Health Care Homes

Transforming CLINICS ABILITY to provide PATIENT CENTERED CARE

ANNUAL REPORT TO THE LEGISLATURE – FEBRUARY 2015

Health Care Homes

Minnesota Department of Health,

PO Box 64882, St. Paul, MN 55164-0882

651-201-3626

http://www.health.state.mn.us/healthreform/homes/

As requested by Minnesota Statute 3.197: This report cost approximately $11,500.00 to prepare, including staff time, printing and mailing expenses.

Protecting, maintaining and improving the health of all Minnesotans

February 16, 2016

The Honorable Tony Lourey
Chair, Health and Human Services
Budget Division
Minnesota Senate
2105 Minnesota Senate Building
95 University Ave. W.
Saint Paul, MN 55155-1606

The Honorable Matt Dean
Chair, Health and Human Services Finance
Committee
Minnesota House of Representatives
401 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155

The Honorable Kathy Sheran
Chair, Health, Human Services and Housing
Committee
Minnesota Senate
2103 Minnesota Senate Building
95 University Ave. W.
Saint Paul, MN 55155-1206

The Honorable Tara Mack
Chair, Health and Human Services Reform
Committee
Minnesota House of Representatives
545 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155

Dear Senator Sheran, Senator Lourey, Representative Mack, and Representative Dean:

The 2008 Legislature required the Minnesota Department of Human Services (DHS) and the Minnesota Department of Health (MDH) to work together to establish the Health Care Home program, and for MDH to produce an annual report on the operations and outcomes of the program. This report provides an overview of activities that took place during 2015, along with highlights from the legislatively mandated independent five-year evaluation of the program.

The major results highlighted in this report include the following:

- The HCH program ended the year with a total of 361 certified clinics (54 percent of Minnesota primary care clinics), with an additional 21 border state clinics certified.
- MDH launched a statewide HCH Advisory Committee that will make recommendations on how to strengthen the program and ensure that it is financially sustainable.
- The HCH program held a successful Learning Days conference, attended by 580 people.
- The program created new programming with a stronger emphasis on community engagement, partnership, integration of behavioral health and practice transformation, and awarded nearly 50 grants to providers around the state.
- The five year evaluation found that HCH clinics have better rates on quality measures than non-HCH clinics. Transforming to a HCH clinic improves quality outcomes on Asthma, Vascular Care, Diabetes, Depression and Colorectal measures.
- Across the five year evaluation period, spending for Medicaid, Medicare and Dual Eligible patients cared for in HCH clinics would have been approximately $1 billion more if those patients had not been in HCH clinics.

Questions or comments on the report may be directed to the Health Care Home Program at (651) 201-3744.

Sincerely,

Edward P. Ehlinger, M.D., M.S.P.H.
Commissioner of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164

Contents

Executive Summary

"This HCH clinic is like the restaurant owner who creates the menu based on the customer's preferences." (Patient Comment)

The Health Care Homes program (HCH) is one of the centerpieces of Minnesota's health reform initiative. Through their focus on redesign of care delivery and meaningful engagement of patients in their care, Health Care Homes are transforming care – and lives - for 3.6 million Minnesotans.

The name "Health Care Home" acknowledges a critical shift that needs to happen in order to truly improve health in Minnesota: a shift from a purely medical model of health care to a focus on linking primary care with wellness, prevention, self-management and community services. The goals of this model are to:

- Continue building a strong primary care foundation to ensure all Minnesotans have the opportunity to receive team-based, coordinated, patient-centered care.
- Increase care coordination and collaboration between primary care providers and community resources to facilitate the broader goals of improving population health and health equity.
- Improve the quality and the individual experience of care, while lowering health care costs.

In 2015, the HCH program continued to take important steps towards these goals. The program:

- Certified 33 clinics, ending the year with a total of 361 clinics (54 percent of Minnesota primary care clinics), with an additional 21 border state clinics certified.
- Contacted all Minnesota primary care clinics and offered capacity building support.
- Launched a statewide HCH Advisory Committee that will make recommendations on how to strengthen the program and ensure that it is financially sustainable.
- Held a successful Learning Days conference, attended by 580 people.
- Expanded its focus on State Innovation Model initiatives by creating new programming with a stronger emphasis on community engagement, partnership, integration of behavioral health and practice transformation.
- Awarded 46 practice transformation grants totaling $716,040, as part of the State Innovation Model initiative, to support providers in redesigning care processes with the goal of providing more patient centered, coordinated, accountable care.
- Awarded two practice facilitation grants totaling $966,601, as part of the State Innovation Model initiative, designed to provide practice facilitation services support.

Looking across the full six-year arc of the program, it is clear that this work is paying off in terms of both improved care and lower costs. The legislatively mandated five-year independent evaluation of HCH certified clinics indicates that:

- HCH clinics have better overall rates on quality measures than non-HCH clinics. Transforming to a HCH clinic improves quality care outcomes on Asthma, Vascular Care, Diabetes, Depression and Colorectal measures.

- From 2010-2014, HCH certified clinics were 9 percent less expensive than non-HCH clinics based on Per Member Per Year (PMPY) reimbursement costs within the Medicaid and Medicare programs.
- HCH clinics have fewer hospitalizations compared to non-HCH clinics. Hospital costs are also lower for HCH clinics compared to non-HCH clinics.
- Across the nearly five year evaluation period, spending for Medicaid, Medicare and Dual Eligible patients cared for in HCH clinics would have been approximately $1 billion more if those patients had not been in HCH clinics.

Health Care Homes are successfully lowering costs and improving quality for the patients they serve, by transforming how primary care is delivered. However, not all Minnesota clinics are participating in this voluntary program, and the clinics that are participating are not equally distributed around the state. Residents of 32 rural counties – more than 500,000 Minnesotans – lack access to a certified HCH in their local community, and are potentially missing out on these important benefits. For residents of an additional 19 counties, only a single clinic has become certified. Ensuring that *all* Minnesotans can benefit from coordinated, patient-centered care that meets their needs, and that we are supporting clinics in making this transition, is a critical priority for the coming year.

As it enters its 7th year, the HCH program is at a critical juncture. The program is evaluating feedback from stakeholders, assessing the needs of 'late adopters' of the HCH delivery model, and determining ways to continue to build community partnerships so that the program can successfully expand and grow, and its benefits can extend to all Minnesotans in all counties. In particular, in the coming year the HCH program will explore:

- Addressing financial sustainability needs of HCHs through analysis of the current state of payment and reimbursement for care coordination and findings from national initiatives.
- Determining the need for evolution of the certification standards and processes.
- Addressing barriers for those clinics that haven't certified as a HCH but want to.
- Focusing on populations experiencing disparities through expansion to the community and the creation of partnerships outside of the traditional health care system.

Because of the strong foundation of success built in the first six years of the program, Minnesota's Health Care Homes are well-positioned to continue to improve patients' experience of care, reduce the cost of care and improve the quality of care outcomes.

Introduction

"Providers have a synergy through the medical home process and it has been beneficial. Becoming a medical home has been powerful and got me thinking differently about my population." (Provider comment)

Health Care Homes: a Minnesota Approach

The Health Care Homes (HCH) program is one of the centerpieces of Minnesota's health reform initiative. Through their focus on re-design of care delivery, Health Care Homes provide patient-centered, comprehensive primary care to 3.6 million Minnesotans. While most states refer to the model as a Patient Centered Medical Home (PCMH), Minnesota embraces the principles of a PCMH but chose the name "Health Care Home" to acknowledge a shift from a purely medical model of health care, and to focus on linking primary care with wellness, prevention, self-management and community services. The goals of this model are to:

- Continue building a strong primary care foundation to ensure all Minnesotans have the opportunity to receive team-based, coordinated, patient-centered care.
- Increase care coordination and collaboration between primary care providers and community resources to facilitate the broader goals of improving population health and health equity.
- Improve the quality and the individual experience of care, while lowering health care costs.

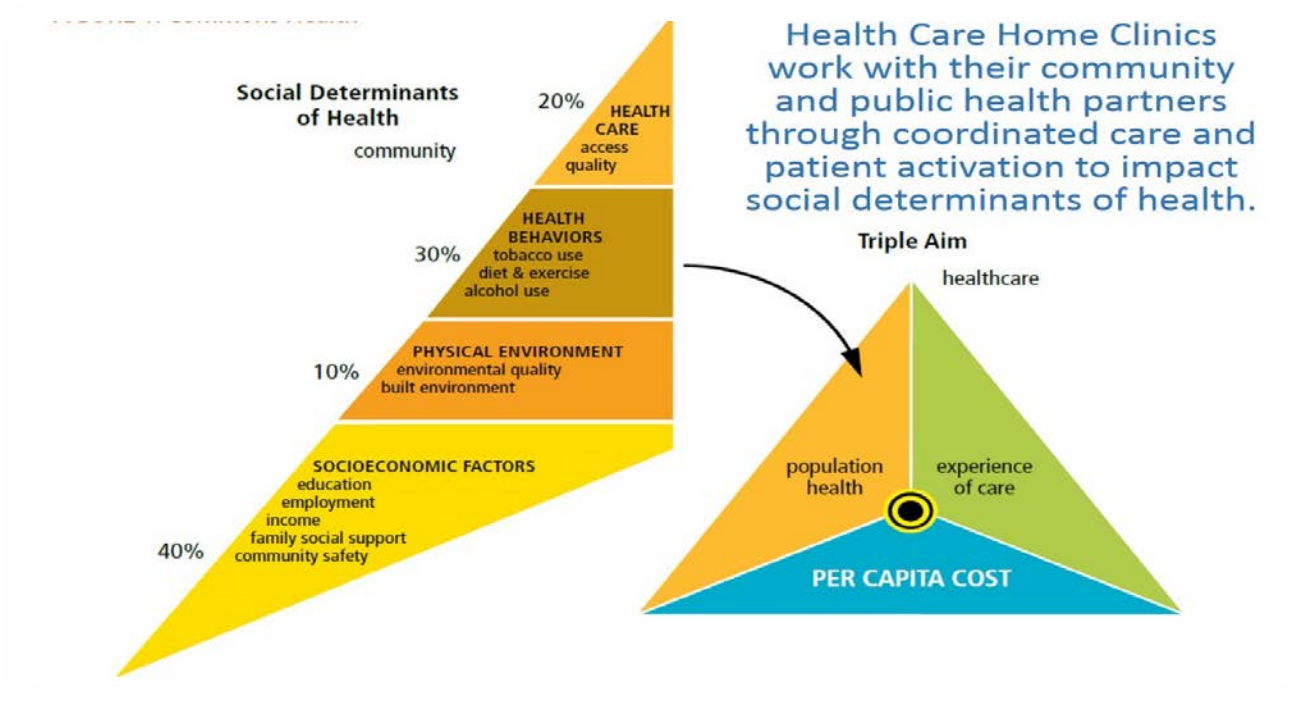
Supporting Health Equity through Health Care Homes and Community Partnerships

"The clinic has community outreach people who are going into shelters and walking the streets on Broadway. We get them into the Health Care Home program for housing, transportation, food, mental health providers, and have a social worker who can talk about stress." (Care Team Comment)

While all PCMH models focus on providing patient-centered care and engaging patients and families, Minnesota's approach incorporates an explicit focus on broader community partnerships and health equity. The HCH certification requirements push clinics to develop partnerships outside of the traditional health care system. These relationships lead to more equitable care, in alignment with the Minnesota Department of Health's (MDH) vision to advance health equity throughout Minnesota.

An important goal of these transformation efforts is to address health inequities with a strategic approach that goes beyond the walls of a clinic. The health care delivery system can only address approximately twenty percent of what creates health; the rest is largely influenced by social determinants of health, such as income, education, housing, and safe communities, that lie outside of the care delivery system. The HCH model builds a strong primary care foundation and expands care partnerships to the community in order to fully address the health needs of individuals.

Figure 1: Commons Health



Transformation to a HCH also prepares primary care clinics for value-based purchasing, which is becoming more common through the growing presence of Accountable Care Organizations (ACO), and through changes in purchasing approaches at the federal level through Medicare. In Minnesota, the work of the State Innovation Model (SIM) is helping to expand the impact of HCH's re-design of primary care delivery through grant funding to support practice transformation that aligns with the standards and priorities of HCH, increased support to ACO or similar arrangements, and the development of 15 Accountable Communities for Health (ACH).

Health Care Homes Advisory Committee

The work of the HCH program is guided by a statewide HCH Advisory Committee. This group, which was formed pursuant to a statutory change in 2014, is guiding MDH in asking and answering questions about the evolution of the HCH program, participation in and learning from the SIM grant initiative, and the development of strategic goals for the future. Members of the Advisory Committee include consumers, health care professionals, employers, researchers, and representatives from health plans, HCH clinics, a quality improvement organization and a state agency (Minnesota Management and Budget/State Employee Group Insurance Program). A list of the Advisory Committee members is available in Appendix A.

The committee has formed several workgroups which encompass the key priority areas of:

- Practice transformation
- Financial sustainability
- Learning collaborative
- Communication and evaluation

Key aims include discussing the needs and barriers of HCH and SIM stakeholders, expanding the knowledge of people in Minnesota about these initiatives, improving the health of all Minnesotans and measuring the value of the program. The remainder of this report will describe key successes, challenges and opportunities for the HCH program in the areas of practice transformation, financial sustainability, learning collaborative and communication and evaluation.

The HCH Advisory Committee met twice in 2015. More information about the committee and its upcoming meetings is available here: http://www.health.state.mn.us/healthreform/homes/hchadviscomm/index.html.

Practice Transformation

"To implement a health care home you need to follow your own heart, have courage and brains. Our patients report feeling an extra touch and access through the care coordination program." (Provider comment)

Health Care Homes: Transforming Primary Care

Becoming a HCH isn't just about meeting certification criteria and checking a box; it's about transforming how care is delivered, how a care team collaborates with the patient and their family to meet needs, and how information is shared and used. Clinics that start down the HCH path are committing to changing their culture as well as their infrastructure.

While there are a variety of state and federal programs and policy levers that are pushing health care providers in this direction, the best metric of how far Minnesota clinics have moved along this path is the number that have become certified through the HCH program.

Health Care Homes Certification

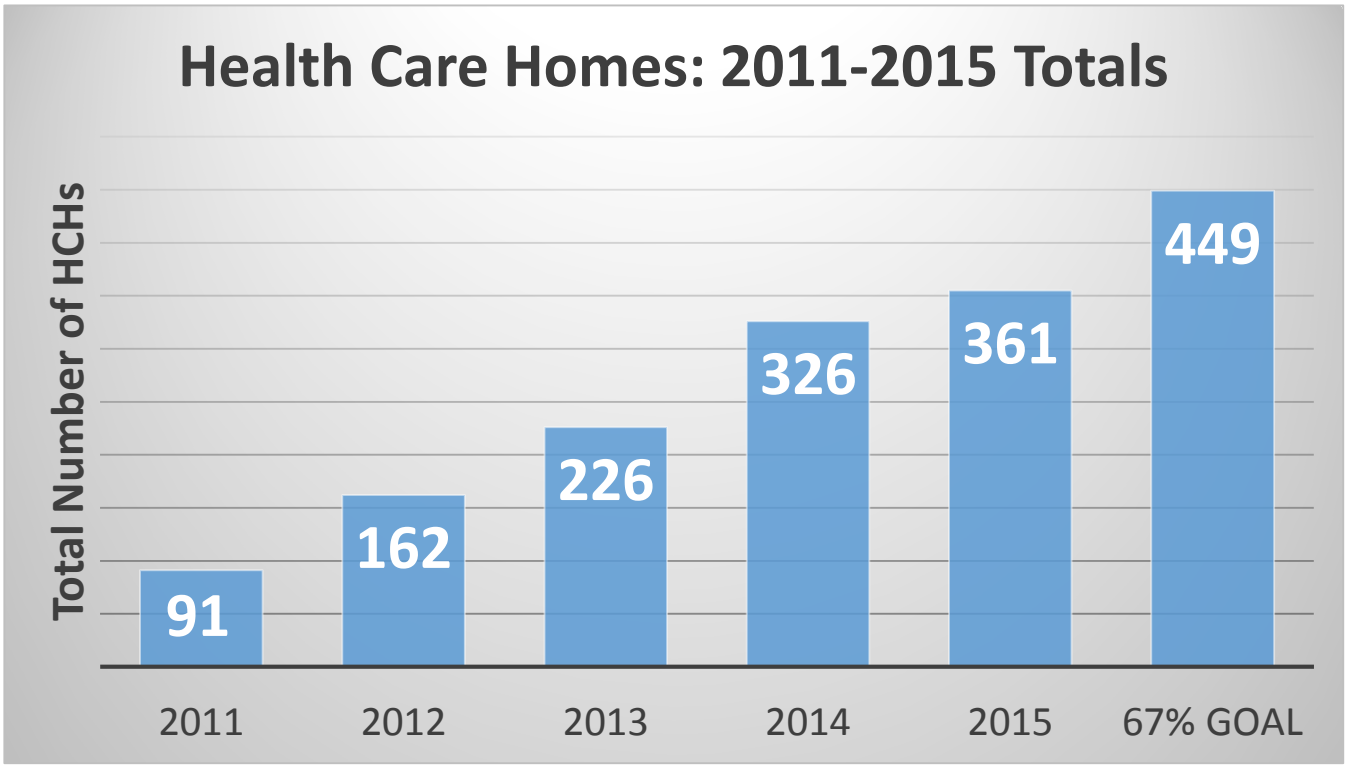
The HCH legislation provides certification criteria that are intended to be challenging but also flexible and innovative, allowing primary care clinics throughout the state to choose to become HCH certified. The certification criteria require clinics to meet standards in five domains:

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

Health Care Home's voluntary certification and recertification process requires a balance between fidelity to the model and flexibility for innovation. The program is not prescriptive and clinics are encouraged to evaluate the population they serve and develop strategies to meet those needs.

At initial certification and year one recertification, the clinic puts into place foundational processes to build the needed infrastructure to deliver patient centered quality care. MDH certifies clinics throughout the year, with review and recommendation from the HCH Community Certification Committee. Figure 2 displays number of HCH clinics certified statewide from 2011- 2015. Beginning at recertification year two, the certified clinic begins using quality outcomes as a component for their annual recertification.

Figure 2: Health Care Homes Clinic Certification by Year, 2011-2015

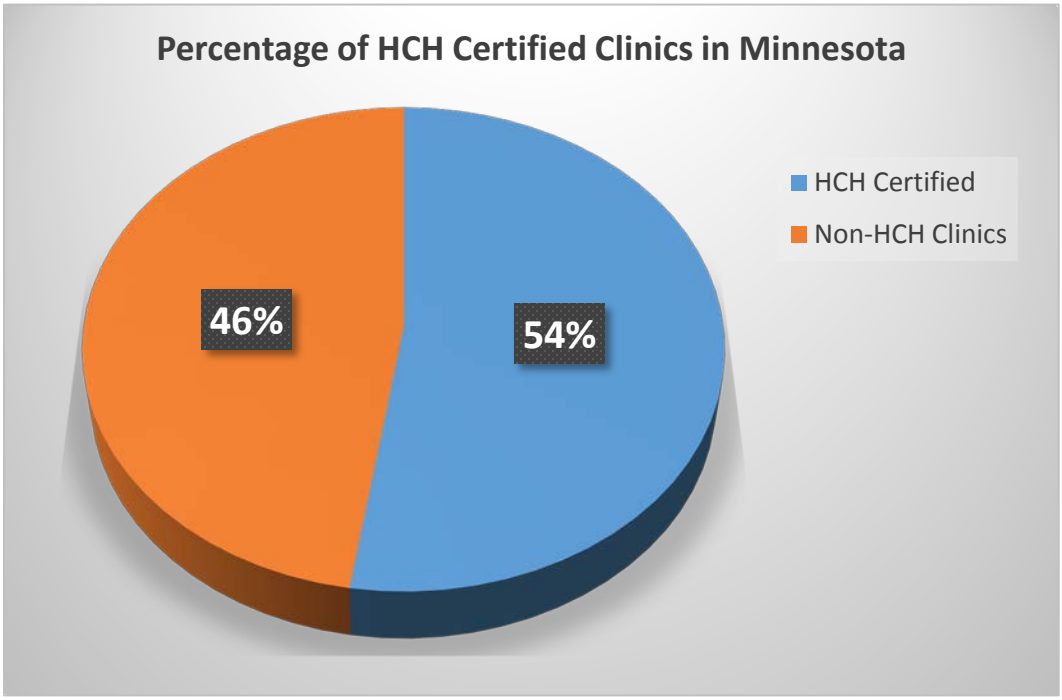


Certification by the Numbers

In 2015, MDH certified 33 clinics, ending the year with a total of 361 certified clinics, representing 54 percent of Minnesota primary care clinics (see Appendix C: Map of HCH Clinics 2015). An additional 21 border state clinics are also certified as HCH clinics since they are part of a Minnesota healthcare system.

In 2015, 100 percent of certified clinics applied for recertification. Overall, since 2010, when the first HCH clinics became certified, 393 clinics have certified as a HCH with only 11 clinics not recertifying. Of those, four clinics closed, while others cited lack of resources including time, money and staff. One plans on recertification at a later time, and some have sought national PCMH certification due to multi-state location of clinics.

Figure 3: Percentage of Health Care Homes Clinics Certified in Minnesota by 2015



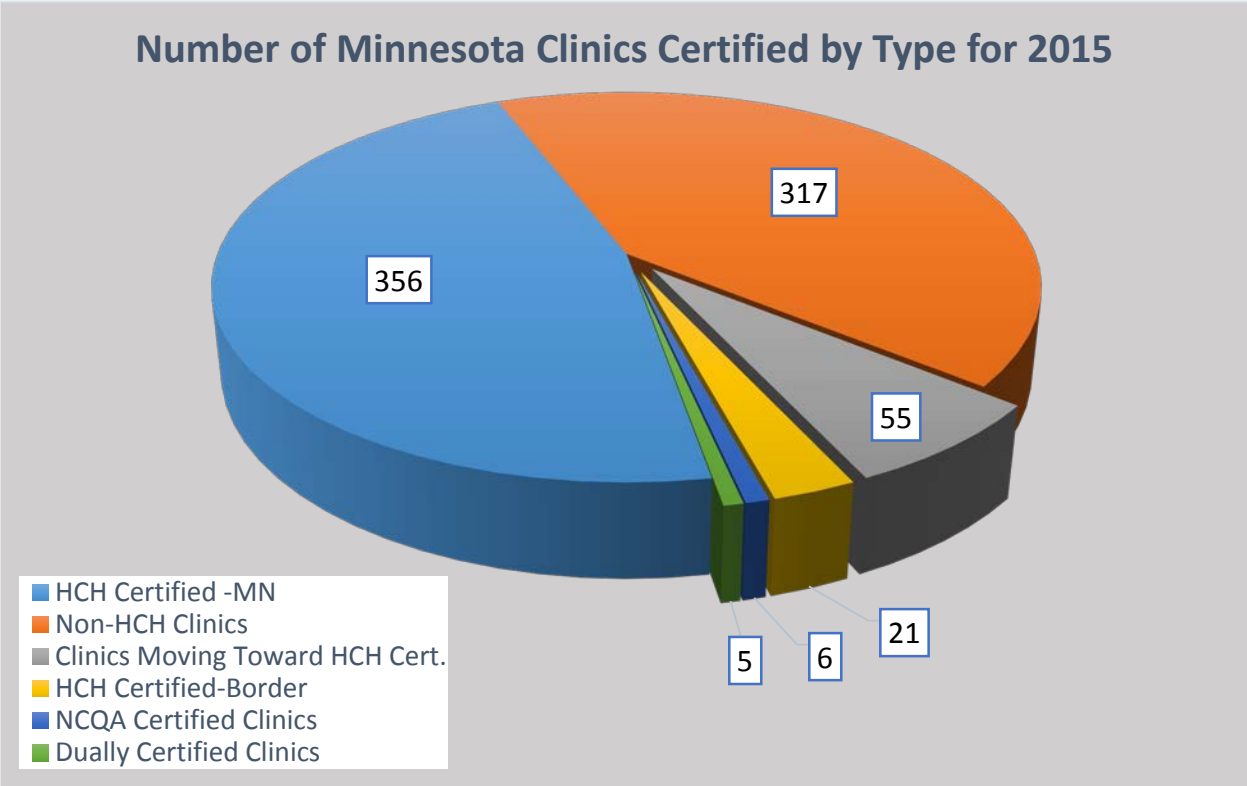
The additional HCH clinics certified in 2015 indicates a slowdown in the number of clinics ready for certification; the HCH program originally projected to certify 67 percent of all Minnesota primary care clinics by the end of 2015. Generally, clinics that are not certified are smaller practices along with numerous pediatric clinics. In addition, some larger organizations have not spread HCH certification to their satellite clinics due to the time required to do so as well as participation in other competing initiatives in which requirements do not align with HCH.

In addition to Minnesota's HCH model, there are national bodies, such as the National Committee for Quality Assurance (NCQA) and the Joint Commission, that offer recognition to clinics that have met certain criteria. The various recognition programs are all established based on core PCMH concepts but vary with regard to site visits and requirements for renewal of recognition. In comparison, Minnesota's program is more closely aligned with other state-specific initiatives and goals, requires on-site certification and recertification visits to more fully evaluate implementation of the model, and includes a strong technical assistance and shared learning/learning collaborative component to promote flexibility and innovation at the clinic level. Clinics in Minnesota that have chosen a national recognition model tend to have clinics located in other states and chose to have alignment throughout their organization.

Capacity Building

One of the strengths of the HCH program is the intensive support that it provides to clinics that are considering, or preparing for, certification so that they are best positioned to succeed. At the end of 2015, approximately 55 clinics are receiving capacity-building assistance to help prepare them for the certification process.

Figure 4: Certification by Program and Clinics Moving Towards Certification for 2015



A continued focus of the HCH program is to build capacity for practice transformation throughout the state. The HCH team, with input from the community, has identified development of community partnerships as a key strategic priority for 2016, and developed initiatives to promote community partnerships and support implementation of HCH, including:

- Educating and providing technical assistance to community partners and interested parties throughout the state about patient- and family-centered care models.
- Supporting clinics through practice facilitation and practice transformation collaboration under the SIM grant to increase the number of certified HCH.
- Aligning the work of the Minnesota Children and Youth with Special Health Needs (CYSHN) program with the HCH initiative.
- Working with the Department of Human Services (DHS) on Behavioral Health Home Integration.
- Partnering with the Statewide Health Improvement Program on the Community Wellness Grant by aligning work between grantees and HCH primary care practices to promote healthy lifestyles and strategies.

The HCH regional nurse planners have contacted all primary clinics to assess readiness for certification and to support clinics' needs, and are maintaining a presence through periodic contact with primary clinics throughout Minnesota.

As noted on the table below, there is a relatively lower percentage of certified primary care clinics in the Northwest and South Central rural regions of the state. Of Minnesota's 87 counties, currently there are 32 in which no clinics have yet been certified. All of these are non-metro counties.

A communication plan to demonstrate and communicate the effectiveness of the HCH program, and to communicate its value to a wider audience of providers, health care coordinators, and patients is under development with the Communication and Evaluation Advisory Workgroup. A primary focus will be to show non-HCH clinics the value and business case for becoming HCH certified.

Table 1: Regions and HCH Certification Information

Region	Clinics	Certified HCH	Clinics to Reach 67% Goal	% Region's Clinics Certified	% Counties with One Or More Certified Clinic	Clinics per 100,000 People	Certified Clinics per 100,000 People	2010 Population
Metropolitan	311	208	Goal met	66.9%	100%	10.91	7.30	2,849,567
Northeast	55	21	15	38.2%	57%	16.86	6.44	326,225
Northwest	37	8	16	21.6%	38%	18.35	3.97	201,618
Central	82	59	Goal met	72.0%	86%	11.25	8.09	729,084
West Central	27	11	7	40.7%	63%	14.27	5.81	189,184
South Central	54	13	23	24.1%	45%	18.54	4.46	291,253
Southeast	52	21	13	40.4%	82%	10.51	4.25	494,684
Southwest	55	23	13	41.8%	63%	24.74	10.35	222,310
Total MN	**671**	**361**	**88**	**54%**	**66.75%**	12.69	6.86	5,303,925
Border States	0	21						
Total	**671**	**376**						

"I feel like the team supports me and before health care home I felt like I was in a solo practice." (Provider comment)

The number of certified providers within HCHs has more than doubled since 2012. Family Medicine, Internal Medicine, Pediatricians, Nurse Practitioners and Physician Assistants providing comprehensive primary care make up the majority of the certified HCH providers. Specialty providers, who provide comprehensive primary care make up two percent of the certified HCH providers. These specialties include geriatricians, women's health, pediatricians and HIV specialists.

Table 2: 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	1,036	447	282	306	188	94
%	44%	19%	12%	13%	8%	4%
2013 n= 3,429	1,547	589	436	473	307	77
%	45%	17%	13%	14%	9%	2%
2014 n= 4,064	1,716	745	512	620	389	82
%	42%	18%	13%	15%	10%	2%
2015 n= 5,182	1,998	1,092	700	838	459	95
%	39%	21%	14%	16%	9%	2%

Next Steps

Continued expansion and success of the HCH program will depend on ensuring that challenges experienced by clinics associated with certification are effectively addressed in a way that does not compromise the principles or goals of the program. Primary care providers cite several barriers to certification, including:

- Recertification cycle can be time-consuming.
- Interoperability concerns with sharing of information to coordinate care with area hospitals, emergency rooms and other community health services such as local public health, which would make it easier for a clinic to meet the expectations of ongoing certification.
- The desire for timely claims/utilization data along with more capability and resources at the clinic level, in order to monitor and address gaps in care.
- Several larger systems are participating in multiple initiatives and have expressed the desire to have continued alignment of reporting requirements at the state and federal level.
- Financial sustainability and expressed concern about the current model of HCH reimbursement.

The question of an appropriate recertification timeline is a topic that the HCH Advisory Committee will be discussing in 2016, with a goal of balancing administrative burden and the need to ensure that certification criteria are met. Other cited barriers will also be reviewed and discussed at the advisory workgroup and advisory committee levels using the expertise of the various representatives with inclusion of other appropriate program personnel for recommendation and next steps.

Minnesota Accountable Health Model: Integrating Care

"They helped me with housing issues, job search, finding community based resources. I got help. They give quick answers back. I get information I need. I had problems with pharmacy, everything was taken care of." (Patient Comment)

Since its inception, the HCH program has supported clinics in developing or deepening their partnerships with community organizations and other resources. The HCH certification standards require by the end of the first year of HCH certification, the clinic demonstrate ongoing community partnerships to enhance their care coordination system and strengthen patient and family centered principles. Minnesota's federal State Innovation Model (SIM) grant has allowed that work to accelerate in 2015.

The goal of Minnesota's SIM grant is to support the "Minnesota Accountable Health Model," and to provide all Minnesotans with better value in health care through integrated, accountable care that is supported by innovative payment and care delivery that is responsive to the needs of each identified community.

To accomplish these goals, transformation of the health care system is necessary through investments in the infrastructure and by directly supporting providers and communities that will participate in these models. The activities supported by the Minnesota Model, which include grants for health information exchange, enhanced data analytics, adoption of emerging professions such as community health workers, practice transformation and the establishment of Accountable Communities for Health (ACH) are accelerating movement towards coordinated, integrated care, and service delivery across an expanded continuum of care and giving providers tools to improve quality, patient experience and health outcomes, while actively engaging communities and reducing health care expenditures.

The Minnesota Model's goal is to increase the number of certified primary care clinics providing coordinated care through a HCH or behavioral health home to 67 percent by 2017. SIM funds are supporting the increase through the funding of practice transformation and facilitation grants. Many of the practice transformation and care process redesign activities supported by the Minnesota Model build on the processes developed by the Health Care Homes program. Two of the SIM grant programs that are most closely tied to the HCH program are the Practice Transformation and Practice Facilitation grants.

Practice Transformation Grant

The Practice Transformation grants support providers in changing processes, with the goal of providing more patient centered, coordinated, accountable care. Particular focus was placed on small and rural providers who face financial barriers to transformation, and those that want to become certified as HCHs or Behavioral Health Homes.

During 2015, MDH released three rounds of grants. The first round awarded 10 grants to primary care, behavioral health and social service organizations committed to practice transformation and the integration of care. Priority was given to clinics seeking HCH certification or recertification. These grants were for six months, and the majority of the projects were completed in 2015. The second round of grants awarded 12 applicants for a nine month period. The focus of this round of grants limited to funding to organizations whose goals included becoming health care homes, behavioral health homes or working on further integration between primary care and behavioral health.

The third round of the Practice Transformation grants was released September 1, 2015. This grant funding was only available to organizations who are part of the Behavioral Health Home first implementers group through the Minnesota Department of Human Services. These will be six months grants and will support working towards building capacity to meet behavioral health homes certification standards. The grants will start in January and end in June 2016.

A total of 15 grants were awarded to certified HCH clinics seeking recertification, and eight clinics were awarded grants to support their transformation for HCH certification.

Practice Facilitation Grants

The Practice Facilitation grants are designed to provide support, including advising and providing resources and innovative approaches, directly to practices implementing transformative activities that help remove barriers to care integration. The goal is to coordinate an approach for these services across various groups, and the awardees will work closely with HCH nurses, Integrated Health Partnerships (IHP) team members and MDH Office of Health Information Technology (OHIT) program staff.

Two organizations were funded to provide practice facilitation services, ICSI/Stratis Health and National Council for Behavioral Health, and began their work in June 2015. The grant work will continue through December 2016.

ICSI/Stratis Health will provide practice facilitation to 10 to 15 primary care and specialty clinics to expand the numbers of patients who are served by team-based integrated/coordinated care in Minnesota. They will work with participating provider organizations to identify project goals and measures in relationship to the targeted areas of: total cost of care; health care homes; integration of health care with behavioral health, social services, long term care and post-acute care services; integration of non-physician health care team members; expanded community partnerships; health IT; and chronic care management.

The National Council on Behavioral Health will provide practice facilitation services for up to 25 care teams from the MN Association for Community Health Centers - Federally Qualified Health Center (MNACHC-FQHC) and the MN Association for Community Mental Health Providers (MACMHP). Ten of these organizations will be in rural and underserved communities. The practice facilitation initiative will guide participants through elements of infrastructure development, including health information exchanges and options for financial sustainability, designing efficient and effective care delivery systems, and enhancing patient experience. Each of the participating teams will identify at least two community partners such as hospitals, social services organizations, or facilities providing long-term care and/or post-acute care services.

Accountable Communities for Health Grants

The development of Accountable Communities for Health (ACH) builds on a foundation of health reform activities already in Minnesota, with Health Care Homes at its core. In 2011, the HCH program funded three Community Care Teams through a competitive grant process to learn how communities and a broad group of providers and public health could work together to coordinate care. This led to an understanding of a need for integration of services to address gaps for patients with complex needs; key learnings from the HCH-funded Community Care Teams grew into a core component of the SIM grant. ACHs build on these learnings and engage community members and a broad range of providers in a process to establish priorities to build partnership that will further integrate and coordinate care with Accountable Care Organizations (ACOs) within their communities.

Minnesota is evaluating whether community-led ACH models result in improvements in quality, cost, and experience of care beyond those achieved by ACOs that don't use this approach. Through the SIM grant, Minnesota awarded about $5.6 million to 15 ACH projects. Each of the projects are locally planned and led. Communities identify a target population with substantial health and social needs. ACHs bring together community partners that contribute to a person's health, such as local public health boards, behavioral health, social services, long-term care, primary care, and schools.

14 of the ACHs includes at least one HCH, and currently 27 HCHs are working with one of the 15 ACHs. In order to address population-specific needs, each ACH projects features a unique mix of partner organizations and a focus on prevailing health and social conditions.

Next Steps

Key Priority: Practice Transformation

Practice Transformation is a key priority area for the HCH program and their Advisory Committee. The Advisory Committee has chartered a Practice Transformation workgroup, which in 2016 will advise on:

- Development of practice transformation initiatives
- Best practices and innovations regarding practice transformation
- Policies and procedures for practice transformation topics
- Ensure patients, families, and consumers are included in Practice Transformation workgroup activities

With the goals of:

- Refining the HCH certification/recertification processes
- Improving population health and care coordination technical assistance to clinics.
- Partnering with MDH Office of Health Information Technology to further work on improving secure data exchange and electronic tools to improve care coordination.

Key Priority: Demonstrating Value and Return on Investment

Health Care Home staff are working to support advisory committee interest in understanding the impact and "business case" to demonstrate the value of the HCH and return on investment in order to demonstrate value to non-certified providers and encourage them to consider certification.

Financial Sustainability

"It would be nice if the process was more seamless. We need a critical mass of payers to do things consistently." (Provider comment)

"Payments need to be flexible to address non-medical services and unleash innovation." (Provider comment)

For clinics that make the decision to become certified as Health Care Homes, financial sustainability is one of many factors that they need to consider. In many cases, the path to certification – and to successfully improving outcomes for complex patients – involves making investments in data infrastructure, care coordination staff, patient education and outreach, and new modes of 24/7 communication and accessibility. Many of these investments benefit *all* patients who receive care through the HCH, regardless of whether they also receive higher-intensity coordinated care because of complex medical needs.

Care Coordination Payments

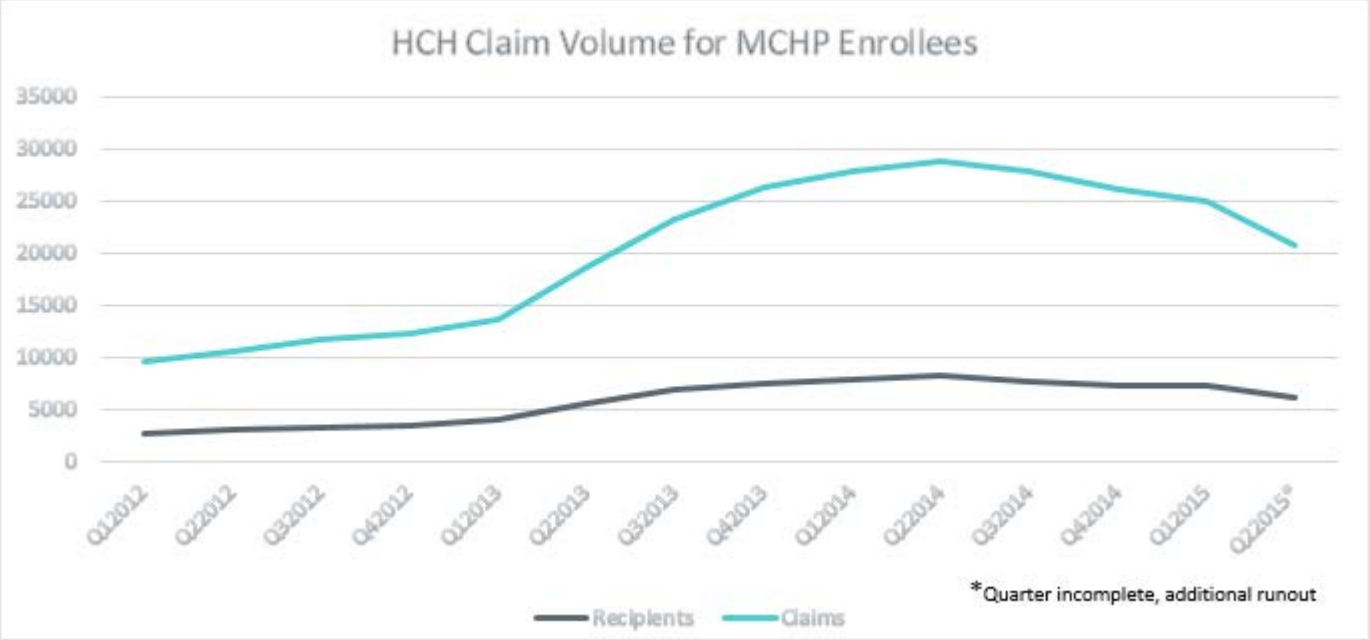
HCH care coordination payments are billed monthly by certified providers for patients with multiple chronic conditions who have agreed to receive patient-centered care coordination. The rate paid ranges from $10 to $60 per person per month and is higher for patients with increased complexity and for patients with serious mental health conditions or who need additional assistance with communication.

The amount paid through the HCH monthly tiered payments for Minnesota Health Care Programs (Medical Assistance and MinnesotaCare) enrollees since 2012 is more than $4,890,000. However, nearly 70 percent of claims are submitted by just a dozen clinics. After peaking in 2014, the number of HCH claims submitted, and HCH payments made for Minnesota Health Care Programs declined in 2015. Compared to the 180 clinics submitting claims or encounters for HCH services in 2014, 132 clinics have submitted claims for services so far in 2015.

There are many factors influencing the lower submission rates (for both MHCP and other payers). A number of clinics have indicated that they experience challenges with the administrative processes related to tiering their patients based on complexity, or with the process of submitting claims and collecting co-pays for non-face to face visits.

Another challenge expressed is the lack of continuity of payments across payers. State law requires health plans to pay a fee for care coordination services that are provided to their members within Health Care Homes, and to do so in a manner that is "consistent with" the system implemented by the Medicaid program. However, providers report that some health plans negotiate alternative arrangements with provider systems, such as one-time provider grants, which may or may not be consistent with the principles, or the application, of the HCH payment methodology as it is implemented within Medicaid. The chart below does not reflect the volume in these alternative arrangements.

Figure 5: HCH Claim Volume 2012-2015



Payment Reforms Underway

There are a number of payment reform strategies underway which recognize and prioritize the importance of primary care and patient-centered care, but also reflect new mechanisms such as total cost of care shared savings payments that support providers' care coordination activities. When the HCH payment methodology was initially developed, and predominantly still today, the fee for service model was the most common payment mechanism for health care services. However, Minnesota payers, along with other states and CMS, are increasingly moving away from fee for service payment structures which incentivize volume rather than value.

Many health care homes are also participating in accountable care-like arrangements where care coordination and other transformation activities are part of the care delivery necessary to achieve performance payments. An example is Minnesota's Integrated Health Partnership (IHP) demonstration, an accountable care model that incentivizes health care providers to take on greater financial accountability for the Total Cost of Care (TCOC) for Medicaid patients. HCH patient-provider relationships that can be identified in encounters are prioritized in the methodology that associates members to an IHP. In the IHP demonstration, DHS contracts directly with providers in a way that allows them to share in savings for reducing the TCOC for enrollees while maintaining or improving quality of care and patient experience. This gives providers flexibility to develop innovative methods for coordinating and delivering care, to improve patient health and experience, and reduce costs with few new requirements.

Fifteen of the current sixteen Integrated Health Partnerships have HCH clinics among their core participating provider locations. The number of HCHs participating in IHP is 136 or 35 percent. The transformational work done by these clinics has laid the groundwork for their success in ACO programs. In the demonstration's first year, 2013, the initial six IHPs saved approximately $14.5 million. In its second year, nine total IHPs saved a dramatic $61.5 million in savings compared to their cost targets.

Next Steps

Program staff plan to use the information from the SIM evaluation and continued stakeholder input to refine payment models that incentivize care coordination with a broad range of community partnerships. This requires use of payment mechanisms that are sufficient to sustain the infrastructure costs for providing care coordination for patients with complex medical and non-medical needs.

Learning Collaborative

"Sharing knowledge occurs when people are genuinely interested in helping one another develop new capacities for action." - Peter Senge, The Fifth Discipline: The Art and Practice of the Learning Organization

Peer learning, and support from HCH nurse planners and other clinical and quality improvement experts, is a critical component of Minnesota's HCH approach. A Health Care Homes statewide learning collaborative is required by Minnesota Statutes, Section §256B.0751. This learning collaborative provides an opportunity for certified HCH clinics and State Innovation Model (SIM) grantees to exchange information and enhance understanding related to quality improvement and best practices, using face-to-face and virtual learning opportunities. The Learning Collaborative is jointly sponsored by the Health Care Home Program and the SIM Program. The HCH/SIM Learning Collaborative sponsored a number of activities in 2015 designed to help participants meet statewide goals.

Table 3: Learning Collaborative Activities 2015

Activity	Number of Activities	Participants	Theme/Topics
2015 HCH/SIM Learning Days Conference	1	580	Moving Forward Together: Building Healthy Minnesota Communities
HCH/SIM Webinars	7	675	Medicare Intensive Behavioral Therapy Benefit for Obesity Counseling, Telehealth, Minnesota's Senior Linkage Line, Connecting Clinics to Communities to Improve Population Health, Transition of Care Post Hospitalization, Behavioral Health Integration, Food Insecurity and Health
HCH Learning Communities on Alzheimer's Peer To Peer Provider Education	9	195	Education program to increase the use of best practices in dementia screening, diagnosis, treatment and referrals
SIM Learning Communities on Emerging Professions	1 Learning Community/ Four Topics	50-75 in attendance per meeting	Emerging Professions
Community Wellness Grant Webinar	1	50	CWG: Partnerships Aligning Community Wellness and Primary Care Redesign
Webinar Series	1	Online Self Study	"Introduction To Health Care Homes"

In 2015, the Learning Days Conference was called "Moving Forward Together: Building Healthy Minnesota Communities." MDH staff and partners made a purposeful effort to invite more community partners along with certified clinics to learn from each other. As the participation diagrams below show, the program was successful in attracting more public health, community and social services attendees. This shift in attendees is vital for transforming care coordination practices, building community partnerships, and addressing social determinants of health.

Figure 6: Learning Days Participant Profile 2014

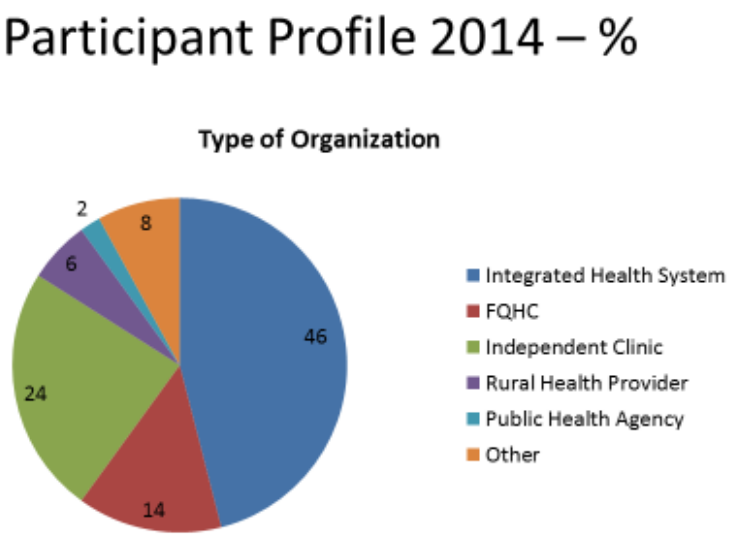
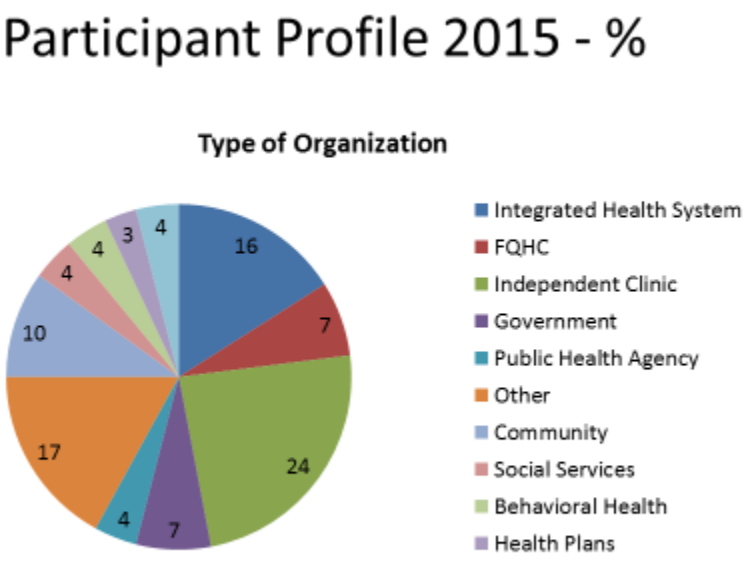
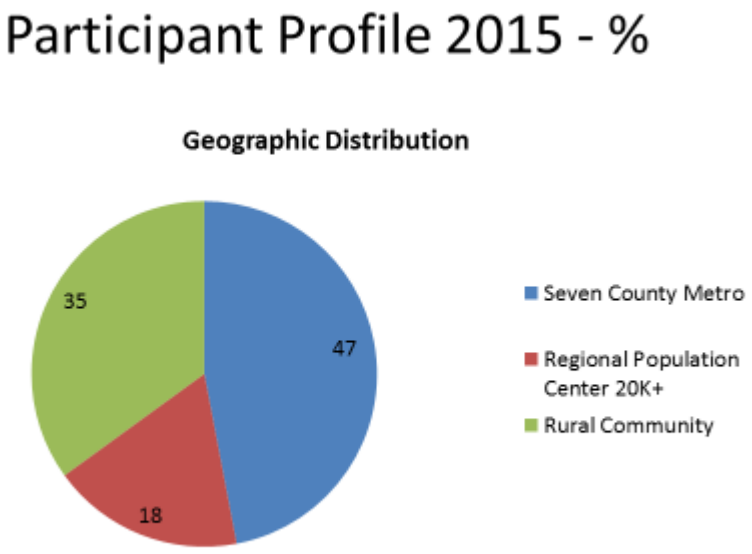


Figure 7: Learning Days Participant Profile 2015



The majority of Learning Day participants come from the seven county metro area. There is a split between remaining participants coming from regional population centers like Rochester or Duluth and rural communities.

Figure 8: Learning Collaborative Geographic Distribution



Engaging Learners at All Levels

The HCH/SIM Learning Collaborative offers a variety of topics to help participants gain knowledge and hear stories from peers about how others have transformed their practices. After six years on this journey, the learning landscape consists of clinics who are new to the primary care practice transformation journey and others who have advanced to Accountable Care Organizations or Accountable Communities for Health. It also includes clinics that have been at the advanced stage but have had enough turnover in staff and leadership they are once again at the beginning of their journey.

The wide variation in learning needs will require expansion of learning opportunities that are tailored to a variety of knowledge levels and are in easily accessible formats. These include:

- More than 50 percent of Minnesota primary care clinics are now certified and many are seeking certification at years two, three, and four, and learning needs vary at different levels within HCH organizations.
- The expanded focus on ACH/SIM initiatives have created new programming needs with a stronger emphasis on community engagement, partnership, integration of behavioral health and practice transformation
- Feedback from learning community participants suggests more emphasis is needed on:
    - Community engagement and collaboration
    - Development of workforce capabilities
    - Creating a business case for health care home certification
    - Increasing public awareness of health reform efforts
    - Elevating the patient/family voice to support and sustain health reform efforts
    - Advocating for payment methodologies to support and sustain health reform
- The program will continue to assess how NCQA organizes patient centered medical home certification and training to ensure it is staying current with differences in methodologies.
- Based on a widespread disparities identified in a report on health equity in Minnesota, MDH has adopted a “health in all policies” approach to create a more equitable system for improving the health of all Minnesotans; these new realities must be reflected in learning opportunities.

Next Steps

Plans for improving Learning Collaborative opportunities include:

Short Term Deliverables (Early 2016):

- Reassess charter, scope and membership of HCH/SIM Learning Collaborative Advisory Committee to support statewide planning and align with the HCH Advisory Committee
- Reassess approach to statewide learning activities, including health equity activities
- Research learning collaborative success stories and best practices emerging from other leading health reform states; including NCQA activities
- Seek input from Minnesota health care home clinics and other community stakeholders on what is needed to improve workforce capabilities for sustained healthcare transformation
- Align HCH strategies and tactics with MDH strategic plan.

Long Term Deliverables (2016-2017)

- Offer multiple modalities for learning; includes developing an e-learning HCH core curriculum
- Support inter-professional learning opportunities in order to improve team based care
- Design learning activities to assist with integration of clinics and communities in efforts to improve population health; especially in rural and regional population centers.
- Facilitate learning activities to inspire innovation.

Communication and Evaluation

"Historically patients have been disengaged. There has been a shift, we rely heavily on our nurse care coordination visits to recognize needs, develop goals and manage our patients in the process." - Clinic Leadership comment

Demonstrating and communicating the value of Health Care Homes to Minnesota clinics and communities is key to achieving Minnesota's Triple Aim goals. People who are doing transformational work need to know that they are making a difference in improving the health of Minnesotans. Providers not yet engaged in health care transformation need to recognize that there are tangible benefits in doing so. Patients and consumers need to recognize that Health Care Home certification adds value to their care and practice, and thus seek it out.

As a whole, Primary Care clinics know about the program, but are unsure if the program has staying power or whether certification is worth the investment to them. Consequently, there are still many opportunities to engage the community in promoting certification as well as engage citizens and health providers on how to transform how health care is delivered.

At the six year mark in the Health Care Homes program, we now have data and success stories to share. It is time to reinvigorate efforts around measurement, evaluation and communication to sustain the progress of the Triple Aim through Health Care Homes certification.

Evaluation – HCHs Save Money, Improve Quality

As noted elsewhere, certified HCH clinics are required to participate in the Statewide Quality Reporting and Measurement System (SQRMS), and to meet certain standards for quality performance and improvement. Clinics are supported in this work through a combination of goal setting in relation to quality improvement processes and technical assistance and site visits by nurse planners.

Health Care Homes in their second year of certification and beyond must meet standards for overall performance and for internal rates of improvement, for the following quality measures:

- Optimal Vascular Care
- Optimal Diabetes Care
- Optimal Asthma Care for adults and children
- Depression remission/follow-up
- Colorectal Cancer Screening.

In addition to the performance reporting that is required as a part of their certification, a legislatively-mandated evaluation by the University of Minnesota examined differences between non-HCH and HCH clinics in relation to quality, disparities and total cost of care. Based on the five year evaluation, the table below shows that transforming from a non-HCH clinic to a HCH clinic improves quality care outcomes on all of the measures. HCH-Transforming clinics refers to those that are within their first year of certification. The largest difference was for asthma care outcomes for both children and adults, where the difference between non-HCHs and HCHs was 17.8 percent for adult asthma care and 20 percent for pediatric asthma care (Table 4).

Table 4: Optimal Care Quality:

Adjusted rates of Optimal care (all goals met) by condition and HCH clinic status

	Non-HCH clinics	HCH-Transforming clinics (1st year of certification)		HCH-Certified clinics	
	% meeting goals	% meeting goals	Difference from non-HCH clinic	% meeting goals	Difference from non-HCH clinic
Vascular care	46.6%	53.2%	6.6%	53.3%	6.7%
Diabetes care	36.6%	40.1%	3.5%	40.6%	4.0%
Asthma care (adults)	16.7%	29.8%	13.1%	34.5%	17.8%
Asthma care (children)	19.2%	30.2%	11.0%	39.2%	20.0%
Depression follow-up	19.5%	23.6%	4.1%	26.7%	7.2%
Depression remission	22.6%	24.3%	1.7%	25.0%	2.4%
Colorectal Cancer screening	58.8%	60.7%	1.9%	63.3%	4.5%

Notes: Percentages are regression-adjusted for clinic self-selection into HCH, patient demographics, interactions between HCH status and year, and clinic size, medical group affiliation, and rurality.

Racial disparities were significantly smaller for Medicare, Medicaid and Dual-Eligible patients served by HCHs compared to non-HCHs for most measures. Also, disparities were often smaller for moderate morbidity versus low morbidity groups.

Adult and pediatric patient experience surveys for the Health Care Homes initiative were used to measure patient satisfaction by including additional patient-centered medical home (PCMH) questions. Because these questions are asked only of patients at HCHs, the responses can't be compared to responses from non-HCH clinics.

There was a key finding from the patient experience survey of Health Care Homes clinics:

- Over half of all primary care clinics had at least 60 percent of their patients who reported a positive score in relation to shared decision making.

Another important finding from the University of Minnesota evaluation had to do with costs associated with the HCH program. The evaluation team analyzed Medicaid and Medicare claims data for the years 2010 through 2014, comparing the use and cost of services between certified HCH clinics and non-HCHs. Use and cost of services were based on seven categories of health care spending measured annually, as well as the Per Member per Year (PMPY) costs.

Figure 9 shows that from 2010-2014, HCH certified clinics were nine percent less expensive than non-HCH clinics based on Per Member Per Year (PMPY) reimbursement costs within the Medicaid and Medicare programs.

Figure 9: Regression Adjusted Reimbursement by Type of Insurance, 2010-2014

Figure 9: regression adjusted reimbursement by type of insurance, 2010-2014							
	Non Certified Clinics		Certified Clinics		PMPY		Program wide
	Number of enrollees	Average Reimbursement	Number of enrollees	Average Reimbursement	% savings	$ savings	$ savings (in millions)
Medicare	543,637	$4,989	275,088	$4,896	1.9%	$ 93.20	$26
Medicaid	1,096,930	$6,578	1,197,949	$5,821	11.5%	$ 756.86	$907
Dual	117,424	$34,434	87,597	$33,581	2.5%	$ 853.45	$75
Total	1,757,991	$7,946	1,560,634	$7,216	**9.2%**	$ 729.64	$1,139

Health Care Homes were less expensive than non-HCHs in three categories of spending: inpatient hospital admissions, hospital outpatient visits, and pharmacy. In particular:

* HCH inpatient hospital costs were 34% lower for Medicaid enrollees, 31% lower for Dual Eligible and 20% lower for Medicare enrollees.

* In part, this was because beneficiaries in certified HCHs had dramatically fewer hospitalizations than non-HCHs, with 29%, 44% and 38% fewer admissions for HCH patients in the Medicaid, Dual and Medicare populations than for non-HCH patients.

* This difference was also due to hospital length of stay. When HCH patients were hospitalized they, across the board, had shorter lengths of stay with, respectively, a .41%, 36% and 32% shorter stays for the Medicaid, Dual and Medicare populations.

* HCH patients also used fewer hospital outpatient services. HCH Medicaid and Medicare enrollees used about eight present (8%) fewer hospital based physician services than non-HCHs and had thirteen percent (13%) lower costs.

Across the nearly five year evaluation period, spending for Medicaid, Medicare and Dual Eligible patients cared for in HCH clinics would have been approximately $1 billion more if those patients had not been in HCH clinics. An estimated additional $500 million could have been saved if the Medicaid, Medicare and Dual Eligible patients who were not in a HCH during this period were in a HCH.

This evaluation did not examine whether HCHs were more likely to also participate in other state or federal health reform activities, such as Medicaid or Medicare Accountable Care Organizations, than non-HCHs. But if so, some portion of these savings could be associated with participation in those other reform efforts. Additional study will be needed to determine if that was the case.

Areas for Continued Growth and Study

While the evaluation showed strong outcomes on a range of cost and quality measures for HCHs, there remain opportunities for improvement in HCH performance. The program continues to look at how to spread these successes by recruiting clinics that are not yet certified. Based on the University of Minnesota 2015 evaluation, there are several findings that show either conflicting results for HCHs, or areas for continuing study:

- While racial disparities were smaller for many groups within HCHs than in non-HCHs, African-American Medicare patients had higher rates of Emergency Department visits, hospitalizations and unplanned hospitalizations in HCH clinics compared to non-HCH clinics.
- Differences by disability and rural status did not show consistent benefits of HCHs in reducing disparities.
- HCH clinics had more emergency department visits than non-HCH clinics (one percent, seven percent and nine percent respectively) and had higher emergency department expenditures (five percent, 18 percent and 21 percent respectively) based on Medicaid, Dual Eligible, and Medicare populations.

While the HCH program has provided benefits through patient centered care to the majority of Minnesotans, there are still gaps in care for certain populations. In order to address these gaps, HCH staff are currently collaborating with other state programs such as State Innovation Model (SIM), the State Health Improvement Program (SHIP) and Behavioral Health Homes to develop plans, projects, policies, and partnerships outside of the traditional health care relationships to enhance the ability to meet individual health care and social needs of populations that experience disparities or higher costs.

Next Steps- Communicating and Evaluating HCH Value

The results from the five-year evaluation show how the Health Care Homes program is effectively contributing to the Triple Aim of reducing healthcare costs, improving patient experience and overall population health.

Compared to earlier results from the 3-year evaluation, the results from the 5-year evaluation show even greater differences in quality and costs when comparing HCH to non-HCH clinics:

- When considering costs, HCH certified clinics continue to have lower hospital outpatient visits, which has reduced the cost of that service compared to non-HCH clinics by 48 percent. Additionally, HCH clinics have 29 percent less patient admissions compared to non-HCH clinics, reducing the cost by 35 percent.
- In relation to quality, HCH clinics have improved their outcomes around Colorectal Screening, Vascular Care, and Diabetes Care compared to the 3-year report.
- HCH clinics have increased the number of minority and non-English speaking patients compared to non-HCH clinics.
- The percent of HCH clinics who bill for care coordination has increased from 27.86 percent in 2013 to 43.15 percent in 2014.

The evaluation results show that, over time, the program is growing and improving, with a larger cohort of HCH clinics, and potentially a greater depth of experience with regard to how to implement patient-centered care for those HCH clinics who have been part of the program.

Going forward, while the HCH statute requires no further legislatively-mandated evaluations, the HCH program will be exploring opportunities for utilizing Minnesota's All Payer Claims Database (APCD) to evaluate the HCH program on a variety of metrics. The APCD allows the opportunity to conduct different types of evaluation and analyses that include data from all payers, not just Medicare and Minnesota Health Care Programs, as well as the potential to examine different types of claims-based metrics such as certain care complications or potentially preventable hospitalizations or ED visits.

The program will also increase its focus on communicating the success of the program through the Performance Measurement work group, which has been transformed into the newly formed Communication and Evaluation work group. This workgroup has helped to approve the current lists of measures required for HCH recertification, and is beginning to develop a communication strategy that advocates the strengths of the HCH program to a wider audience.

This advisory work group has started on a number of deliverables related to promotion and dissemination strategies around HCH branding. Some of these deliverables focus on website usage and internet traffic, and a social media analysis of keywords related to the HCH program. Additionally, the next Communication and Evaluation work group has decided to focus on the core standards of the HCH program for the upcoming Learning Days Collaborative. In doing so, information such as quotes, videos, and testimonials are being collected for dissemination by the work group to be turned into presentable items for the Learning Collaborative.

Short Term Deliverables (within 90 days)

- Draft Communications & Evaluation Workgroup Charter
- Review workgroup membership and adjust based on charter
- Align Health Care Homes' strategies and tactics with Minnesota Department of Health strategic plan

Long Term Deliverables (start in 2016 budget year)

- Revise and deploy community engagement plan
- Evaluate population health impact of health care home activities; include data analytics to advance health equity and correlation to care coordination activities.
- Use storytelling to showcase successful clinics and patient outcomes, communicate program messages and package results for leaders to communicate business case and/or ROI.

Conclusion

"Circumstances have been extremely difficult for us and our care coordinator is there to listen, answer questions, and help us put a plan into action that will aid in my husband's healing. When tests are due we are notified and now have contact with community resources and specialist appointments as we need them." (Patient Comment)

The Health Care Homes program (HCH) is one of the centerpieces of Minnesota's health reform initiative. Through their focus on re-design of care delivery and meaningful engagement of patients in their care, Health Care Homes are transforming care – and lives - for 3.6 million Minnesotans. Through their growing partnerships with a wider range of community organizations, and their participation in Accountable Communities for Health, Health Care Homes are also beginning to transform communities.

The goals of Minnesota's HCH program are to:

- Continue building a strong primary care foundation to ensure all Minnesotans have the opportunity to receive team-based, coordinated, patient-centered care.
- Increase care coordination and collaboration between primary care providers and community resources to facilitate the broader goals of improving population health and health equity.
- Improve the quality and the individual experience of care, while lowering health care costs.

In 2015, the HCH program continued to take important steps towards these goals through certification of primary care providers and clinics, provision of technical assistance, grant funding, provision of statewide learning opportunities, focus on community engagement and partnerships, integration of behavioral health and the launch of a HCH Advisory Committee.

As the five-year evaluation results show, Health Care Homes are successfully lowering costs and improving quality for the patients they serve, by transforming how primary care is delivered. However, not all Minnesota clinics are participating in this voluntary program, and the clinics that are participating are not equally distributed around the state. Residents of 32 rural counties – more than 500,000 Minnesotans – lack access to a certified HCH in their local community, and are potentially missing out on these important benefits (see Appendix C for a listing of counties with 0 to 1 HCH clinic).

The program is now at a juncture to evaluate feedback from stakeholders, assess the needs of late adopters of the HCH model and determine ways to continue to invest in community partnerships so that the program can be successfully extended to all counties. In this way, *all* Minnesotans (including those in rural areas, tribal communities, and populations that experience health disparities) can experience the benefits that come from having a Health Care Home. Because of the strong foundation of success built in the first six years of the program, Minnesota's Health Care Homes are well-positioned to continue to improve patients' experience of care, reduce the cost of care and improve the quality of care outcomes.

Appendices

Appendix A: List of HCH Advisory Committee Members

First	Last	Category of Representation	Affiliation
Dana	Brandenburg	Health Care Professional	Psychiatrist
Rhonda	Cady	Academic Researcher	Gillette Children's
Brittney	Dahlen	Statewide Representative HCH Clinic	Lake Superior Health Care
Dale	Dobrin	Statewide Representative HCH Clinic	MD, South Lake Pediatric Clinic
Shawn	Franklin	Statewide Representative HCH Clinic	ACMC
Emily	Goetzke	Statewide Representative HCH Clinic	RN, Mankato Clinic
Andrea	Hillerud	Health Plan Representative	Blue Cross/Blue Shield Health Plan
Michelle	Hodurski	Consumer/Patient in a Health Care Home	consumer
Rahul	Koranne	Health Care Professional	MD (2 year term)
Lucas	Nesse	Employer	Minnesota Business Partnership
Kelly	Rheingans	Health Care Professional	RN, Care Coordinator
Julie	Sonier	State Agency	State Member, SEGIP
David	Thorson	Health Care Professional	MD, Primary Care Provider
Cally	Vinz	Quality Improvement Organization	ICSI
Robert	Wilsey	Consumer/Patient in a Health Care Home	consumer
Melissa	Winger	Consumer/Patient in a Health Care Home	(2 year term)

Appendix B: Health Care Homes by County and Region (As of 11/11/15)

County	2010 Population	% of Popula	Region	Total # of Clinics	# of Health Care Homes	% of Clinics Certified
Aitkin	16,202	0.3%	Northeast	4	0	0.0%
Anoka	330,844	6.2%	Metropolitan	24	18	75%
Becker	32,504	0.6%	Northwest	6	1	16.7%
Beltrami	44,442	0.8%	Northwest	3	2	66.7%
Benton	38,451	0.7%	Central	1	0	0.0%
Big Stone	5,269	0.1%	Southwest	3	0	0.0%
Blue Earth	64,013	1.2%	South Central	9	6	66.77%
Brown	25,893	0.5%	South Central	3	1	33.33%
Carlton	35,386	0.7%	Northeast	4	0	0.0%
Carver	91,042	1.7%	Metropolitan	12	4	33.3%
Cass	28,567	0.5%	Central	18	2	11.11%
Chippewa	12,441	0.2%	Southwest	4	0	0.0%
Chisago	53,887	1.0%	Central	7	5	71.43%
Clay	58,999	1.1%	West Central	9	3	33.33%
Clearwater	8,695	0.2%	Northwest	3	0	0.0%
Cook	5,176	0.1%	Northeast	4	1	25.0%
Cottonwood	11,687	0.2%	Southwest	6	4	66.7%
Crow Wing	62,500	1.2%	Central	10	2	20.0%
Dakota	398,552	7.5%	Metropolitan	43	21	48.84%
Dodge	20,087	0.4%	Southeast	1	1	100.0%
Douglas	36,009	0.7%	West Central	8	2	25.0%
Faribault	14,553	0.3%	South Central	6	2	33.3%
Fillmore	20,866	0.4%	Southeast	6	3	50.0%
Freeborn	31,255	0.6%	Southeast	3	0	0.0%
Goodhue	46,183	0.9%	Southeast	6	1	16.67%
Grant	6,018	0.1%	West Central	5	0	0.0%
Hennepin	1,152,425	21.7%	Metropolitan	179	96	53.63%
Houston	19,027	0.4%	Southeast	5	0	0.0%
Hubbard	20,428	0.4%	Northwest	2	0	0.0%
Isanti	37,816	0.7%	Central	1	1	100.0%
Itasca	45,058	0.8%	Northeast	8	1	12.5%
Jackson	10,266	0.2%	Southwest	4	2	50.0%
Kanabec	16,239	0.3%	Central	2	0	0.0%
Kandiyohi	42,239	0.8%	Southwest	4	2	50.0%
Kittson	4,552	0.1%	Northwest	3	0	0.0%
Koochiching	13,311	0.3%	Northeast	4	0	0.0%
Lac qui Parle	7,259	0.1%	Southwest	4	0	0.0%
Lake	10,866	0.2%	Northeast	4	1	25.0%
Lake of the Woods	4,045	0.1%	Northwest	1	0	0.0%
Le Sueur	27,703	0.5%	South Central	7	0	0.0%
Lincoln	5,896	0.1%	Southwest	4	0	0.0%
Lyon	25,857	0.5%	Southwest	10	5	50.0%
McLeod	36,651	0.7%	South Central	5	0	0.0%
Mahnomen	5,413	0.1%	Northwest	3	1	33.33%

County	2010 Population	% of Popula	Region	Total # of Clinics	# of Health Care Homes	% of Clinics Certified
Marshall	9,439	0.2%	Northwest	1	0	0.0%
Martin	20,840	0.4%	South Central	6	0	0.0%
Meeker	23,300	0.4%	South Central	6	3	50.0%
Mille Lacs	26,097	0.5%	Central	7	2	28.57%
Morrison	33,198	0.6%	Central	6	3	50.0%
Mower	39,163	0.7%	Southeast	6	0	0.0%
Murray	8,725	0.2%	Southwest	2	1	50.0%
Nicollet	32,727	0.6%	South Central	5	2	40.00%
Nobles	21,378	0.4%	Southwest	4	3	75.0%
Norman	6,852	0.1%	Northwest	3	0	0.0%
Olmsted	144,248	2.7%	Southeast	19	10	52.63%
Otter Tail	57,303	1.1%	West Central	8	3	37.55%
Pennington	13,930	0.3%	Northwest	1	1	100.0%
Pine	29,750	0.6%	Central	77	1	14.29%
Pipestone	9,596	0.2%	Southwest	5	0	0.0%
Polk	31,600	0.6%	Northwest	13	2	15.38%
Pope	10,995	0.2%	West Central	2	0	0.0%
Ramsey	508,640	9.6%	Metropolitan	91	49	53.85%
Red Lake	4,089	0.1%	Northwest	3	0	0.0%
Redwood	16,059	0.3%	Southwest	4	2	50.0%
Renville	15,730	0.3%	Southwest	5	0	0.0%
Rice	64,142	1.2%	Southeast	6	2	33.3%
Rock	9,687	0.2%	Southwest	1	1	100.0%
Roseau	15,629	0.3%	Northwest	3	0	0.0%
St. Louis	200,226	3.8%	Northeast	47	24	51.06%
Scott	129,928	2.4%	Metropolitan	10	5	50.00%
Sherburne	88,499	1.7%	Central	6	5	83.33%
Sibley	15,226	0.3%	South Central	5	0	0.0%
Stearns	150,642	2.8%	Central	34	18	52.94%
Steele	36,576	0.7%	Southeast	2	1	50.0%
Stevens	9,726	0.2%	West Central	4	1	25.0%
Swift	9,783	0.2%	Southwest	2	1	50.0%
Todd	24,895	0.5%	Central	5	4	80.00%
Traverse	3,558	0.1%	West Central	4	1	25.0%
Wabasha	21,676	0.4%	Southeast	3	0	0.0%
Wadena	13,843	0.3%	Central	3	1	33.33%
Waseca	19,136	0.4%	South Central	3	0	0.0%
Washington	238,136	4.5%	Metropolitan	16	12	75.00%
Watonwan	11,211	0.2%	South Central	3	0	0.0%
Wilkin	6,576	0.1%	West Central	1	0	0.0%
Winona	51,461	1.0%	Southeast	5	1	20.00%
Wright	124,700	2.4%	Central	12	8	66.67%
Yellow Medicine	10,438	0.2%	Southwest	3	2	66.67%

Appendix C: Counties with 0-1 Health Care Homes (As of 11/11/15)

County	2010 Population	Region	Total # of Clinics	# of Health Care Homes
Aitkin	16,202	Northeast	4	0
Becker	32,504	Northwest	6	1
Benton	38,451	Central	1	0
Big Stone	5,269	Southwest	3	0
Brown	25,893	South Central	3	1
Carlton	35,386	Northeast	4	0
Chippewa	12,441	Southwest	4	0
Clearwater	8,695	Northwest	3	0
Cook	5,176	Northeast	4	1
Dodge	20,087	Southeast	1	1
Freeborn	31,255	Southeast	3	0
Goodhue	46,183	Southeast	6	1
Grant	6,018	West Central	5	0
Houston	19,027	Southeast	5	0
Hubbard	20,428	Northwest	2	0
Isanti	37,816	Central	1	1
Itasca	45,058	Northeast	8	1
Kanabec	16,239	Central	2	0
Kittson	4,552	Northwest	3	0
Koochiching	13,311	Northeast	4	0
Lac qui Parle	7,259	Southwest	4	0
Lake	10,866	Northeast	4	1
Lake of the Woods	4,045	Northwest	1	0
Le Sueur	27,703	South Central	7	0
Lincoln	5,896	Southwest	4	0
McLeod	36,651	South Central	5	0
Mahnomen	5,413	Northwest	3	1
Marshall	9,439	Northwest	1	0
Martin	20,840	South Central	6	0
Mower	39,163	Southeast	6	0
Murray	8,725	Southwest	2	1
Norman	6,852	Northwest	3	0
Pennington	13,930	Northwest	1	1
Pine	29,750	Central	77	1
Pipestone	9,596	Southwest	5	0
Pope	10,995	West Central	2	0
Red Lake	4,089	Northwest	3	0
Renville	15,730	Southwest	5	0
Rock	9,687	Southwest	1	1
Roseau	15,629	Northwest	3	0
Sibley	15,226	South Central	5	0
Steele	36,576	Southeast	2	1

County	2010 Population	Region	Total # of Clinics	# of Health Care Homes
Stevens	9,726	West Central	4	1
Swift	9,783	Southwest	2	1
Traverse	3,558	West Central	4	1
Wabasha	21,676	Southeast	3	0
Wadena	13,843	Central	3	1
Waseca	19,136	South Central	3	0
Watonwan	11,211	South Central	3	0
Wilkin	6,576	West Central	1	0
Winona	51,461	Southeast	5	1

Appendix D: Map of HCH Clinics 2015