MINNESOTA
HEALTH CARE HOMES

Health Care Homes: Redefining Health, Redesigning Care

ANNUAL REPORT TO THE LEGISLATURE

12/31/2018

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Contents

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

The Honorable Michelle Benson
Chair, Health and Human Services
Finance and Policy Committee
Minnesota Senate
3109 Minnesota Senate Building
95 University Ave. W.
St. Paul, MN 55155

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

The Honorable Jim Abeler
Chair, Human Services Reform
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95 University Ave. W.
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The Honorable Rena Moran
Chair, Health and Human Services
Policy Committee
Minnesota House of Representative
509 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155

Dear Senator Abeler, Senator Benson, Representative Moran, and Representative Liebling:

The Health Care Homes (HCH) program has been working in partnership with clinics and providers around the state to transform care since 2008. As required by statute, this report provides an overview of activities that took place during 2018.

The landscape for health care payment and delivery is changing rapidly and the HCH program is also evolving to keep pace with these changes and to accelerate momentum towards health reform and primary care transformation. Payment models are becoming increasingly value based and there is a recognition that the health care system alone affects only 10 - 20% of what creates health, whereas a larger percentage of health is influenced by social determinants. A foundational infrastructure that provides accessible, effective, team-based coordinated care within a health care system is essential to successful participation in these models. Work that began in the past year to respond to these changes will continue in 2019, as we build on our 10-year history of successful practice transformation.

The HCH program has built a strong foundation of success across the state. Minnesota's HCHs are well positioned to continue to improve patients' experience of care, reduce the cost of care, improve the quality of care outcomes and enhance health equity in Minnesota.

Thank you for your commitment to improving the health of all Minnesotans. Questions or comments on the report may be directed to Bonnie LaPlante, Health Care Homes Program Director at (651) 201-3744 or bonnie.laplante@state.mn.us.

Sincerely,

Jan K. Malcolm
Commissioner
P.O. Box 64975
St. Paul, MN 55164-097

Executive Summary

"There was a 41.5% reduction in hospitalization rates when comparing hospitalization rates twelve months prior to enrollment into care coordination services with hospitalization rates twelve months after initiation of care coordination. This equates to a healthcare savings of approximately $863,000."

HCH team member, Affiliated Community Medical Center, Kandiyohi, Lyon, Meeker, and Redwood Counties

Minnesota Health Care Homes (HCH) are *redefining health and redesigning care*. Primary care is an important attribute of the health care system and the majority of Minnesota's HCH clinicians and their care teams are changing the traditional way of providing care across the state. Certified primary care clinicians provide access and a first point of entry to the health care system; treat a wide range of health problems; and offer prevention, early detection and self-management services. They also help patients navigate through a complex system, foster ongoing relationships between patients and clinicians by including patients and families as members of the health care team, and build bridges between the patient's providers through their care coordination efforts. All resulting in improved patient satisfaction, cost savings and improved quality outcomes.

There is a strong recognition that medical care is estimated to account for only 10-20 percent of the modifiable contributors to healthy outcomes for a population. The other 80 to 90 percent are broadly called the social determinants of health (SDOH): health-related behaviors, socioeconomic factors, and environmental factors. [1] For the medical community to have a significant and lasting impact on the health of their patients and communities, it must address the needs of patients outside the clinic walls. Effectively implementing programs to identify and attend to these social factors depends on the specific needs of the patient population, the ability of the practice to assess these needs, and the availability of community resources.[2]

During 2018, the HCH program, with support from stakeholders, continued evolving the HCH standards to clarify the current foundational standards and develop new standards to strengthen certified primary care clinicians' ability to improve health equity and population health, and succeed in value based care. Primary care clinicians, members of the care team, community stakeholders, consumers and other professionals support the HCH rulemaking process and the need to improve whole person health through integration with other health services, strengthening community partnerships, identifying and addressing the SDOH and the use of data to improve the health of the population served.

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[1] Hood, C. M. (2016). County health rankings: Relationships between determinant factors and health outcomes. American Journal of Preventive Medicine , 129-135.

[2] Physicians A.A. (2018). The Everyone Project; Advancing Health Equity in Every Community, Guide tp Social Needs Screening. Physicians, American Academy of Family

Making a Difference: 2018 Health Care Home Program Outcomes

The HCH Program continued to take important steps to advance the program in 2018 by:

- Certifying nine clinics, ending the year with a total of 372 Minnesota clinics certified as HCHs
- Offering capacity building support towards HCH certification to all uncertified Minnesota primary care clinics; HCH practice improvement specialists and integration specialists are actively working with 25 health systems with a total of 55 clinics to achieve certification
- Working with the Minnesota Department of Human Services (DHS) to certify two additional Behavioral Health Homes (BHH) bringing the total of certified providers to 25
- Seeking input for enhancing the HCH program's focus to increase community linkages, advance health equity, increase ability to impact social determinants of health, and identify barriers and needed resources. Work includes strengthening the HCH administrative rule with input from a 31-member advisory committee
- Funding three Learning Community grants to expand partnership between HCH clinics, public health and behavioral health
- Providing support to primary care clinics and behavioral health providers through in-person technical assistance, on-line educational courses, five webinars, two regional trainings and a two-day conference for 332 participants to support re-design of health care delivery
- Collaborating internally with the Minnesota Department of Health (MDH) programs such as Office of Health Information Technology, Children and Youth with Special Health Needs, the Statewide Health Improvement Partnership program, and Public Health Practice
- Collaborating externally with the Institute for Clinical Systems Improvement and Stratis Health in developing learning opportunities for clinic staff

Benefits of a Health Care Home

The majority of Minnesota primary care clinics are certified as a HCH. Through implementing HCH standards, practices are improving the quality, effectiveness, and efficiency of the care they deliver while responding to each patient's unique needs and preferences. The change from the traditional way of practicing to a HCH model, positions clinics to better respond to the changing health care environment. A recently released report from Patient Centered Primary Care Collaborative (PCPCC), Advanced Primary Care: A Key Contributor to Successful ACOs, suggests the interdependence of advanced primary care models (such as the HCH) and Accountable Care Organizations (ACO) results in achieving improved population health, lower costs, and better patient experiences in health care. In 2018, the HCH program continued to advance primary care by assisting clinicians, their teams and community partners to build a strong foundation through HCH certification, by offering technical assistance and learning opportunities, and by advancing the HCH standards to improve population health and health equity thus strengthening primary care clinicians' ability to be successful in a value based environment.

Introduction

"The implementation of the HCH Standards and model has been facilitative; it is good for patient care and the organization of our processes, to do our work better, rather than a 'check the box' approach to meet a requirement."

Chief Operations Officer, Scenic Rivers Health Services, Itasca County

Health Care Homes: Redefining Health, Redesigning Care

Minnesota's HCH model of care delivery, known nationally as a patient centered medical home (PCMH), is redefining health and redesigning primary care across the state. Use of the HCH model in health care redesign, by implementing systematic changes into a primary care practice, yields better care for patients,[3] while improving clinical outcomes and delivering significant cost savings to the system.[4] Multiple studies have shown that the longer a practice has been certified, and the higher the risk of the patient pool in terms of comorbid conditions, the more significant the positive effect of practice transformation, especially in terms of cost savings.[5]

Through a collaboration between DHS and MDH, the HCH program has used voluntary certification combined with technical assistance and structured learning opportunities to drive quality improvement (QI) and transformation in a majority of Minnesota's primary care clinics. The HCH approach shifts the clinic's or health system's focus from responding to only the acute care needs of individuals to proactively engaging a population of patients and focusing on their health goals, needs, and abilities to achieve desired health outcomes. The model encourages using the expertise of all members of the care team, including patients and their families.[6] In 61 out of 87 Minnesota counties, 4,064 certified clinicians and their teams are providing patient centered, team based, coordinated care to an estimated 3.9 million people.

The landscape for health care payment and delivery is changing rapidly and the HCH program must keep pace with changes to continue momentum in health reform and primary care transformation. Payment models are becoming increasingly value based. A foundational infrastructure that provides accessible, effective, team-based coordinated care within a health care system is essential to successful participation in these models.
The work over the past year has considered these changes and is evolving the program with a strong

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[3] State Health Access Data Assistance Center (SHADAC), September 2017. Evaluation of the Minnesota Accountable Health Model. University of Minnesota School of Public Health.

[4] Wholey DR, Finch M, et. al., December 2015. Evaluation of the State of Minnesota's Health Care Homes Initiative Evaluation Report for Years 2010-2014. University of Minnesota School of Public Health

[5] Patient Centered Primary Care Collaborative (2017).The Impact of Primary Care practice Transformation on Cost, Quality and Utilization, Robert Graham Center

[6] Agency for Healthcare Research and Quality, n.d.; Agency for Healthcare Research and Quality

focus on the key strategic areas of learning and technical assistance, financial sustainability, communication and partnerships, measurement and evaluation, and program innovation. HCH's foundation of patient centered, team based, coordinated care and positive clinical and cost results, has gained support from primary care and community stakeholders to advance the standards through rule changes to:

- Strengthen clinic-community linkages, population health, and health equity
- Assist clinics in preparing for value-based care
- Align with existing and emerging models of care delivery
- Provide an opportunity for primary care clinics to achieve and maintain certification at one of three levels

This report reviews the program's evolution that includes the rule revisions to advance the current foundational standards for certification and recertification of primary care clinics, enhancements to the HCH program offered learning opportunities, development of new tools to help stakeholders better understand the HCH program, and grants to assist clinics and partners share data to improve quality of care.

Care Delivery Innovation

The process of certifying and recertifying primary care clinics includes providing technical assistance to clinics and their partners for meeting program requirements and continuing to improve care delivery. Besides certifying and recertifying clinics and providing technical assistance, in 2018 the HCH program officially launched the process of amending its administrative rules, and initiated a contract with Minnesota Management and Budget, Management Analysis and Development (MAD) consultants to evaluate the certification and recertification process to make process improvements.

"They have saved me from: multiple ER visits, excessive and alternating medications, unnecessary procedures, unnecessary labs, time, money, and above all else given me peace of mind. All by having flexible scheduling hours and the option of calling after hours and weekends. I will never forget being on vacation and calling Dr. X out of frustration and a little bit of desperation, because my [family member] was in need. [The doctor] just simply stated it would be his pleasure to talk and help keep us out of the ER. …. This to me is real medical care."

Patient, Christopher J Wenner, MD, PA, Stearns County

Health Care Homes Certification Activity

To be certified, a primary care clinic must demonstrate that they have met standards in five domains, each with specific criteria. Standards and criteria reflect the main goal of the program, to recognize individual patients and families as the most important part of the care delivery process.

The five domains for certification are:

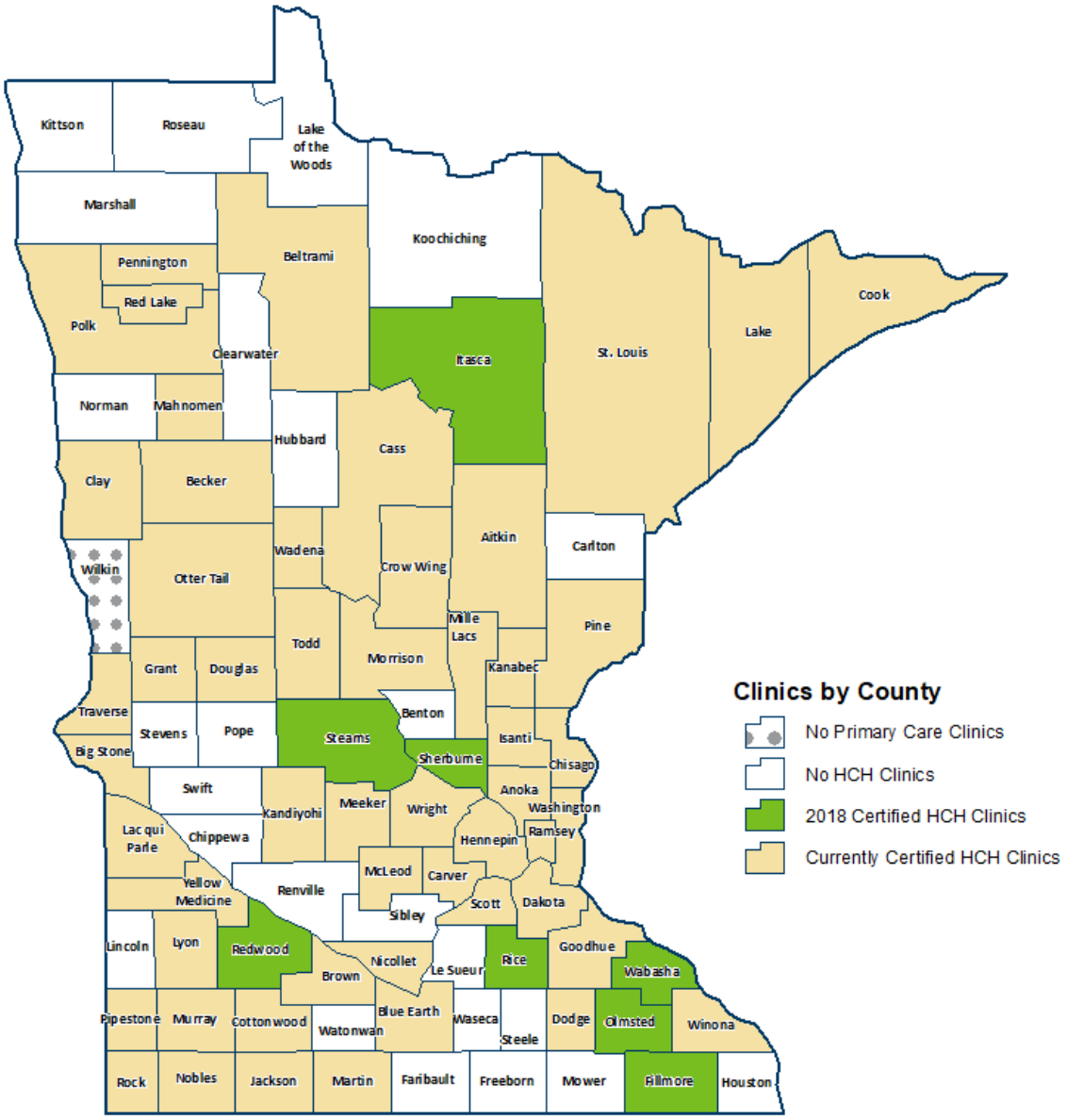
- **Access & Communication**: care when the patient needs it; ongoing communication with the patient and family
- **Registry & Tracking**: electronic, searchable registry to assess needs of the population
- **Care Coordination**: coordinated care focused on patient and family needs
- **Care Planning**: a patient centered care plan for patients with chronic or complex conditions
- **Performance Reporting & Quality Improvement**: continuous improvement processes that focus on patient experience and health, and cost-effectiveness of services

Three registered nurse (RN) practice improvement specialists provide technical assistance to primary care clinics to assist them in attaining initial certification and in recertifying every three years. An additional RN integration specialist works with clinics that have dual certification as a HCH and a Behavioral Health Home (BHH), and provides assistance to clinics and mental health providers seeking BHH status.

During 2018, nine clinics were newly certified and 74 clinics became recertified (see Appendix L), for a total of 372 certified clinics in Minnesota. The total number of currently certified clinics represents over half of the 700 primary care clinics in the state. Since 2010 when MDH certified the first clinics, 437 clinics have achieved certification as a HCH in Minnesota and bordering states. Forty-five (45) clinics are no longer certified, due to clinic closures, organizational changes that disqualify the clinic from eligibility as a primary care provider, lack of resources for maintaining certification (time, money and staff), or changing recognition to a national organization due to having clinics located in multiple states.

Sixty-one (61) of Minnesota's 87 counties (70 percent) have at least one certified HCH clinic (see Map 1 below). Counties with at least one additional clinic certified in 2018 are highlighted in green. Map 1 also shows the one county in Minnesota (Wilkin) that does not have a primary care clinic within its borders. It is important to note, however, that people in this area have access to primary care services in neighboring counties or a bordering state. An additional 20 clinics in the border states of Iowa, North Dakota, and Wisconsin are certified as a HCH because they are part of a Minnesota healthcare system (see Appendix K).

Map 1: HCH Clinic Locations by County in Minnesota



Appendix I provides the total number of primary care clinics and certified HCH clinics in each county in Minnesota.

Health Care Homes Model Progression

The HCH program began in 2008 as a part of a broad, bipartisan health reform initiative to transform patient clinical care through coordinated, team-based, patient-centered care and innovative payment models. The Minnesota Department of Health finalized HCH administrative rules in 2010, and in that year began certifying clinics. Recognizing a need to update HCH standards to reflect evolution of the

program and the health care environment since 2010, MDH initiated a rule revision process in 2018. This process will likely continue throughout 2019.

Current State to Future State

Minnesota's 2013-17 State Innovation Model (SIM) grant program funded through the Centers for Medicare and Medicaid Innovation focused on efforts to improve health in communities, provide better care, and lower costs. Through participation in SIM, the HCH program and clinics gained additional tools and resources for integration into a community model of health care that includes behavioral health, public health, social services, and other community partners sharing responsibility to keep people and communities healthy. This work provides a foundation for continuing to improve upon a successful model of community-centered care and to align with the goals of Minnesota's Integrated Health Partnership model and national quality improvement initiatives such as the Medicare Access and CHIP Reauthorization Act (MACRA)[7].

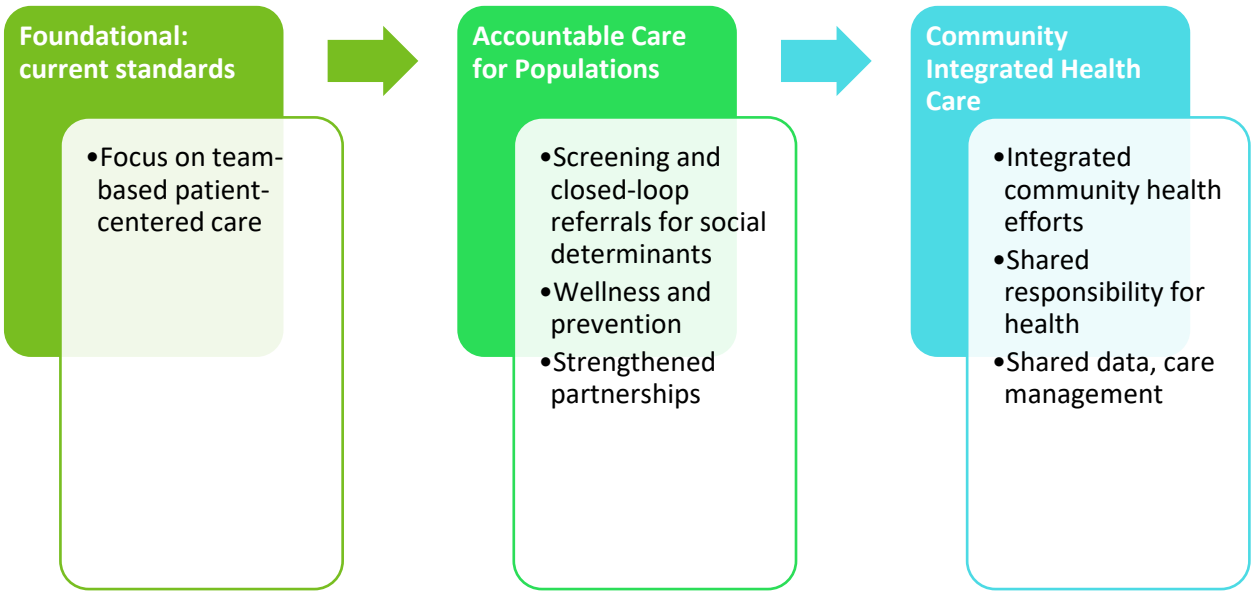
Based on health care reform efforts and changes in health care delivery systems, the following are core reasons for moving ahead with rule amendments.

- **Value-based care**: The landscape for health care payment and delivery is changing rapidly and HCH must keep pace with changes to continue momentum in health reform and primary care transformation. Payment models are becoming increasingly value based. A foundational infrastructure that provides accessible, effective, team-based coordinated care within a health care system is essential to successful participation in these models.
- **Community & Population Health**: A broader focus that incorporates community and regional partnerships into HCH standards is an important strategy for advancing population health and improving the quality of whole person care.
- **Health equity:** Medical care alone affects only about 20 percent of what creates health. Social determinants of health factors such as education, income, housing, and transportation have a much larger influence. The rule is out of date with broader trends in health care delivery such as management of the social determinants of health.

Potential changes to HCH requirements may include a model that recognizes differing capabilities of clinics. The model could apply standards for advanced performance around key factors and activities that influence health such as screening and referrals for social determinants, addressing total health needs of the clinic population, identifying and addressing health disparities, and working with community partners to develop shared population health improvement goals. The model or progression framework would allow clinics to seek recognition voluntarily at the foundational and advanced levels, but would not require clinics to move beyond the foundational standards to advanced levels.

[7] Centers for Medicare and Medicaid Services. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html Accessed 11/14/2017.

Figure 1: HCH Certification Progression Framework



Rulemaking Process

The process for vetting the future path for HCH began with a request for information and a series of community meetings that generated input from individuals and organizations across the state. HCH continues to solicit input from the HCH Advisory Committee and work groups, DHS partners, certified and non-certified clinics, state and federal policymakers, health care, and public health stakeholders, and to incorporate lessons learned from the 15 Accountable Communities for Health, recommendations from the Governor's Health Care Financing Task Force, and the Minnesota Olmstead Plan. Overall, providers, professional associations, and community partners have expressed support for the proposed path forward and provided input on the types of support needed for success.

"We must take a longer look at whole person care. For homeless families, for example, it is very hard to provide medical care for someone whose basic needs are not being met. In our area, emergency shelter contracts have evaporated and all we can offer now is a tent. We are networked with community resources, but not really integrated."

HCH Advisory Committee Program Innovation Work Group Member

Progress on rule amendments in 2018 includes:

- Convening a 31-member rule advisory committee for four quarterly meetings to review suggested changes to HCH standards
- Obtaining Governor's office approval of the Administrative Rule Preliminary Proposal
- Publishing the Request for Comments on possible rule amendments in the State Register
- Continuing work with stakeholders to move forward with advancing standards for clinic certification in 2019

Behavioral Health Homes (BHH) Services

DHS implemented BHH services as a Medicaid covered service July 1, 2016 for eligible individuals with Serious Mental Illness, Serious and Persistent Mental Illness, Emotional Disturbance, or Severe Emotional Disturbance. Individuals with these diagnoses are among a subpopulation known to be at higher risk for poorer health outcomes and fragmented care.

BHH services build upon the successes of HCH and create a comprehensive care coordination service that integrates physical health, mental health, the health concerns of substance use, long-term services and supports, and social services for individuals. There are currently 25 providers certified by DHS to provide BHH services. According to claims data, approximately 2,500 individuals have engaged in BHH services, a number that has steadily risen each month and indicating that more individuals are continuing to access the service. This count of 25 providers includes eight certified HCHs. HCHs create a platform to integrated and value based care, and for some HCHs, BHH services have been a way to successfully engage and better serve a subset of their population.

Through HCH and BHH services, MDH and DHS share a commitment towards supporting coordinated, whole person care, particularly through the integration of primary care and behavioral health, with close referral relationships across social services and community based partners to address the social and environmental factors affecting a person's health. An interagency agreement between DHS and MDH formalizes this commitment and outlines the following cooperative work:

- Participation by the Integration Specialist nurse planner in the DHS Community and Care Integration Reform division, including BHH services certification processes
- Building capacity of providers related to community partnerships and integrated approaches to coordinated, whole person care
- Planning and implementation of learning opportunities that meet the needs of HCH and BHH services providers, including the coordination of these activities across the HCH Learning Collaborative and DHS practice transformation work
- Designing and developing a practice transformation learning framework that will assist in supporting Minnesota health care providers in the integration of primary and behavioral health care

Building Capacity for Practice Transformation

"I have gone through four modules and think this is awesome. I am so grateful for this as it will be very helpful in educating and getting staff on the same page."

Ortonville Area Health Services staff member, referring to an HCH eLearning course, St. Louis County

The HCH program continues to support clinics through their practice transformation journey using innovative strategies developed in collaboration with stakeholders and ongoing technical assistance for achieving certification. In response to stakeholder feedback collected through continued monitoring and evaluation of HCH learning activities, program staff initiated more peer-to-peer regional learning opportunities, launched on-line courses, and funded three Learning Communities. All of these strategies support the needs of clinics to limit time and travel for participation.

Technical Assistance

While the number of certified clinics is one important metric of success for the HCH program, the broader goal of this work is to ensure that all Minnesota patients have access to high quality, patient-centered, coordinated care. To move towards that goal, the HCH program provides technical assistance to help *all* primary care clinics build capacity to meet the needs of patients and families and strengthen community partnerships. Registered nurses serve assigned regions of the state as practice improvement specialists, providing technical assistance to all eligible primary care clinics, certified and uncertified. Types of technical assistance provided include training, consultation, and development of online and print resources.

Table 1: Technical Assistance for Certification

Type of Technical Assistance	Examples of clinic need	Support Provided
Training • Networking meetings • Presentations	Clinic difficulty maintaining patient advisory membership/involvement Staff turnover/loss of historical knowledge and momentum	Share ideas from other clinics, explore alternate methods Retraining, orientation to HCH; enhance the assets and strengths of new staff
Consultation • Site visits • Phone calls • Email • Site visits	Exploration of HCH certification prompted by external incentive (funding, affiliation, ACO, Integrated Health Partnerships) Organizational restructuring prompting need for new approach	Show alignment with HCH, help design a clinic model with HCH requirements
Resources • Implementation guides • Readiness tools • Performance measurement reports • Templates	How to determine who would be best served by care coordination services How to use benchmarks for clinic quality improvement efforts	Suggest resources, reports, tools to help determine risk of clinic population How to use and understand the HCH Benchmark Report

As part of the program's overall strategy to build capacity for patient-centered care in all primary care clinics throughout the state, and to encourage new clinics to become certified, HCH practice improvement specialists who are experts in providing practice transformation technical assistance promote the benefits of certification with clinics that are not certified. Outreach includes meeting with uncertified clinics, providing resources, and facilitating connections and learning networks with certified clinics on how they can transform their practice on the journey to becoming a patient centered medical home. Several clinics and clinic organizations have indicated interest in or are actively working toward

attaining certification or spreading certification to additional clinics within the organization by the end of 2019.

Learning

Certified health care homes must demonstrate that they are continually learning and redesigning their practices to meet the standards for patient-centered, team-based care and improved community health and health equity. The HCH program supports this ongoing process with accessible learning opportunities.

In 2018, HCH implemented learning activities (see Table 2) to address the needs of an increasingly complex range of stakeholders at all stages of learning, and added to the current learning portfolio of webinars and an annual conference with on-demand eLearning courses accessible from the new MDH Learning Management System (LMS). Central to achieving these goals was applying best practice for eLearning design and delivery, developing strategic partnerships to design and deliver learning content, and facilitating opportunities for primary care providers and community partners to connect and learn from each other through regional training events and learning communities.

Learning Management System

The HCH program was one of the first MDH programs to offer free, accessible, on-demand learning through a new MDH Learning Management System (LMS). In 2018, HCH staff designed, developed and launched five on-line learning courses, and adopted the LMS as the gateway for all HCH learning related activities. The system is an efficient platform for tracking, evaluating and analyzing learning activities, and offers opportunities for peer-to-peer learning through on-line discussion boards.

Training for Community Health Partnerships

In an effort to support peer-to-peer learning and community partnership, HCH held regional trainings for clinics and their partners in the St. Cloud and Mankato area. Facilitated by the Institute for Clinical Systems Improvement, these two trainings helped regional clinics, behavioral health service providers and partner organizations forge connections and learn tools for collaborating to enhance whole person care and community health.

Table 2: 2018 Learning Activities

Topic	Activity	Month	Registered
Foundations of Health Care Homes Certification	eLearning Course	January	98
Check Up from the Neck Up	eLearning Course	March	22
Learning Days	Conference – St. Paul	April	322
MIPS 101	eLearning Course	May	26
Integrating Primary Care and Behavioral Health	Regional Meeting – St. Cloud	May	99
The MIPS Experience: A HCH First Year Participant Story	Webinar	June	25
Integrating Primary Care and Behavioral Health	Regional Meeting – Mankato	June	53
Open Clinical Notes: A Tool for Patient Engagement	Webinar	July	53
Training and Evaluation That Works	Training Event - St. Paul	July	105
Shared Decision Making	eLearning Course	August	24
Juniper: A Resource for Chronic Disease Management, Falls Prevention, and Community Health	Webinar	September	37
Implicit Bias in Health Care	eLearning Course	September	20
Behavioral Health Integration Summit	Statewide Convening – St. Paul	September	112
Health Disparities: Using Data to Identify and Act	Webinar	October	62
The Psychology of Change: Creating an Environment Where Improvement Can Thrive	Webinar	December	60

Learning Community Grants

In 2018, MDH also funded three Learning Communities to increase and strengthen partnerships between certified Health Care Home clinics, local public health, and behavioral health organizations through the use of data and information to support shared population health goals. The Learning Communities are supported by an external vendor and MDH subject matter experts using the Connecting Communities with Data: A practical guide for using electronic health record data to support community health-version 1.0 as a roadmap.

HCH Advisory Work Group Key Strategic Areas

Minnesota's 2008 bipartisan health reform efforts established the HCH program to redesign care delivery and engage patients in their care. Since 2010 when the program certified the first primary care clinics, MDH has continuously evaluated the program to improve and increase its value to primary care clinics and patients, health systems, payers, and other organizations with an interest in advanced primary care.

During this last year the HCH team and the HCH Advisory Committee and its work groups have moved forward with advancing the HCH program in the key strategic areas of Program Innovation; Financial Sustainability; Evaluation and Measurement; Communication and Partnerships; and Learning and Technical Assistance.

Program Innovation Work Group

"Without the Program Innovation Work Group the priority of innovation would be lost. It feeds actionable steps to the other work groups. Priorities must continue to be evaluated as the needle is constantly changing; we need to be adaptable, therefore innovation is critical."

HCH Rule Advisory Committee Member

Minnesota's healthcare delivery environment is transforming through the implementation of the HCH model. Clinics across the state are realizing the benefits of a team based care approach, driven by outcomes, and guided by patient and family advisories to ensure consumer perspective. The Program Innovation Work Group reflects the voice of the program's stakeholders.

Through the broad stakeholder representation and two-year history, the Program Innovation Work Group advises HCH on technical aspects of practice delivery with an eye on innovation. The 26-member work group comprised of rural and urban, certified and uncertified, quality leaders, community entities, and DHS, the HCH program maintains a pulse on the changing healthcare environment to inform innovation, best practice and progression of the model for the future.

Outcomes

Provided recommendations to the Health Care Homes program on:

- The future of the care planning standard considering best practice, emerging evidence, and the impact of technology
- Opportunities for advancing the current care coordination model considering the DHS case management redesign plan and needs of Minnesota's aging population
- Learning innovation and planning, considering: content, delivery methods, technical assistance, peer-to-peer learning, and training

Next Steps

- Continue to inform recommendations to modify the HCH Administrative Rule advancing the HCH standards
- Ongoing consideration and alignment with other state and national initiatives

- Ongoing review and recommendations for QI of HCH processes, learning, and other program features
- Participating in advancing and strengthening the HCH standards to enhance patient care delivery and ensure fidelity to the mission, scope and goals established by the program

Financial Sustainability Work Group

"This [medical home and team based care] initiative will ready [our organization] for value-based care, increasing organizational risk, and increasing our focus on population health based quality outcomes…. This new model of care will result in improved outcomes, better patient experience and reduced patient costs."

Vice President, Sanford Sioux Falls Region, Cottonwood, Jackson, Lyon, Nobles, Pipestone, Redwood, Rock, and Yellow Medicine Counties

Implementing and sustaining the transformative elements necessary to be a Health Care Home requires resources. The purpose of the Financial Sustainability Work Group is to assist the HCH program in promoting resources through guidance on the adoption of financial models supportive of practice transformation, care coordination, promotion of health equity, development of community partnerships, enhanced population health, and positive provider/patient experience.

Care Coordination Payments

Payment of a HCH claim as a billed service is one of the ways providers use to financially support their care coordination efforts. In the first six months of 2018, a total of 27,101 finalized claims for 10,583 Minnesota Health Care Program beneficiaries, totaling $610,554, were paid through HCH claims by DHS or the Medicaid Managed Care Organizations. Figure 2 reflects the quarterly trends of submitted and paid HCH claims for Minnesota Health Care Program members through the most recent quarter for which complete data is available. DHS or the Medicaid Managed Care Organizations have paid $7,910,704 between January 2013, when HCH care coordination payments first became a billed service, and June 2018.

Another way providers work to make their care coordination efforts financially sustainable is through participation in the Integrated Health Partnership program. Over the four years for which shared savings settlement information is available (2013-2017), $92,489,226 in shared savings payments have been made to participating providers.

Figure 2: Volume of HCH Claims from Public Health Care Program Members

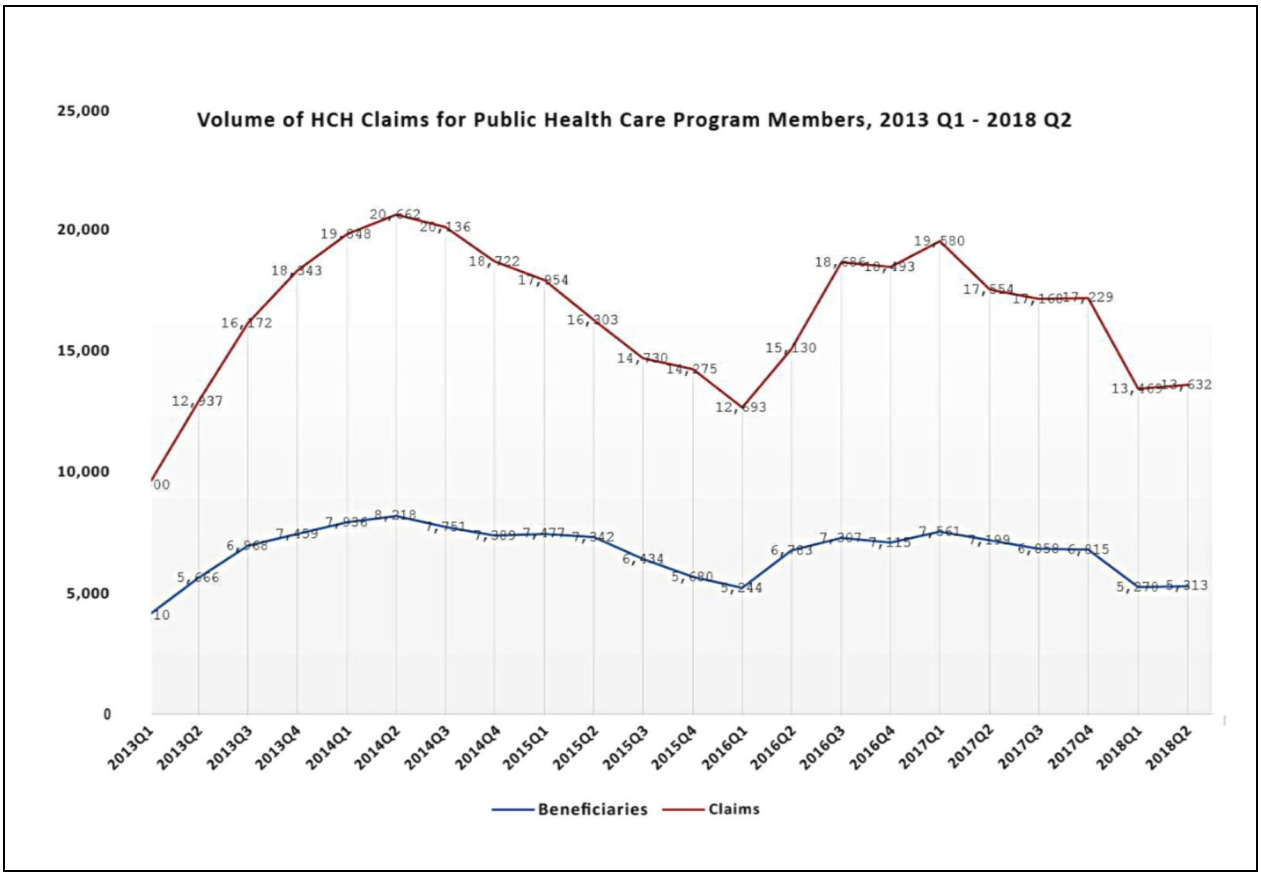
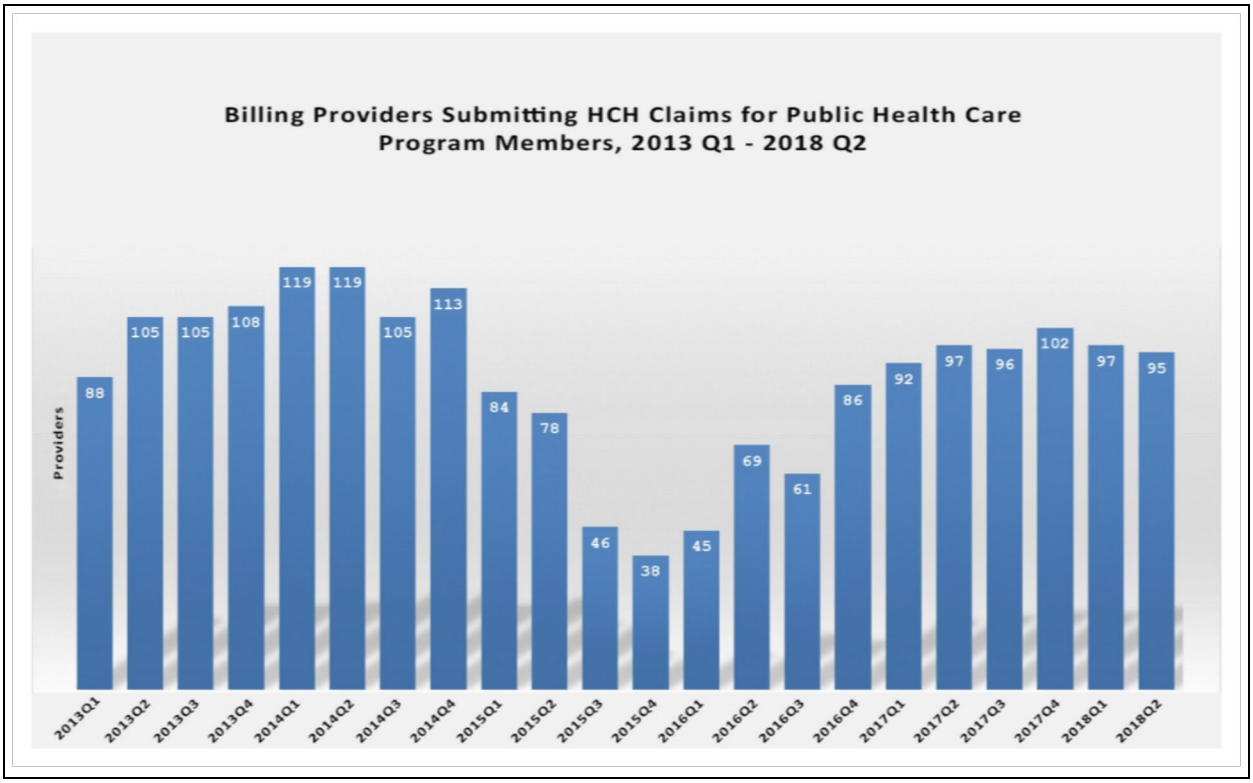


Figure 3: Providers Submitting HCH Claims for Public Health Care Program Members



Submission of HCH claims peaked in 2014. While the number of submitted claims rose throughout 2016 and into the first quarter of 2017 from a low in early 2016, there has been a steady decline in the number of claims submitted since that high point (see Figure 2). The number of billing entities submitting claims during this recent time period has remained fairly steady (see Figure3).

Despite billing entities submitting fewer per-person HCH claims over the past year and a half, the number of certified HCH clinics participating in alternative payment reform initiatives, such as the Integrated Health Partnerships (IHP) demonstration, has continued to increase.

Outcomes

The Financial Sustainability Work Group in 2018 has:

- Discussed building a business case using available data to support HCH program outcomes
- Enhanced connections to employers and payers through face-to-face meetings to provide education about the current program, program progression and sustainability needs for practice transformation.
- Discussed strategies to build a narrative about the HCH program that resonates with key stakeholders
- Discussed an approach to financial sustainability that contains numerous elements beyond just reimbursement

Next Steps

- Continue to advise on building relationships with payers
- Continue to provide recommendations on creating a narrative on the positive benefits related to HCH certification
- Identify opportunities for piloting new payment arrangements
- Promote outreach to health care purchasers

Learning and Technical Assistance Work Group

"Health Care Homes has been a leader in providing education and support for primary care clinics on the path to providing more patient-centered, team-based care. It's been great to work with program staff to support learning that encourages partnership with local public health and community services to improve the health of all Minnesotans."

Healthy Systems Supervisor, MDH Office of Statewide Health Improvement Initiatives

The HCH Learning and Technical Assistance Work Group provides expertise to guide planning and implementation of learning activities for HCH stakeholders. In 2018, the work group monitored implementation of the annual learning plan and provided input for future innovation. The work group operates in the spirit of continuous improvement to ensure alignment of learning with stakeholder needs, learning innovation and delivery of quality products and outcomes.

Outcomes

- Monitored implementation of strategic HCH learning curriculum and implementation
- Provided technical feedback on new eLearning courses
- Analyzed learning activity participation and feedback and made recommendations to guide future planning
- Studied Kirkpatrick "gold standard" model of learning to drive organizational change, and made recommendations for enhanced learning and supports
- Explored role of technical assistance and coaching to support learning and organizational change
- Monitored new learning partnerships with the Institute for Clinical Systems Improvement, Stratis Health, Metropolitan Area Agency on Aging, and MDH Office of Health Information Technology and made recommendations for continued development

Next Steps

- Monitor implementation of 2019 learning plan by providing input and evaluating feedback on learning content, delivery, usability and measurement
- Guide and monitor innovative concepts for enhanced learning through technical assistance, peer based learning, and supporting learning to drive organizational change
- Work with HCH staff to ensure that learning activities are attuned to stakeholder needs and deliver value

Partnerships and Communications Work Group

"Our goal is to improve the health and well-being of the people in our community, it is vital that we work with other community agencies."

Clinic Director, RiverView Clinic – Crookston, Polk County

Partnerships and communication are essential to the growth and evolution of the HCH program. In 2018, HCH staff took steps to identify and strengthen alliances with internal and external stakeholders, and improve communication through a strategic approach, incorporating new brand management tools and training.

Outcomes

- Strengthened alliances with internal and external stakeholders through HCH advisory committees and work groups, community and interagency partnerships, and participation in conferences and initiatives with aligned interests
- Identified and enlisted stakeholders as advocates for enhancing the HCH program
- Created communication tools and resources to enhance partnerships, including the HCH Connections quarterly e-newsletter and LEARN e-news bulletin
- Mapped stakeholder groups to receive communication about the HCH program
- Identified key audiences and developed key messages to support program rebranding
- Developed brand assets and guidelines to increase effectiveness of HCH communication
- Produced new HCH marketing materials incorporating new brand and messaging
- New brand rolled out across all media platforms
- Developed communication planning tools for continuing work on audience analysis and strategic communication

Next Steps

- Increase staff proficiency for strategic communication planning and implementation using new communication planning tools and brand assets
- Enhance communication to increase visibility of the HCH program to primary care providers, state agencies, community partners, and consumers
- Expand impact of HCH program through relationship building, partnerships and stakeholder engagement whenever possible
- Amplify HCH stories by incorporating qualitative and quantitative data that demonstrate value
- Identify and monitor key media channels/sources covering health policy initiatives
- Assess value of HCH community outreach efforts

Measurement and Evaluation Work Group

"You can't change what you can't measure!"

HCH Advisory Committee Member

Clear evidence and reliable data can demonstrate the benefits of the HCH model. Data management at the clinic level and communication of these results tell the story of practice transformation throughout Minnesota. Certified HCH clinics are innovating and building evidence as they move through their HCH journey and are advancing their work to provide whole person care for the unique needs of patients and the populations they serve. HCH with the assistance of work group members are responding to the

measurement and evaluation needs of clinics, in a rapidly changing health care environment, through the following activities.

Outcomes

Over the course of 2018, the HCH program has taken a number of important steps to address strategic goals related to measurement and evaluation.

- Participated in stakeholder discussions about the future of quality improvement goals and measurement in Minnesota
- Gathered information to understand how HCH measures could align with state and national quality measures to minimize provider burden
- Started evaluation of the current HCH clinic quality improvement benchmarking portal
- Released a Request for Proposals for an evaluator to design an evaluation plan to measure how implementing HCH standards impacts the Quadruple Aim: improved patient outcomes, improved patient experience, reduced cost of care and increased provider satisfaction

Next Steps

- Continue evaluating the HCH Benchmarking Portal with input from HCH stakeholders
- Explore possibility of using All Payer Claims Data to assess Care Coordination return on investment
- Identify the clinics' definition of burden and research strategies to reduce burden
- Develop a mechanism to measure "joy in practice" and clinician job satisfaction
- Assist with designing the future HCH certification/recertification Licensing and Certification system to capture more quantitative, actionable data and also reduce reporting burden on clinics

Conclusion

"Care coordinators are able to spend dedicated time linking patients/families to needed resources because of a robust team taking care of health and medical needs."

Patient Centered Medical Home – Care Manager, Bluestone Physician Services, Washington County

HCH activities improve health outcomes while improving the experience and cost of care and is a strong foundation for maximizing value in health care delivery. The Primary Centered Primary Care Collaborative (PCPCC) 2018 evidence report supports the role of advanced primary care, such as the HCH, as critical to the success of care delivery reform. [8] Minnesota's HCH model has expanded patient-centered, team based, coordinated care to most regions of the state. Expansion of the HCH footprint around the state allows more Minnesotans an opportunity to receive comprehensive and equitable

[8] (Patient Centered Primary Care Collaborative; Robert Graham Center, 2018)

whole person care that respects each person's unique needs, culture, values and preferences, and offers high value care.

Care coordination is one of the foundational components of the HCH model and holds an important place in managing care within a community's medical and social support system by intentionally organizing and assisting with patient care activities. Care coordination promotes patient and family centered care and are activities to help patients, caregivers and families effectively manage health conditions and navigate the health care system. Health Care Home care coordination services are high touch, and build a strong relationship between the patient, clinicians and the care team. This trusting relationship facilitates the consideration of patients' personal medical and social history, needs and preferences when adapting care services to serve specific patients.

Throughout 2018, the Health Care Homes program continued to support clinics through their practice transformation journey using strategies developed in collaboration with stakeholders and ongoing technical assistance for achieving certification. Health Care Home program staff initiated more peer-to-peer regional learning opportunities, launched on-line, on demand learning courses to support HCH and practice transformation activities, and funded three Learning Communities to increase and strengthen partnerships between certified Health Care Home clinics, local public health, and behavioral health organizations through the use of data and information to support shared population health goals. This work is helping us move towards our goals of ensuring that all patients have access to patient-centered coordinated care, wherever they live.

We now know so much more about what creates health than we used to. We know that medical care only accounts for roughly 10-20 percent of what creates health, with social determinants such as education, social circumstances, environmental factors, and access to healthy foods, transportation, housing and recreational opportunities are much bigger factors. This means that the way we deliver care needs to continue to evolve, with a stronger focus on community partnerships, deliberate goals to address health equity and population health needs, a better understanding of a patient's broader life experiences and how they influence health, and better use and sharing of data. Certified health care homes and other advanced primary care providers are well positioned to continue to *Redefine Health and Redesign Care* in Minnesota to achieve these goals. The continuation of our work to advance the HCH standards in 2019, in partnership with stakeholders around the state, will be an important step forward in redefining how primary care should be delivered in Minnesota.

Appendices

Appendix A: HCH Advisory Committee members

ACADEMIC RESEARCHER IN MINNESOTA

- **Rhonda Cady**
  Gillette Children's Specialty Healthcare

CERTIFIED HEALTH CARE HOME REPRESENTATIVE

- **Dale Dobrin**
  South Lake Pediatric Clinic
- **Rebecca Nixon**
  North Memorial
- **Tracy Telander**
  HealthEast

CONSUMER OR PATIENT

- **Philip Deering**
- **Ashlea McLeod**
- **Melissa Winger**

EMPLOYER

- **Shawna Gisch**
  UnitedHealth Group

HEALTH CARE PROFESSIONAL

- **Dana Brandenburg**
  U of MN Department of Family Medicine and Community Health
- **Thomas Kottke**
  HealthPartners
- **Christine Singer**
  West Side Community Health Services
- **David Thorson**
  Primary Care Provider

HEALTH PLAN IN MINNESOTA REPRESENTATIVE

- **Mika Baer**
  Ucare

QUALITY IMPROVEMENT ORGANIZATION REPRESENTATIVE

- **Sarah Horst**
  Institute for Clinical Systems Improvement (ICSI)

Appendix B: Program Innovation Work Group members

- **Barbara Schubring**
  YMCA of Minneapolis
- **Ben C. Bengtson**
  St. Luke's Health System
- **Brittney Dahlin**
  Minnesota Association of Community Health Centers
- **Caryn McGeary**
  Affiliated Community Medical Center
- **Charlie Mandile**
  HealthFinders Collaborative
- **Claire Neely, MD**
  Institute for Clinical Systems Improvement (ICSI)
- **Daniel Backes**
  CentraCare Health
- **Eileen Weber**
  University of Minnesota School of Nursing
- **Erin Wiig**
  St. Lukes Health System
- **Jennifer Blanchard**
  Minnesota Department of Human Services
- **Jenny Kolb**
  Fairview Health Services
- **Jill Swenson**
  Sanford Health
- **Jo McLaughlin**
  HealthPartners
- **John Halfen, MD**
  Lakewood Health System
- **Joy May**
  Hutchinson Health
- **Kristen Godfrey Walters**
  Hennepin County Medical Center
- **Kristi Van Riper**
  University of Minnesota Physicians
- **Melissa Winger**
  Consumer
- **Nancy Miller**
  Stratis Health
- **Nicky Mack**
  North Memorial Health
- **Rachel Finley**
  Fairview Health Services
- **Rhonda Buckallew**
  Unity Family Healthcare
- **Rhonda Cady**
  Gillette Children's
- **Savannah Aultman**
  Alexandria Clinic
- **Sue Gentilli**
  Allina Clinics

Appendix C: Financial Sustainability Work Group members

- **Aaron Bloomquist**
  North Memorial
- **Charles Abrahamson**
  Health Partners
- **Dale Dobrin**
  South Lake Pediatric Clinic
- **David Thorson**
  Entira Clinics
- **Deb Krause**
  MN Health Action Group
- **Jeff Schiff**
  Department of Human Services
- **Jill Swenson**
  Sanford Health

Appendix D: Learning and Technical Assistance Work Group members

- **Alex Dahlquist**
  Office of Statewide Health Improvement Initiatives
- **Deb McKinley**
  Stratis Health
- **Jill Swenson**
  Sanford Health
- **Peter Carlson**
  North Memorial Health
- **Sarah Horst**
  Institute for Clinical Systems Improvement

Appendix E: Partnerships and Communications Work Group members

- **Michelle Dilley**
  Children's Minnesota
- **Michelle Gerard**
  Wilder Research Foundation
- **Ryan Davenport**
  DavenPR
- **Scott Smith**
  Minnesota Department of Health

Appendix F: Measurement and Evaluation Work Group members

- **Corinne L Abdou**
  Wayzata Children's Clinic, P.A.
- **Dan Schletty**
  Riverwood Healthcare Center
- **Denise McCabe**
  MDH Statewide Quality Reporting Measurement System
- **Erica Schuler**
  Ridgeview Medical
- **Gena Graves**
  HealthPartners/ Park Nicollet
- **Karolina Craft**
  DHS Care Delivery and Payment Reform
- **Maria McGannon**
  South Lake Pediatrics
- **Michele Gustafsson**
  Entira
- **Miranda Cantine**
  Ortonville Area Health Services
- **Nate Hunkins**
  Bluestone Physician Services
- **Nathan Shippe**
  U of MN: Public Health
- **Peter Harper**
  U of MN: Family Medicine
- **Susan Gentilli**
  Allina Clinics

Appendix G: Health Care Homes Certification Committee members

- **John Halfen, MD**
  Lakewood Health Systems
- **Jen Hartmann, SW**
  Morrison County Social Services
- **Lisa Hoffman-Wojcik**
  Open Door Health Center
- **Ellen K. Ryan, RN, MSN**
  First Light Health System
- **Becky Walsh, CPC**
  PrimeWest Health
- **Melissa Winger**
  Patient and Family Advocate

Appendix H: Rule Advisory Committee members

- **Carolyn Allshouse**
  Family Voices of Minnesota
- **Sandy Anderson**
  Sleepy Eye Medical Center
- **Bev Annis**
  HCH Site Visit Evaluator
- **Mary Benbenek**
  Minnesota Nurse Practitioners
- **Sara Bonneville**
  DHS Integrated Health Partnerships
- **Rhonda Cady**
  Gillette Children's Hospital
- **Miranda Cantine**
  Ortonville Area Health Services
- **Deborah Cushman**
  Minnesota Literacy Council
- **Brittney Dahlin**
  Minnesota Association of Community Health Centers
- **Dale Dobrin**
  South Lake Pediatrics
- **Kristen Godfrey Walters**
  Hennepin Healthcare
- **Gena Graves**
  Park Nicollet
- **Beth Gyllstrom**
  MDH Performance Improvement and Research
- **John Halfen**
  Lakewood Health Systems
- **Sarah Horst**
  Institute for Clinical Systems Improvement
- **Clarence Jones**
  Consumer representative
- **George Klauser**
  Lutheran Social Service of Minnesota
- **Jenny Kolb**
  Fairview Health Services
- **Jane Kluge**
  CentraCare Health
- **Nicky Mack**
  North Memorial Health
- **Joanne McLaughlin**
  HealthPartners
- **Jodi Painschab**
  Stellis Health
- **Naomi Samuelson**
  Murray County Medical Center
- **Daisey Sanchez**
  Health Finders Collaborative
- **Anne Schloegel**
  MDH Office of Health IT
- **Cherylee Sherry**
  MDH Statewide Health Improvement Partnership
- **Dawn Simonson**
  Metropolitan Area Agency on Aging
- **Isolina Soto**
  West Side Community Health Center
- **Jill Swenson**
  Sanford Health
- **Eileen Weber**
  University of Minnesota School of Nursing
- **Will Wilson**
  MDH Office of Rural Health and Primary

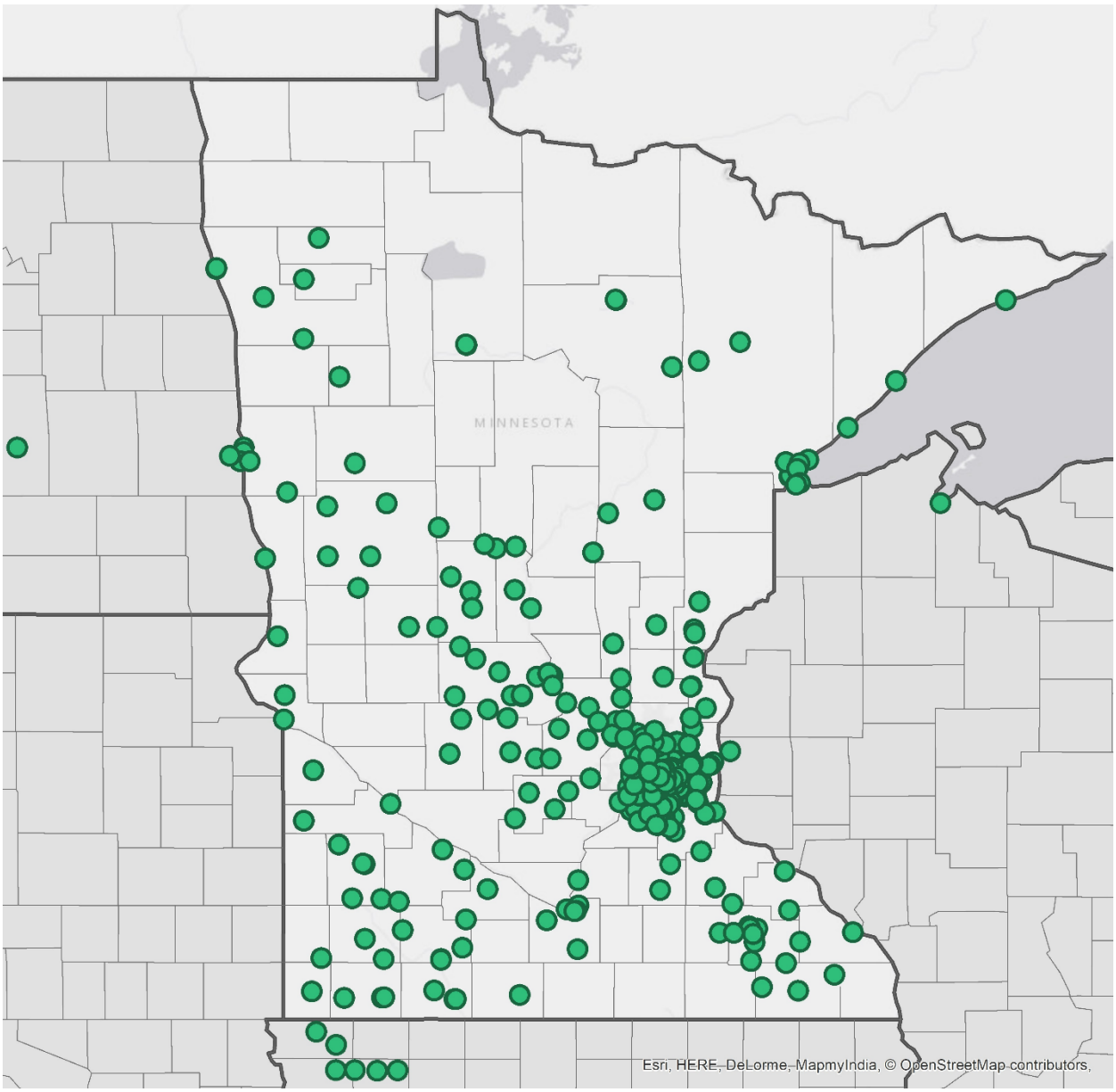
Appendix I: Counties based on number of Health Care Homes

County	2010 Population	% of Population	Region	Total # of Clinics	# MN Current HCH	% of Clinics Certified	County has at least One HCH	County with at least one clinic
Aitkin	16,202	0.3%	Northeast	3	2	67%	1	1
Anoka	330,844	6.2%	Metropolitan	19	17	89%	1	1
Becker	32,504	0.6%	Northwest	7	1	14%	1	1
Beltrami	44,442	0.8%	Northwest	3	2	67%	1	1
Benton	38,451	0.7%	Central	1	0	0%	0	1
Big Stone	5,269	0.1%	Southwest	3	2	67%	1	1
Blue Earth	64,013	1.2%	South Central	11	6	55%	1	1
Brown	25,893	0.5%	South Central	5	2	40%	1	1
Carlton	35,386	0.7%	Northeast	4	0	0%	0	1
Carver	91,042	1.7%	Metropolitan	14	4	29%	1	1
Cass	28,567	0.5%	Central	10	1	10%	1	1
Chippewa	12,441	0.2%	Southwest	3	0	0%	0	1
Chisago	53,887	1.0%	Central	5	5	100%	1	1
Clay	58,999	1.1%	West Central	7	4	57%	1	1
Clearwater	8,695	0.2%	Northwest	2	0	0%	0	1
Cook	5,176	0.1%	Northeast	1	1	100%	1	1
Cottonwood	11,687	0.2%	Southwest	6	4	67%	1	1
Crow Wing	62,500	1.2%	Central	9	1	11%	1	1
Dakota	398,552	7.5%	Metropolitan	37	21	57%	1	1
Dodge	20,087	0.4%	Southeast	1	1	100%	1	1
Douglas	36,009	0.7%	West Central	4	2	50%	1	1
Faribault	14,553	0.3%	South Central	5	0	0%	0	1
Fillmore	20,866	0.4%	Southeast	6	4	67%	1	1
Freeborn	31,255	0.6%	Southeast	2	0	0%	0	1
Goodhue	46,183	0.9%	Southeast	7	3	43%	1	1
Grant	6,018	0.1%	West Central	4	1	25%	1	1
Hennepin	1,152,425	21.7%	Metropolitan	142	91	64%	1	1
Houston	19,027	0.4%	Southeast	4	0	0%	0	1
Hubbard	20,428	0.4%	Northwest	2	0	0%	0	1
Isanti	37,816	0.7%	Central	1	1	100%	1	1
Itasca	45,058	0.8%	Northeast	8	2	25%	1	1
Jackson	10,266	0.2%	Southwest	4	2	50%	1	1
Kanabec	16,239	0.3%	Central	1	1	100%	1	1
Kandiyohi	42,239	0.8%	Southwest	5	2	40%	1	1
Kittson	4,552	0.1%	Northwest	2	0	0%	0	1
Koochiching	13,311	0.3%	Northeast	7	0	0%	0	1

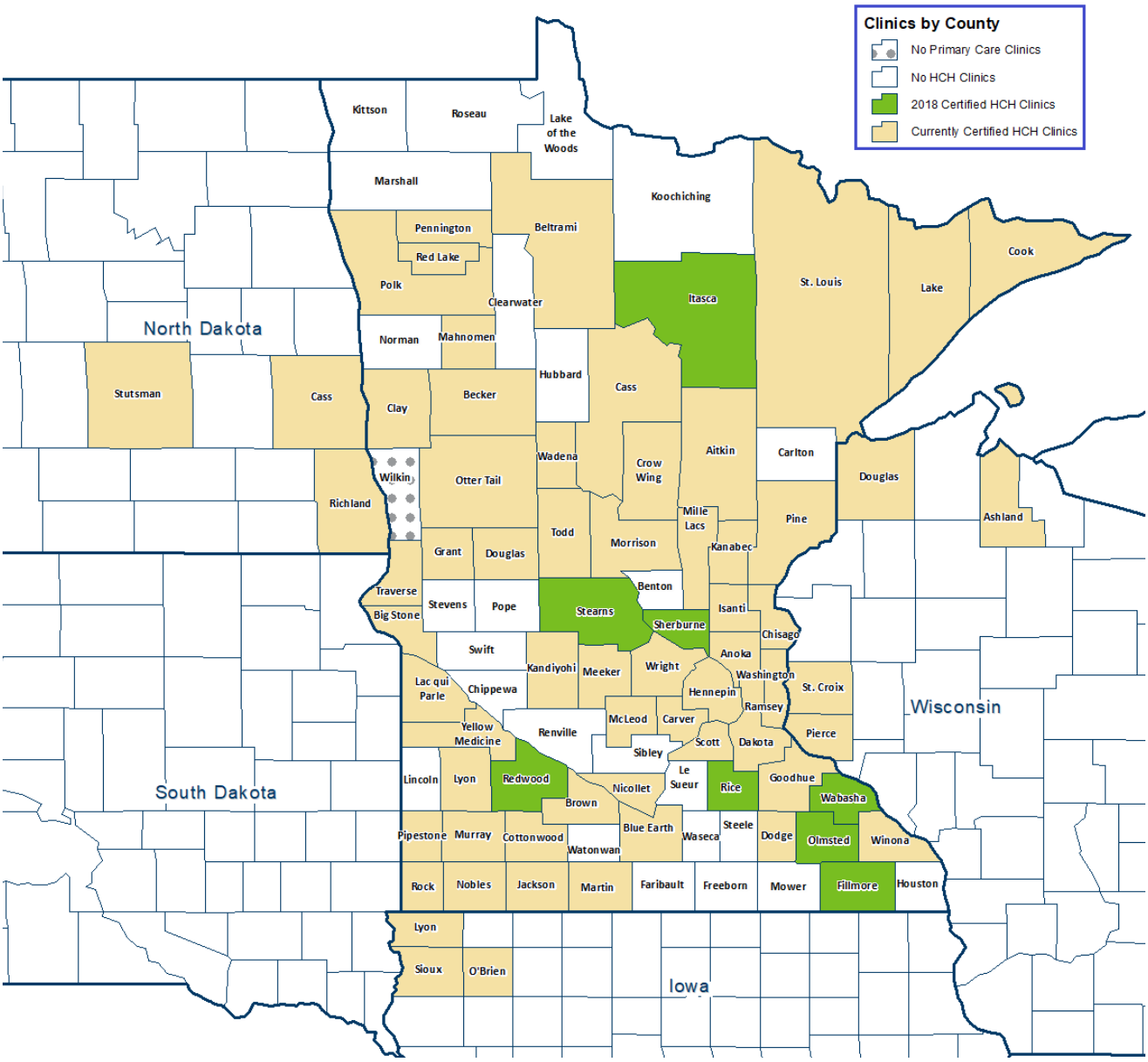
County	2010 Population	% of Population	Region	Total # of Clinics	# MN Current HCH	% of Clinics Certified	County has at least One HCH	County with at least one clinic
Lac qui Parle	7,259	0.1%	Southwest	3	1	33%	1	1
Lake	10,866	0.2%	Northeast	2	2	100%	1	1
Lake of the Woods	4,045	0.1%	Northwest	1	0	0%	0	1
Le Sueur	27,703	0.5%	South Central	5	0	0%	0	1
Lincoln	5,896	0.1%	Southwest	5	0	0%	0	1
Lyon	25,857	0.5%	Southwest	5	5	100%	1	1
McLeod	36,651	0.7%	South Central	5	4	80%	1	1
Mahnomen	5,413	0.1%	Northwest	3	1	33%	1	1
Marshall	9,439	0.2%	Northwest	1	0	0%	0	1
Martin	20,840	0.4%	South Central	6	1	17%	1	1
Meeker	23,300	0.4%	South Central	5	4	80%	1	1
Mille Lacs	26,097	0.5%	Central	5	2	40%	1	1
Morrison	33,198	0.6%	Central	6	3	50%	1	1
Mower	39,163	0.7%	Southeast	4	0	0%	0	1
Murray	8,725	0.2%	Southwest	3	2	67%	1	1
Nicollet	32,727	0.6%	South Central	3	2	67%	1	1
Nobles	21,378	0.4%	Southwest	3	3	100%	1	1
Norman	6,852	0.1%	Northwest	3	0	0%	0	1
Olmsted	144,248	2.7%	Southeast	12	12	100%	1	1
Otter Tail	57,303	1.1%	West Central	7	4	57%	1	1
Pennington	13,930	0.3%	Northwest	1	1	100%	1	1
Pine	29,750	0.6%	Central	6	3	50%	1	1
Pipestone	9,596	0.2%	Southwest	4	1	25%	1	1
Polk	31,600	0.6%	Northwest	10	4	40%	1	1
Pope	10,995	0.2%	West Central	2	0	0%	0	1
Ramsey	508,640	9.6%	Metropolitan	68	46	68%	1	1
Red Lake	4,089	0.1%	Northwest	3	1	33%	1	1
Redwood	16,059	0.3%	Southwest	4	4	100%	1	1
Renville	15,730	0.3%	Southwest	4	0	0%	0	1
Rice	64,142	1.2%	Southeast	8	4	37%	1	1
Rock	9,687	0.2%	Southwest	1	1	100%	1	1
Roseau	15,629	0.3%	Northwest	3	0	0%	0	1
St. Louis	200,226	3.8%	Northeast	34	10	29%	1	1
Scott	129,928	2.4%	Metropolitan	10	6	60%	1	1
Sherburne	88,499	1.7%	Central	7	7	100%	1	1
Sibley	15,226	0.3%	South Central	5	0	0%	0	1
Stearns	150,642	2.8%	Central	21	19	90%	1	1

County	2010 Population	% of Population	Region	Total # of Clinics	# MN Current HCH	% of Clinics Certified	County has at least One HCH	County with at least one clinic
Steele	36,576	0.7%	Southeast	2	0	0%	0	1
Stevens	9,726	0.2%	West Central	4	0	0%	0	1
Swift	9,783	0.2%	Southwest	2	0	0%	0	1
Todd	24,895	0.5%	Central	6	4	67%	1	1
Traverse	3,558	0.1%	West Central	1	1	100%	1	1
Wabasha	21,676	0.4%	Southeast	5	2	40%	1	1
Wadena	13,843	0.3%	Central	3	1	33%	1	1
Waseca	19,136	0.4%	South Central	3	0	0%	0	1
Washington	238,136	4.5%	Metropolitan	22	17	77%	1	1
Watonwan	11,211	0.2%	South Central	2	0	0%	0	1
Wilkin	6,576	0.1%	West Central	0	0	0%	0	0
Winona	51,461	1.0%	Southeast	2	2	100%	1	1
Wright	124,700	2.4%	Central	12	8	67%	1	1
Yellow Medicine	10,438	0.2%	Southwest	3	1	33%	1	1
State of Minnesota	5,303,925			700	372	53%	61	86

Appendix J: Dot Map of HCH Clinic Locations



Appendix K: Map of HCH Clinic Locations by County in Minnesota and Border States



Appendix L: Certification, Recertification, and Spread during 2018

Type of Certification	*Organization**	*Cities*	*Counties*
Certified	Scenic Rivers Health Services	Bigfork	Itasca
Certified	HealthFinders Collaborative	Faribault	Rice
Spread	Winona Health	Rushford	Fillmore
Spread	CentraCare Health System	Albany, Big Lake	Sherburne, Stearns
Spread	Avera Medical Group	Redwood Falls	Redwood
Spread	Olmsted Medical Center	Lake City, Rochester	Olmsted, Wabasha
Spread	HealthFinders Collaborative	Northfield	Rice
Recertified	Murray County Medical Center	Fulda, Slayton	Murray
Recertified	Northwest Family Clinics	Crystal, Plymouth, Rogers	Hennepin
Recertified	Sanford Sioux Falls Region	Adrian, Balaton, Boyden (IA), Canby, George (IA), Hartley (IA), Jackson, Lakefield, Luverne, Edgerton, Minnesota, Mountain Lake, Rock Rapids (IA), Sanborn (IA), Sheldon (IA), Tracy, Walnut Grove, Westbrook, Windom, Worthington	Cottonwood, Jackson, Lyon, Nobles, Pipestone, Redwood, Rock, Yellow Medicine
Recertified	Cedar Riverside People's Center	Minneapolis	Hennepin
Recertified	Sleepy Eye Medical Center	Comfrey, Morgan, Sleepy Eye	Brown, Redwood
Recertified	Burnsville Family Physicians	Burnsville	Dakota
Recertified	Affiliated Community Medical Centers	Litchfield, Marshall, New London, Redwood Falls, Willmar	Kandiyohi, Lyon, Meeker, Redwood

Type of Certification	*Organization**	*Cities*	*Counties*
Recertified	Richard W. Schoewe, MD	Roseville	Ramsey
Recertified	HealthPartners	Andover, Anoka, Apple Valley, Arden Hills, Bloomington, Brooklyn Center, Coon Rapids, Cottage Grove, Eagan, Elk River, Hugo, Inver Grove Heights, Lino Lakes, Mahtomedi, Maplewood, Minneapolis, Roseville, Sartell, Somerset (WI), St. Louis Park, St. Paul, Stillwater, White Bear Lake, Woodbury	Anoka, Dakota, Hennepin, Ramsey, Sherburne, Stearns, Washington
Recertified	Christopher J. Wenner, MD, PA	Cold Spring	Stearns
Recertified	Neighborhood HealthSource	Minneapolis	Hennepin
Recertified	Bluestone Physician Services	Stillwater	Washington
Recertified	Southside Community Health Services	Minneapolis	Hennepin
Recertified	North Metro Pediatrics, PA	Coon Rapids	Anoka

* Listed in calendar order of certification/recertification.