan to raise public awareness about HCH and patient centered coordinated care[22]. This plan highlights strategies, tactics and tools to best communicate with consumers. However, there here have been a variety of challenges to implementing a statewide consumer engagement communications plan due to resource limitations and this plan has not been implemented.

- **Consumer-oriented literature.**

  In conjunction with its partners, MDH has developed a limited number of paper brochures and other paper and web based tools about HCH that clinics can use.

- **Certification seal for certified health care homes.**

  To make it clear to consumers which clinics are certified as HCH, MDH designed and distributes a seal that certified HCH can display in clinics.

There has been considerable transformation to HCH in primary care in Minnesota. The communications messaging that MDH has in place has not effectively supported the extensive implementation work. Consumer groups and providers that work to support HCH implementation have consistently identified this as a major problem. There are two major barriers to improved consumer knowledge and engagement:

- A considerable number of patients and families are not informed about the concepts of patient centered coordinated care in HCH.
- Continued knowledge gaps impacts consumers understanding of their roles as an active health care recipient. Many patients and family's continue to move through the health

[22] http://www.health.state.mn.us/healthreform/homes/background/index.html

care system as passive recipients of care rather than as central participating members of the health care team.

Patients who are engaged as active partners in their care and are informed about the options for coordinated care are vital to achieving improved health outcomes. HCH and communities are asking for consumer engagement materials in various electronic media formats and for more information regarding HCH that would foster consumer engagement and activation. A lack of funding for comprehensive consumer engagement activities, media and materials has been a significant barrier to education of consumers about the ways that patients and families can most effectively work with their primary care provider, the elements of the health care home and what it means to be an activated engaged consumer

In October of 2013, the Minnesota Department of Health, the HCH Team, and Minnesota Community Measurement requested HCH to identify patient stories that highlight achievements and the benefits of HCH. Minnesota's statewide Aligning Forces for Quality alliance, led by MN Community Measurement, was asked by funder Robert Wood Johnson Foundation to describe the advancements being made in Minnesota's HCH initiative. One important way to highlight the benefits of HCH is to share patient success stories that focus on coordinated patient centered care and patient partnership. Minnesota's HCH: Transformative Change in Primary Care Delivery[23] is the story of Julia a HCH patient.

In 2014 HCH will work with other health reform initiatives to expand community with Minnesotans on how to work in partnership to receive patient centered coordinated care.

[23] Appendix B – Robert Wood Johnson Foundation Bright Spot – November 2013

Health Care Home Performance Measurement

Robust quality measurement is a cornerstone of the HCH initiative to improve population health, patient experience and affordability.

Statute requires that HCH meet specific outcome measures for the purposes of annual recertification.[24] The language states that "for continued certification under this section, HCH must meet process, outcome and quality standards as developed and specified by the commissioners. The commissioners shall collect data from HCH necessary for monitoring compliance with certification standards and for evaluating the impact of HCH on health care quality, cost and outcomes."

Per the HCH Rule, the Commissioner of Health must announce benchmarks for patient health, patient experience and cost-effectiveness. The goal for HCH recertification is to over time move from process verification to recertification based on outcome benchmarks. During 2012, the MDH-sponsored Health Care Homes Performance Measurement Advisory Work Group (comprising a number of community stakeholders including representatives from the provider community, health plans and government) developed recommendations for measurement for the evaluation and benchmarking for recertification of HCH. The workgroup charged the Health Care Home Measurement Technical Team to develop a benchmarking methodology for HCH.

The workgroup developed a strategy that used several measures reported by clinics through the Statewide Quality Reporting and Measurement System including asthma for adults and pediatric patients, depression, diabetes, vascular care and colonoscopy screening for the HCH benchmarking methodology. On October 1, 2012, the Commissioner of Health approved the recommended HCH benchmarking methodology. Benchmarking was implemented in January 2013 for those clinics seeking recertification as a HCH.

Through a contract with Minnesota Community Measurement (MNCM), a nonprofit organization that promotes quality improvement,[25] a HCH portal was built to display the benchmarking reports and supporting data for HCH. The methodology includes benchmarking against performance with the statewide and HCH averages and an internal comparison for improvement for HCH. Over time certification procedures will rely on benchmarking to determine the applicants recertification status.

In addition to implementation of benchmarking for recertification the HCH Performance Measurement Advisory Workgroup's tasks have focused on the following areas:

- Providing guidance on the upcoming addition of patient experience 12 month survey tool with Patient Centered Medical Home (PCMH) questions for pediatrics and adults for collection of patient experience data that will be included in the HCH benchmarking data portal.[26]

[24] MN Statute 256B.0751 - 256B.0753
[25] Minnesota Community Measurement: http://mncm.org/
[26] http://www.health.state.mn.us/healthreform/homes/outcomes/patient_experience.html

- Monitoring of the progress of the care coordination pilot. This measurement pilot involved testing the recently developed HCH advance care plan measure and the HCH follow up after discharge measure.[27]
- Reviewing and providing input to the progress of the HCH evaluation conducted by the University of Minnesota.

Care Coordination Measure Pilot

In May of 2013, MDH, in collaboration with MNCM, developed two new care coordination measure specifications. The measures are intended for quality improvement, benchmarking for recertification and program evaluation purposes of HCH clinics. In May 2013, certified HCH participated in a measurement pilot pertaining to the recently developed HCH advanced care plan and HCH follow-up after hospital discharge measures. The advanced care plan measures the percentage of patients with evidence of an advanced care plan documented in their medical record. The follow-up after discharge measures the percentage of recently hospitalized patients (selected conditions only) who are contacted by a health care provider after discharge. To promote participation and reduce provider burden, MDH proposed mini-grants to support care coordination outcome measurement implementation. The purpose of the grant was to provide expert support and facilitation for up to twenty certified or soon-to-be-certified HCH that participated in the care coordination measure pilot for advanced care planning and transition follow up after hospital discharge. Seven clinics applied and were awarded the care coordination grant for up to $5,000.

Overall, 57 certified HCH clinics participated in the advanced care plan measurement pilot. Two challenges identified during the pilot included difficulties experienced by clinics that had to extract information from scanned documents to define and validate whether or not the patient's wishes were addressed within the advanced care plan. Approximately 75 – 100 HCH will be participating in the follow-up measure pilot. The major challenge for clinics with the follow-up measure is obtaining data from hospitals that are outside of their network in a timely manner.

Performance Measurement Next Steps:

Challenges exist for accurate performance measurement which allows for effective quality improvement activities and benchmarking for clinic transformation with a balance between the appropriate level of provider burden in a fair and accurate manner. Certifying clinics based on quality benchmarking for clinical quality and patient experience is the goal for ongoing recertification of HCH. As implementation proceeds over the next year, it will be essential to have accurate, fair measures and benchmarks that reflect the systems redesign work of the HCH. The Performance Measurement Workgroup will continue to meet to guide the progress of HCH measurement, benchmarking and evaluation in 2014.

[27] http://www.health.state.mn.us/healthreform/homes/outcomes/care_cordination_grant.html

Health Information Technology Reforms and Health Care Homes

Most certified clinics had an Electronic Health Record (EHR) at certification. The two clinics that did not have an EHR at certification have electronic searchable registries and other electronic components such as scheduling and lab results and are working to fully implement an EHR.

Many of the key features of HCH are also emphasized in health information technology reform efforts. Improved access and exchange of essential clinical information can enhance communication and patient-centered, team-based approaches to care coordination. While the provisions of the HITECH Act and other reform efforts certainly support the HCH initiative, the challenge of implementing the meaningful use measurement systems and interoperability specifications necessary to receive the cost incentives are significant. Of high importance for HCH are IT efforts around transitions of care, building effective patient registries and care plans and collecting accurate data for quality improvement. Equally challenging for clinics is the ability to share information for care coordination and improved transitions in care, where there are barriers both due to state privacy laws and technology to exchange data.

Next steps are to continue working with the Office of Health Information Technology and Stratis Health[28] to support implementation of meaningful use in conjunction with practice transformation in HCH and collaborate with the Health Information Technology work in the SIM grant.

[28] http://www.stratishealth.org

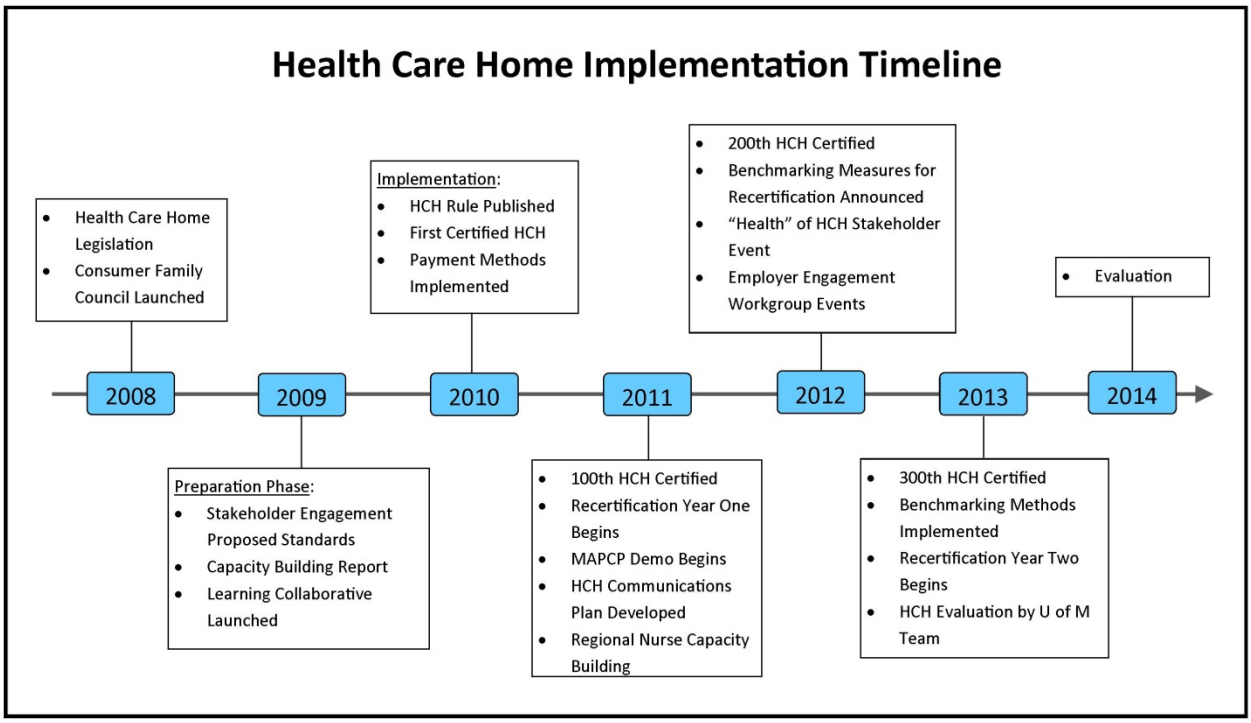
Health Care Home Evaluation

Robust evaluation and outcomes measurement are a critical part of the HCH initiative. Statutory language[29] directs the commissioners of Health and Human Services to provide to the legislature comprehensive evaluations of the HCH model three and five years after implementation. The evaluation is required to include an assessment of:

- The number of Minnesota health care program enrollees in HCH and the number and characteristics of enrollees with complex or chronic conditions, identified by income, race, ethnicity and language.
- The number and geographic distribution of HCH providers.
- The performance and quality of care of HCH.
- Measures of preventive care in HCH.
- HCH payment arrangements and costs related to implementation and payment of care coordination fees.
- The estimated impact of HCH on health disparities.
- The estimated savings from implementation of the HCH model for the fee-for-service, managed care and county-based purchasing sectors.

As a first step toward meeting the legislative requirement for evaluation of the HCH program, in March of 2012 MDH released a Request for Information (RFI) to seek input from providers and evaluators of care delivery redesign throughout the state. MDH conducted a competitive process to contract with an independent evaluator to conduct an evaluation of the implementation of the 2008 HCH legislation work that has been conducted over the following timeline.

[29] MN Statute 256B.0752



MDH/DHS selected a research team from the University Of Minnesota School Of Public Health to lead the evaluation. The University of Minnesota Research team includes investigators with extensive experience in health systems analysis. Their team includes experts in quantitative methods, qualitative methods, survey development and administration, health care policy, health economics, quality measurement, and risk adjustment.

The first evaluation report was completed in January 2014. The focus of the evaluation analysis is the first 220 certified HCH. The report includes a preliminary examination of how the HCH initiative supports the triple aim of improving quality and access and decreasing health care costs while providing patient-centered care. For comprehensive results see the HCH legislative evaluation report[30].

HCH Evaluation Key Results

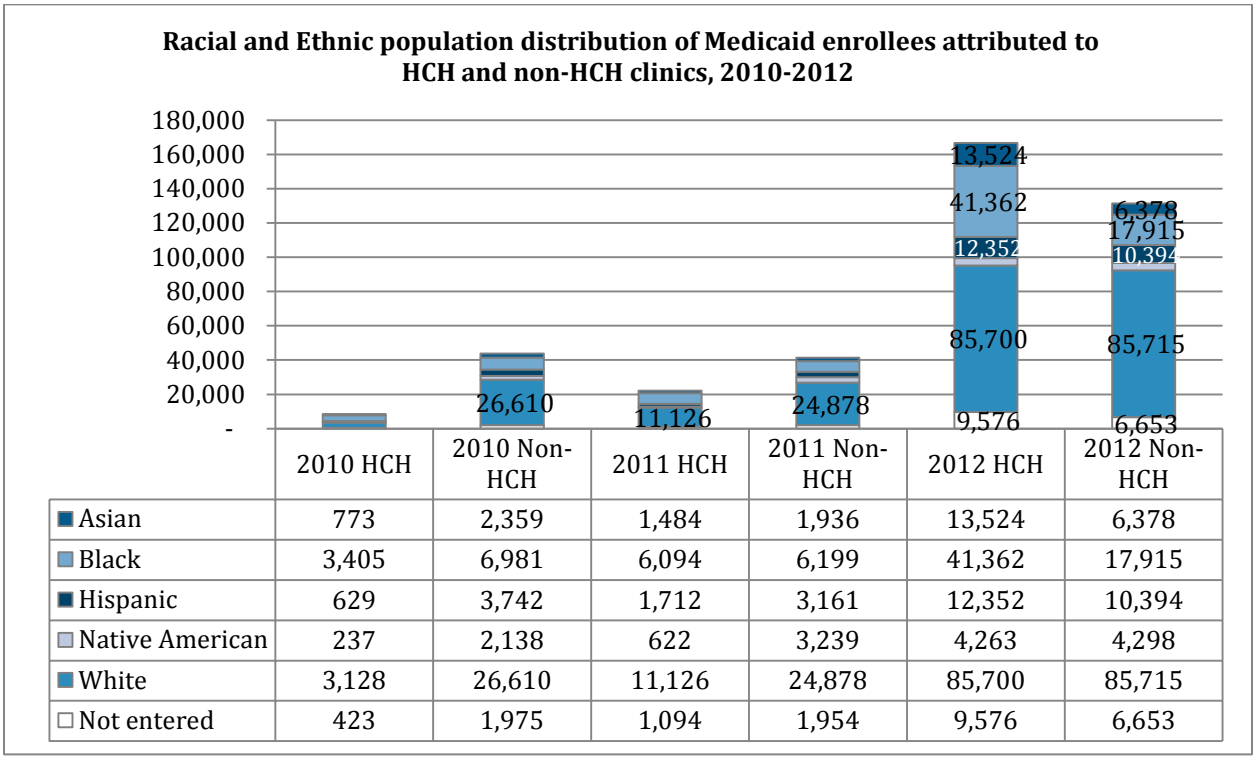
Health Care Home Model

A key strength of the HCH Initiative is that the HCH model is based on a well-defined standards and certification process, which uses direct observation in site visits and has supporting payment methodology and measurement processes.

[30] Link to HCH evaluation report

Minnesota Health Care Program Enrollee Demographics

The number and percent of Medicaid enrollees in HCH certified clinics increases over time. HCH clinics tend to care for patients who are persons of color, speak a primary language other than English, and have lower levels of educational attainment than patients in non-HCH clinics.



	2010 HCH	2010 Non-HCH	2011 HCH	2011 Non-HCH	2012 HCH	2012 Non-HCH
Asian	773	2,359	1,484	1,936	13,524	6,378
Black	3,405	6,981	6,094	6,199	41,362	17,915
Hispanic	629	3,742	1,712	3,161	12,352	10,394
Native American	237	2,138	622	3,239	4,263	4,298
White	3,128	26,610	11,126	24,878	85,700	85,715
Not entered	423	1,975	1,094	1,954	9,576	6,653

Health Care Home Provider Demographics

Nearly half of the certified Family Medicine and Pediatrics providers in the state were providing care within HCH.

Distribution of Primary Care Physicians in Minnesota and in Health Care

ABMS or AOA specialty board certification	Minnesota*			Health Care Homes	
	Number	Percent of total in MN		Number	Percent in HCH of total in MN
Total Primary Care	5,787	100%		2,187	38%
Family Medicine	2,874**	50%		1,283	45%
Internal Medicine	2,040**	35%		527	26%

Pediatrics	873**	15%		377	43%

*Includes only physicians with single board certifications.
**Denotes primary care physicians.
***Source: Minnesota Department of Health (MDH), 2011[31]

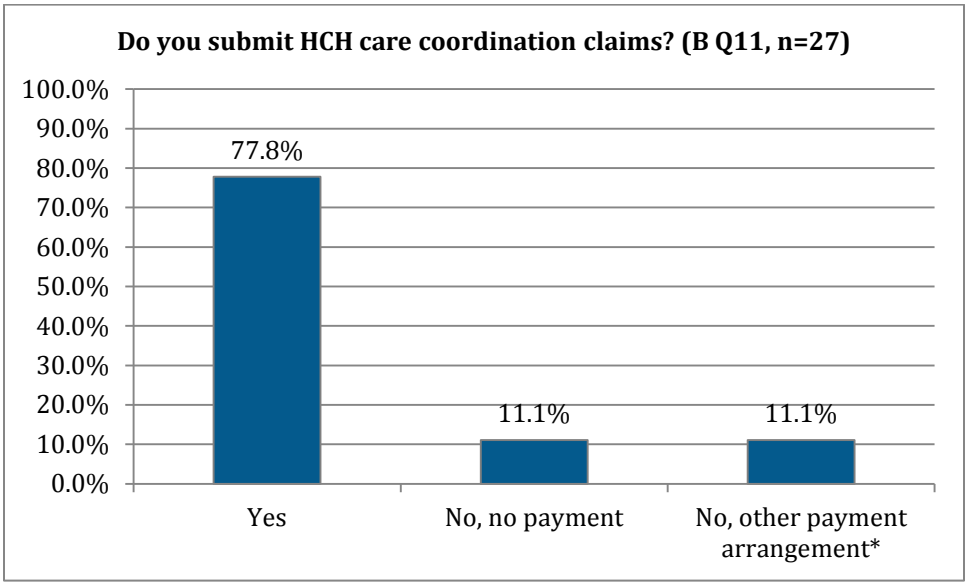
Performance and Quality of Care and Preventive Care Measures

In comparison of Statewide Quality Reporting and Measurement System (SQRMS) care quality measures, quality of care provided by clinics certified as HCH was higher than non-certified primary care clinics for most assessed quality measures. [32]

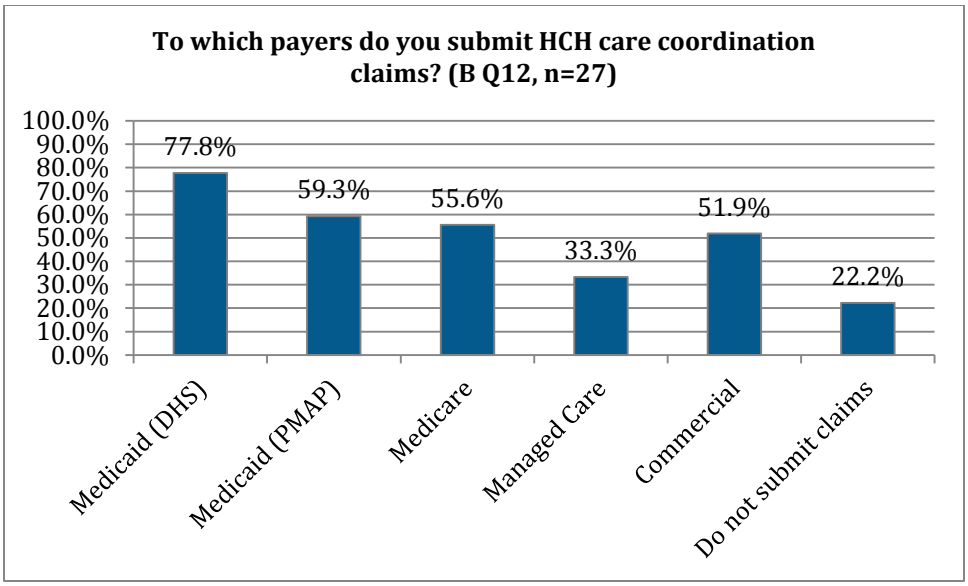
Impact on Disparities in Care

Compared to populations of color in non-certified clinics, populations of color cared for by HCH used fewer emergency department and ambulatory care services, had fewer evaluation and management visits, and used more professional services and hospital outpatient services.

Health Care Homes Payment Arrangements



[31] Health MDo. *The Geographic Distribution of Minnesota Physicians, by Specialty*. St. Paul, MN: Minnesota Department of Health; January, 2013 2013
[32] Health Care Home Evaluation Report Link 71



It is clear that HCH organizations feel it is important to obtain adequate financing to support initial transformation and maintain care coordination and billing, clinics are still working out the details of how to efficiently bill for and access payments for HCH services. The majority of HCH organizations responding to these surveys report submitting HCH care coordination claims, most often to governmental payers including Medicaid and Medicare programs. However, analysis of claims submitted to Medicaid shows about half of certified clinics submitting care coordination claims in 2012.[33]

Estimated Cost Savings

Certified HCH, while averaging higher costs and use during their start-up years, had lower overall Medicaid expenditures of 9.2% less than non-HCH comparison clinics

Calculation of Costs over 3 years of Health Care Homes Initiative				
	Total Number of Enrollees over 2010, 2011, and 2012	**Total Cost over 2010, 2011, and 2012**	**Average Cost per Enrollee over 2010, 2011, and 2012**	**Estimated HCH Cost Savings over 2010, 2011, and 2012**
HCH clinics	**203,071**	**$525,626,946**	**$ 2,588**	**9.2%**
Non-HCH clinics	**264,523**	**$753,975,197**	**$ 2,850**	

[33] Health Care Homes Evaluation Report link, page 88

Evaluation Limitations

Some evaluation limitations were noted by the University of Minnesota. Evaluation of HCH is challenging because HCH have not been operating that long, clinics vary in how they implement HCH, and there are major differences in where clinics started their transformation.
First, the evaluation is of the HCH Initiative in its initial phases. The first clinic was certified as a HCH in July 2010. While the probability of clinics that are not HCH becoming certified has increased over time, the number of HCH clinics and the number of enrollees attributed to HCH clinics in the first years of the initiative were low, making evaluation difficult.

Second, the analysis of costs used actual costs for Medicaid Fee-for-Service enrollees and estimated costs for Medicaid managed care organizations (MCOs). The strength of this approach is that it is a good estimate of the cost to the Medicaid program for these enrollees. The weaknesses are that costs are estimated only for a subset of Medicaid enrollees and that costs may not be the strongest measure of resource use.[34]

The financial evaluation is limited to an evaluation of Medicaid programs as the HCH initiative does not have access to claims data for all the payers that are required to reimburse HCH's for care coordination through Minnesota Statues, Section 62U.03. While there is data for all payers in Minnesota that would greatly benefit the HCH evaluation and allow evaluators to really understand continuity of care essential to effective HCH, the HCH initiative does not have access to the All Payer Claims Database (APCD) because of statutory restrictions on use of the APCD.[35] As a result, evaluators will need to consider other options to evaluate the effectiveness of HCH's from an all payer approach.

Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration Evaluation Activities

Alongside the state-mandated evaluation, MDH and DHS are also participating in a comprehensive evaluation of the state's HCH implementation led by independent contractors as part of the MAPCP demonstration. The MAPCP demonstration is a three year project that Medicare is conducting across the country to test the impact of providing broad based financial support from all major health care payers to facilitate the transformation of primary care practices into HCH. The team from the Centers for Medicare and Medicaid Services (CMS) and their contractors visited Minnesota in 2012 and 2013 to interview state agency staff, HCH clinic and provider staff, payers, consumers and professional associations and consumers involved in implementation of the HCH. The MAPCP first annual report will be delivered by CMS in 2014.

Agency for Healthcare Research and Quality (AHRQ) TransforMN Study

In addition to the State mandated HCH evaluation and the MAPCP demonstration evaluation MDH and DHS have also established a partnership with investigators at the HealthPartners

[34] HCH Evaluation Link and page number 99
[35] Minnesota Statutes 62U.03, 62U.04, Minnesota Rule 4653

Institute for Education and Research, funded by a $600,000 grant from the Agency for Healthcare Research and Quality (AHRQ), to study the transformation in implementing systematic care coordination and improving quality performance through HCH. The study is called TransforMN.

The TransforMN study aims to understand the transformation process among the first 132 certified primary care clinics and to what degree the transformation was related to various desired outcomes. The study seeks to understand the priorities, strategies and context of transformed clinics. It aims to learn about the relationship of transformation to quality, utilization and satisfaction. It also hopes to implement the lessons from this study throughout Minnesota and to disseminate them nationally.

Results show on average HCH clinics have significantly better performance scores for diabetes and cardiovascular disease than other clinics.[36] The extent of and change in practice systems over that same time period for the first 132 clinics serving adults certified as HCH was measured by the Physician Practice Connections Research Survey (PPC-RS), a self-report tool similar to the National Committee for Quality Assurance (NCQA) standards for patient-centered medical homes.

The findings show that for every 10% increase in the PPC-RS practice systems score there was a 1.0% improvement in the clinics diabetes composite measure and a 2.4% increase in the vascular measure. Thus as clinics become more systematic and organized in implementing their processes, the better their quality scores are. When predicting the diabetes composite score this relationship was even stronger among clinics that started with a relatively low or moderate PPC-RS score three years earlier (but was weak among those with the highest scores three years earlier). The urban location and size did not affect the relationships between changes in PPC-RS scores and diabetes or vascular composites.

Practically, the study identified many specific aspects of clinic characteristics, change strategies, and patient complexity that appeared to be important for clinics working on this transformation. MDH will integrate this information into ongoing certification and learning collaborative work.

Next Steps for HCH Evaluation

Despite the limitations to evaluating HCH through these initiatives, the Minnesota evaluations do suggest that HCH are associated with positive trends of improved quality and reduced costs while serving those with high medical need. In 2014, the first year of the evaluation results from the MAPCP evaluation will be ready for review and distribution. The University School of Public Health will continues its evaluation work for the state by extending its work and digging deeper into the data to better understand the transformation aspects of HCH for the next 102 certified clinics in 2013 for 322 certified clinics. The initial evaluation provides a strong foundation for understanding HCH's and as HCH's mature and the number continues to grow there will be a much better understanding of the effects of HCH implementation.

36 (Leif I. Solberg, 2013)

Payment Methodology

The number of HCH clinic or systems paid care coordination services for Minnesota Health Program or Medicare Fee-for-Service enrollees grew in 2012 and 2013, and the majority of clinics are now billing at least one payer for HCH care coordination services. Based on the response from billing managers to the University of Minnesota's evaluation survey, the number of clinics billing for care coordination is expected to continue to increase. Despite this growth, challenges remain to achieving continuity of payments across payers and simplified administrative processes that provide payment based on patient complexity level as required by the current legislation.

- The commercial market has in place a variety of incentive and risk-based contracts that may or may not include explicit payments to support care coordination. The use of health savings accounts and high-deductible health plans has also added a layer of confusion for both providers and patients as they try to access HCH services. Patients with health savings accounts and high-deductible plans are currently required to pay the care coordination fees out of pocket. As a result, some people decline the care coordination when it could be of great benefit. These new payment models will need to ensure that payment for care coordination is not duplicated.
- Some clinics are moving in the direction of "accountable care" and total-cost-of-care payment models and are not interested in a fee-for-service care coordination payment model. Others want a fee-for-service care coordination payment but have challenges with technology and the ability to implement the current payment process and tiering. There are others that have successfully implemented the current payment model for Medicaid and fee-for-service Medicare patients.
- There are significant barriers to implementation of care coordination payment methods for ERISA-covered employer purchasers. In response, the state implemented a contract with Minnesota Health Action Group to develop a purchaser steering committee, workshops for employers and a HCH purchaser toolkit.
- In addition, it is difficult for providers to identify Medicare Advantage patients versus Medicare fee-for-service patients that are paid for through the MAPCP demonstration.

Although federally regulated groups are not required to participate by law, there is significant interest in voluntary participation. MDH and DHS will continue working collaboratively with these purchaser groups to further expand the scope of participation in the initiative and make advanced primary care available to even more Minnesotans. These efforts can build on the current participation of the State Employee Group Insurance Program (SEGIP), for example.

As a result of stakeholder input regarding concerns about lack of alignment between the tiered payment level and their members' relative care coordination needs, DHS engaged consultant support for identifying shorter term options for addressing some of the challenges faced by providers on the complexity tier structure, and payment process. These considerations, which were shared with HCH providers in 2013, included modifying the complexity tiering structure, shifting tiering assignment responsibilities, and streamlining the claims submission process.

Additional feedback regarding the high-level options and prioritization of possible changes was solicited through survey to HCH providers. The responding clinics noted that most have established regular process for submission of HCH claims, including integrating the HCH tier assignment into clinical or billing systems and processes. When asked to prioritize potential changes, there was a moderate desire to prioritize updates to the tier assignment to better reflect patient complexity ahead of changes to the billing or claims submission process. In addition to this survey and other stakeholder feedback, considerations for payment methodology revisions will be informed by the findings of the University of Minnesota's evaluation. Review of potential improvements to the payment methodology are being done with the input of providers, provider organizations, and other payers and must be done with consideration of the feasibility of implementation for providers, DHS FFS and contracted managed care organizations.

The HCH initiative lives in the dynamic milieu of health care payment reform. For example the development of accountable care organizations. Minnesota Medicaid accountable care demonstration builds on the HCH care coordination framework and further enhances primary care. Both before the ACA and because of federal efforts through the ACA, Minnesota is transforming more broadly to a value driven payment structure. DHS and MDH continue to assess the current HCH payment methodology with this broader context in mind so as to give careful consideration to the impacts and interactions with other reform efforts.

CMS Advanced Primary Care Practice Demonstration

Minnesota is one of eight states selected by the CMS to participate in the Medicare Multi-payer Advanced Primary Care Practice (MAPCP) demonstration project. This three-year demonstration, which started in October of 2011, focuses on seniors and adds fee-for-service Medicare as one of the payers for certified HCH. The goal was to create an additional incentive for rural clinicians or clinics with a large number of Medicare patients to work toward certification as a HCH.[37]

Over the past two years, MDH and DHS continued to work with CMS and their Medicare Part B contractor to implement payment to certified clinics. Overall claim volume has been lower than expected due to billing process challenges. We are unable to identify the true number of recipients of HCH services due to the number of certified clinics that are providing HCH care coordination and not submitting claims. There is ongoing training for recipients and outreach to practices regarding billing practices.

The Minnesota team met regularly the past two years with CMS and their evaluation contractors regarding data exchange and preparations for program evaluation. Early in the demonstration, available information had either too much lag time to be useful for care coordination, or was limited to the recipients for whom claims were being billed, a very small number. In 2013, CMS and their contractor agreed to apply a beneficiary assignment and expand the available data to include all attributable Medicare FFS beneficiaries so that Minnesota could align reporting and analytics for its state program recipients. Interested HCH who had signed required data sharing agreements began receiving care management reports for their state program enrollees.

[37] http://www.health.state.mn.us/healthreform/homes/medicare/index.html

DHS continues to work with its contracted vendor to integrate Medicare and Medicaid data to support the objectives of providing panel management and patient care management reports to Minnesota health care providers.

Next Steps for Health Care Homes

Planning for the Future Ongoing Implementation of Health Care Homes

In 2012 MDH and DHS held a stakeholder event called the "Health of the Health Care Home." Stakeholders included consumers, certified clinics, government officials, quality staff and providers. The purpose of this stakeholder event was to talk about the current progress of HCH, to shape the planning and to identify key implementation elements and trends that support the continued successful implementation of HCH. Stakeholders identified the following items as focus areas for 2013 and 2014. DHS and MDH staff has prioritized these items and implementation planning is in progress. Strategies include:

1. **Consumer Engagement**

Patients who are engaged as active partners in their HCH are vital to achieving the IHI Triple Aim outcomes. Still, too many patients move through the health care system as passive recipients of care rather than as central members of the health care team and HCH and the concepts for patient centered coordinated care is not widely known by Minnesotans. Strategies include:

- Working with the SIM grant team on consumer engagement strategies that may meet the needs for promoting patient activation/engagement for patient-centered coordinated care.
- Develop consumer messaging and media packages to increase public awareness about HCH.

2. **Patient- and Family-Centered Care**

One critical tenet of HCH is a focus on patient- and family-centered care. While many providers are moving in this direction, other providers deliver care in silos rather than focusing on a whole-person, patient-centered approach. Strategies include:

- Implementing activities to ensure active emphasis on the patient voice in the implementation of HCH at all levels.
- Facilitating the alignment of patient and family centered care concepts in the implementation of the State Innovation Model grant.

3. **Payment Methodology**

- Aligning payment methods across all payers, including ERISA self-insured employer purchasers.
- Working with providers to implement billing for Medicare recipients throughout the rest of the MAPCP demonstration.
- Prioritizing to continue to ensure successful use of the HCH payment tiering or claims process based on stakeholder input.

- Addressing and implementing strategies to support ongoing foundational work to new total cost of care methods such as ACO's.

4. Certification

- Continuing certification standards and process. Supporting clinics in increasing the number of certified HCH through active capacity-building activities.
- Supporting clinics through practice facilitation collaboration under the SIM grant to rapidly increase the number of certified HCH.
- Certifying 23 clinics per quarter with focus on,
    - Certification of clinics with higher proportions of patients with chronic and complex conditions, including children with special health needs.
    - Working with the Tribal leaders and community mental health centers.
    - Targeting in regions of the state where there are currently fewer certified clinics.

5. Performance Measurement (Outcomes Measurement) and Evaluation

- Continuing collecting outcomes measures through the statewide quality reporting systems for use with recertification benchmarking and evaluation of HCH.
- Implementing the pilot for care coordination measures for transitions and end-of-life advanced care planning.
- Implementing Patient Experience survey tools for adults and pediatrics that includes questions that are specific to patient-centered medical homes.
- Implementing lessons learned from the legislatively required HCH evaluation and preparing a 2014 report that expands on the 2013 work for cost and quality.
- Finalizing MAPCP evaluation with the CMS evaluation vendor and beginning wrap up of demonstration.

6. Learning Collaborative Plan

- Implementing a collaborative learning approach with the SIM grant to meet the needs of certified HCH, those working towards certification and other inter-professional providers.
- Continuing to evaluate the participant satisfaction with the learning collaborative and the amount of learning and plan for implementation with a variety of face to face and virtual learning methods.
- Supporting evaluation of the HCH Care Coordination Toolkit for Working with Persons with Complex Needs and Older Adults

7. Linkages to Community Resources

- Continuing to implement practice facilitation resources (i.e., regional nurses, SIM grant practice facilitation) to assist clinics in developing enhanced partnerships with behavioral health, local public health and other community partners.
- Emphasizing and building community partnerships that support HCH.
- Partnering with the SIM grant to implement ACHs.
- Focusing on reduction in health disparities through collaboration with communities and through the HCH evaluation.

Conclusion

As Minnesota progresses with its reform goals to have patient-centered, coordinated care for all people, the HCH has a key role in leading the way for practice transformation. The HCH standards provide robust infrastructure and guidance to practices that are working to transform their clinics. The model has a set of tools that allow for systems change and thus for providers to care for patients with all types of conditions. There has been significant learning by HCH and ongoing sharing through the learning collaboratives and quality improvement initiatives that will continue to expand through the SIM grant with special emphasis for small and rural clinics and communities.

Though challenges exist, the creation of the HCH initiative has well-positioned Minnesota to respond to the quickly changing health care marketplace the state currently faces. The HCH model with its focus on patient-centered coordinated care is serving as a useful vehicle for focusing primary care on prevention of illness instead of just responding to illness. It is also creating a foundation for additional health care reforms, such as Accountable Care Organizations and Accountable Communities for Health.

Appendix A – Health Care Homes by County

Health Care Home Clinic/County Report 2013

County	Total 2010 Population	% of Total Population	Region	Total # of Clinics	# of Health Homes	% of Clinics Certified
Aitkin	16,202	0.31%	Northeast	3	0	0%
Anoka	330,844	6.24%	Metropolitan	22	18	82%
Becker	32,504	0.61%	Northwest	7	2	29%
Beltrami	44,442	0.84%	Northwest	3	2	67%
Benton	38,451	0.72%	Central	1	0	0%
Big Stone	5,269	0.10%	Southwest	3	0	0%
Blue Earth	64,013	1.21%	South Central	11	5	45%
Brown	25,893	0.49%	South Central	3	0	0%
Carlton	35,386	0.67%	Northeast	4	0	0%
Carver	91,042	1.72%	Metropolitan	11	4	36%
Cass	28,567	0.54%	Central	9	4	44%
Chippewa	12,441	0.23%	Southwest	4	0	0%
Chisago	53,887	1.02%	Central	7	5	71%
Clay	58,999	1.11%	West Central	6	2	33%
Clearwater	8,695	0.16%	Northwest	3	0	0%
Cook	5,176	0.10%	Northeast	3	1	33%
Cottonwood	11,687	0.22%	Southwest	6	3	50%
Crow Wing	62,500	1.18%	Central	6	5	83%
Dakota	398,552	7.51%	Metropolitan	37	22	59%
Dodge	20,087	0.38%	Southeast	1	0	0%
Douglas	36,009	0.68%	West Central	5	0	0%
Faribault	14,553	0.27%	South Central	5	1	20%
Fillmore	20,866	0.39%	Southeast	5	2	40%
Freeborn	31,255	0.59%	Southeast	2	1	50%
Goodhue	46,183	0.87%	Southeast	5	1	20%
Grant	6,018	0.11%	West Central	5	0	0%
Hennepin	1,152,425	21.73%	Metropolitan	159	85	53%
Houston	19,027	0.36%	Southeast	4	0	0%
Hubbard	20,428	0.39%	Northwest	2	0	0%
Isanti	37,816	0.71%	Central	1	1	100%
Itasca	45,058	0.85%	Northeast	8	1	13%
Jackson	10,266	0.19%	Southwest	4	2	50%
Kanabec	16,239	0.31%	Central	1	0	0%
Kandiyohi	42,239	0.80%	Southwest	6	2	33%
Kittson	4,552	0.09%	Northwest	2	0	0%
Koochiching	13,311	0.25%	Northeast	4	0	0%
Lac qui Parle	7,259	0.14%	Southwest	4	0	0%
Lake	10,866	0.20%	Northeast	3	0	0%

County	Total 2010 Population	% of Total Population	Region	Total # of Clinics	# of Health Homes	% of Clinics Certified
Lake of the Woods	4,045	0.08%	Northwest	1	0	0%
Le Sueur	27,703	0.52%	South Central	6	0	0%
Lincoln	5,896	0.11%	Southwest	4	0	0%
Lyon	25,857	0.49%	Southwest	6	4	67%
McLeod	36,651	0.69%	South Central	5	0	0%
Mahnomen	5,413	0.10%	Northwest	3	1	33%
Marshall	9,439	0.18%	Northwest	1	0	0%
Martin	20,840	0.39%	South Central	6	0	0%
Meeker	23,300	0.44%	South Central	6	2	33%
Mille Lacs	26,097	0.49%	Central	6	2	33%
Morrison	33,198	0.63%	Central	5	2	40%
Mower	39,163	0.74%	Southeast	4	1	25%
Murray	8,725	0.16%	Southwest	3	0	0%
Nicollet	32,727	0.62%	South Central	3	2	67%
Nobles	21,378	0.40%	Southwest	4	2	50%
Norman	6,852	0.13%	Northwest	3	0	0%
Olmsted	144,248	2.72%	Southeast	12	8	67%
Otter Tail	57,303	1.08%	West Central	9	2	22%
Pennington	13,930	0.26%	Northwest	1	1	100%
Pine	29,750	0.56%	Central	7	1	14%
Pipestone	9,596	0.18%	Southwest	4	0	0%
Polk	31,600	0.60%	Northwest	10	2	20%
Pope	10,995	0.21%	West Central	2	0	0%
Ramsey	508,640	9.59%	Metropolitan	82	41	50%
Red Lake	4,089	0.08%	Northwest	3	0	0%
Redwood	16,059	0.30%	Southwest	4	2	50%
Renville	15,730	0.30%	Southwest	5	0	0%
Rice	64,142	1.21%	Southeast	6	2	33%
Rock	9,687	0.18%	Southwest	2	1	50%
Roseau	15,629	0.29%	Northwest	3	0	0%
St. Louis	200,226	3.78%	Northeast	37	12	32%
Scott	129,928	2.45%	Metropolitan	8	7	88%
Sherburne	88,499	1.67%	Central	7	6	86%
Sibley	15,226	0.29%	South Central	5	0	0%
Stearns	150,642	2.84%	Central	23	15	65%
Steele	36,576	0.69%	Southeast	3	1	33%
Stevens	9,726	0.18%	West Central	4	1	25%
Swift	9,783	0.18%	Southwest	2	1	50%
Todd	24,895	0.47%	Central	5	4	80%
Traverse	3,558	0.07%	West Central	4	1	25%
Wabasha	21,676	0.41%	Southeast	4	0	0%

County	Total 2010 Population	% of Total Population	Region	Total # of Clinics	# of Health Homes	% of Clinics Certified
Wadena	13,843	0.26%	Central	2	0	0%
Waseca	19,136	0.36%	South Central	4	0	0%
Washington	238,136	4.49%	Metropolitan	15	14	93%
Watonwan	11,211	0.21%	South Central	3	0	0%
Wilkin	6,576	0.12%	West Central	1	0	0%
Winona	51,461	0.97%	Southeast	4	0	0%
Wright	124,700	2.35%	Central	10	5	50%
Yellow Medicine	10,438	0.20%	Southwest	3	2	67%
	5,303,925			735	314	43%

**** 64% of counties in Minnesota have a certified HCH***

Region	Clinics	Certified Health Care Homes	% Region's Clinics Certified
Metropolitan	334	191	57%
Northeast	62	14	23%
Northwest	42	8	19%
Central	90	50	56%
South Central	57	10	18%
West Central	36	6	17%
Southeast	50	16	32%
Southwest	64	19	30%
Total MN	735	314	43%

Appendix B – Robert Wood Johnson Foundation Bright Spot – November 2013

Minnesota's Health Care Homes: Transformative Change in Primary Care Delivery

 Julia Freeman, 51, is a woman who knows how to get what she wants. She has worked as a labor organizer for more than a dozen years and is currently the Senior Organizer for Racial Justice at a Minneapolis-based non-profit organization that trains community organizers. Yet she struggled for 17 years with her type 2 diabetes, unable to get to goal despite frequent clinic visits.

"I was diagnosed with type 2 diabetes in 1996," recalls Freeman. "Year after year, I was told by doctors that I needed to get my diabetes under control, but without the knowledge or tools to do so, I always failed. I felt like I was constantly disappointing my doctor, and so every few years, I would change clinics, hoping for a better outcome. My A1C was sometimes as high as 15 and never below 11."

Freeman said she was particularly troubled by the prospect of having to take insulin, since she was under the impression that insulin was a step toward even poorer health and, ultimately, death. "Both my parents were diabetic, and I have lost aunts, uncles and cousins to diabetes," she says. "They were all insulin dependent. In fact, my dad died on his way to dialysis. It was something that I experienced first-hand, so that's why I believed it."

So in late 2012, when Freeman decided to change clinics yet again, she was hopeful, but not optimistic. She chose a clinic right around the corner from her residence, the HealthPartners Midway Clinic in St. Paul. Initially unaware that it was certified as a HCH, she soon realized this clinic would give her a better experience than she had ever had before and with a better outcome.

Minnesota's HCH, also known nationally as medical homes, are an important component of Minnesota's comprehensive, nation-leading 2008 health reform law. The HCH initiative – a joint effort between the Minnesota Department of Health and the Minnesota Department of Human

Services – represents a transformative change in the delivery of primary care; patients and families are at the center of their care and the right care is provided at the right time, in the right place. In addition, the 2008 legislation includes payment to primary care providers for partnering with patients and families to provide coordination of care.

For Freeman, seeking treatment at a HCH was life changing. Her doctor first worked with her to dispel the myths she had about diabetes and its treatment. She was then introduced to a nurse who specialized in diabetes treatment, something she had never had before.

"My doctor, my nurse and I met as a team and co-created a plan for me," explains Freeman. "They said to me, 'the key person in this is you. We can help you, but you are the key.' I felt for the first time that I wasn't in this alone. The responsibility was on me, but I felt as though I had a whole team dedicated and committed to helping me turn around my numbers. For the first time I was really educated about the disease and what it does to my body. Not in a way that was fearful, but in a way that I felt I could conquer it."

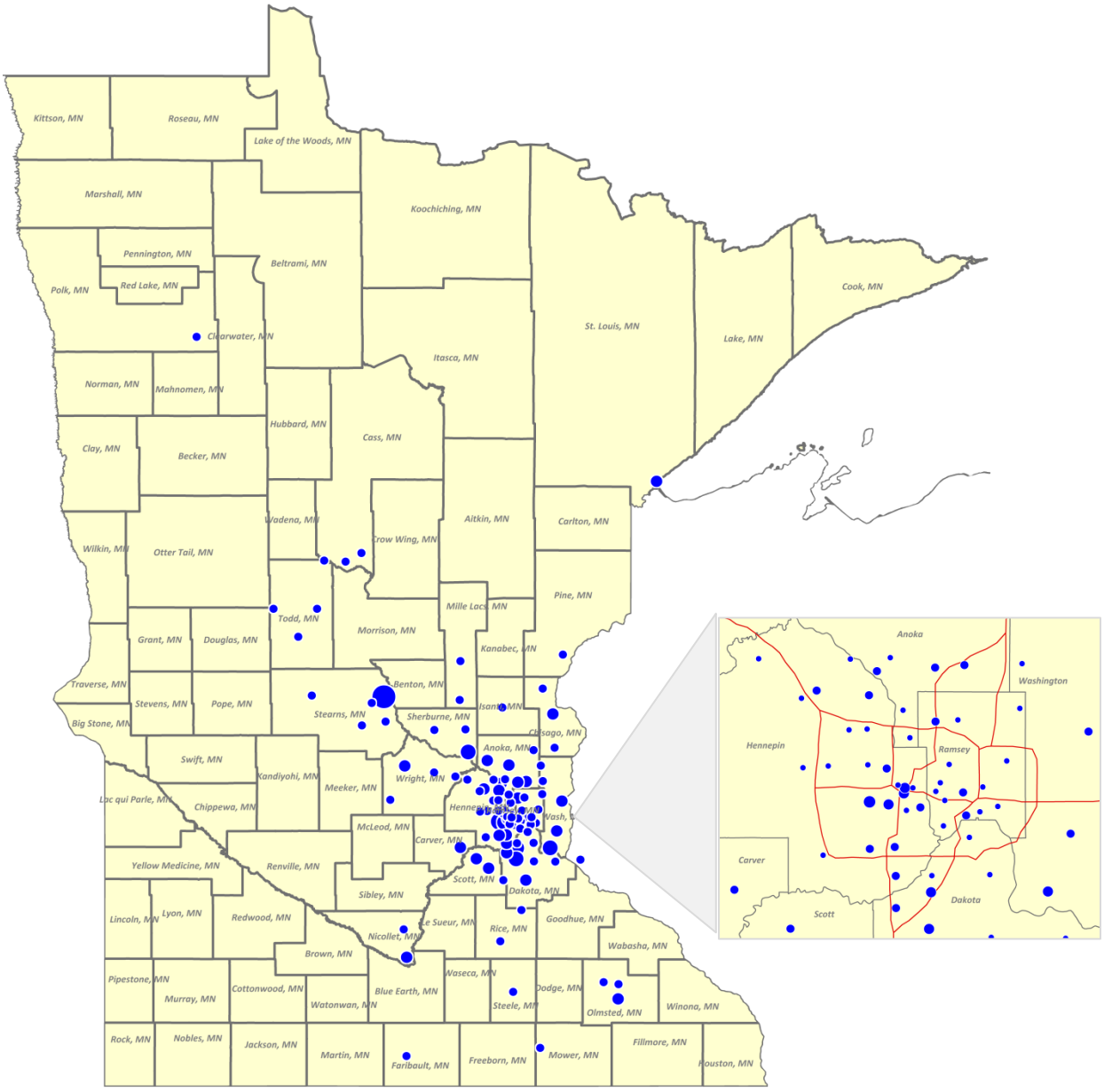
Freeman's diabetes management plan included insulin, a concept that she had become more comfortable with as she learned more about its role in controlling diabetes. She was also compelled to start testing her blood sugar regularly, a habit she had previously believed to be unnecessary. In February, she and her care team had established several goals to meet by summer, including weight loss, lower cholesterol, lower blood pressure and decreased A1C. By May, she had met or exceeded all of her goals and is still improving.

"I'm someone who thinks that knowledge is power, and you can be proactive if you have the knowledge," says Freeman. "I'm in the best health I have ever been in my whole entire life, and with the knowledge that I have now, I know that my children and grandchildren will never be diabetic. I've talked to them and shared with them what I've learned. Now we all know what to look for and how to combat diabetes. We've become a real proactive anti-diabetes family."

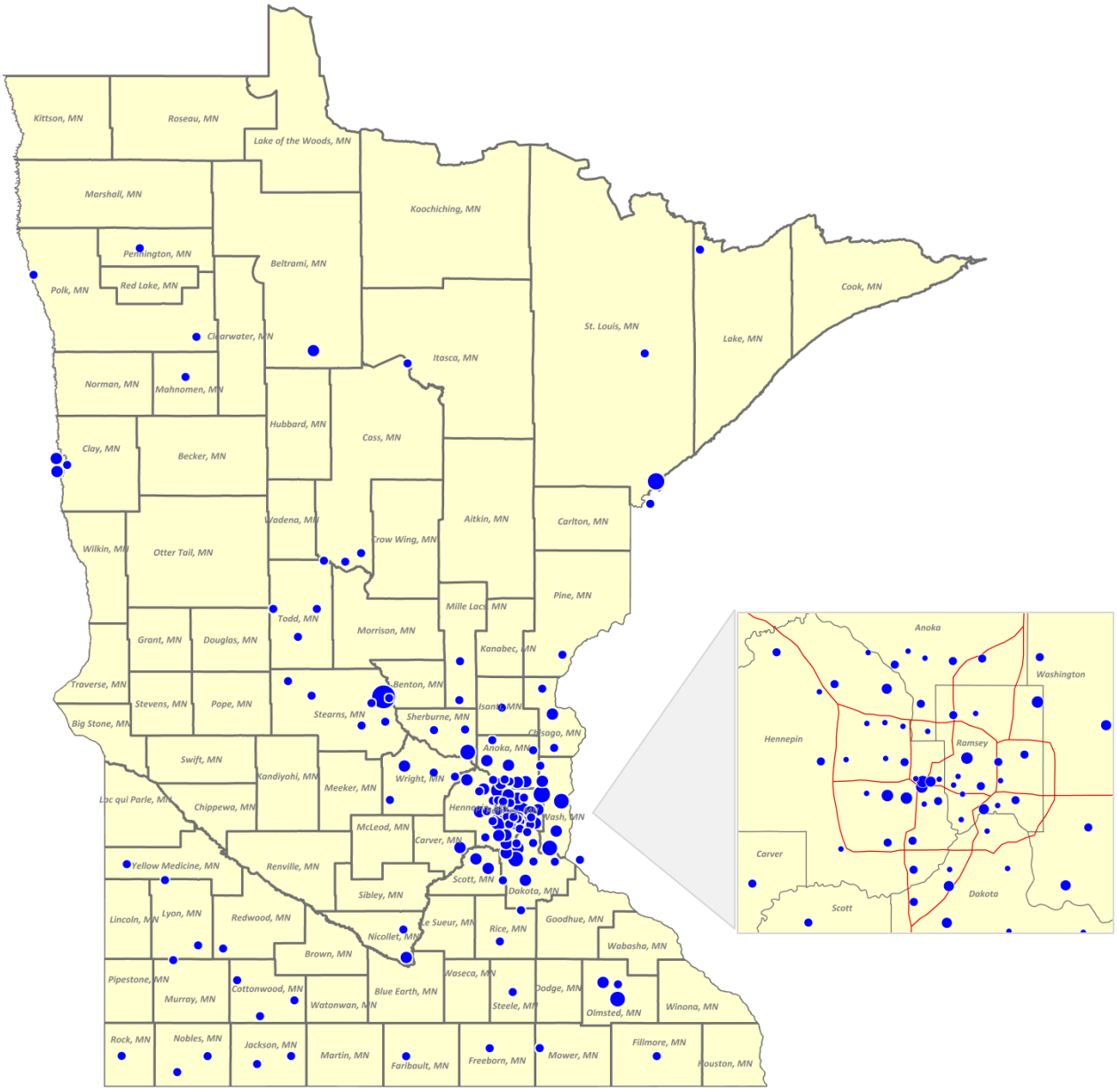
The Minnesota Department of Health maintains a list of certified health care home clinics on their website.

Appendix C - State Maps of Health Care Homes

Locations of Minnesota's Certified Health Care Homes - 2011

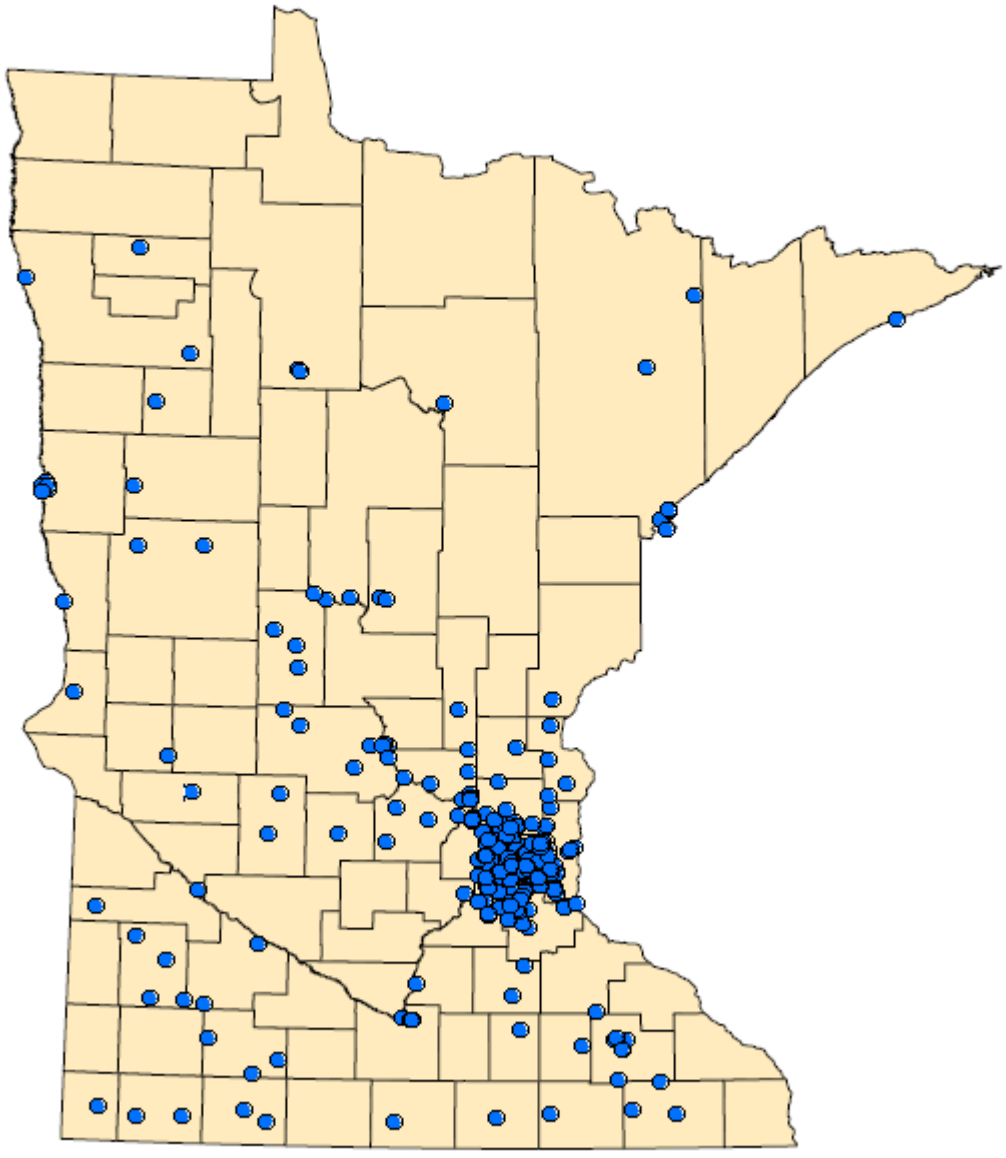


Locations of Minnesota's Certified Health Care Homes – 2012



2013 Certified Health Care Homes (as of November 1st, 2013)

Locations of Minnesota's Certified Health Care Homes



Source: MN Department of Health, November 1, 2013