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Health Care Homes: Annual Report on Implementation

Minnesota Department of Health
Minnesota Department of Human Services
Report to the Minnesota Legislature - 2014

January 2015

health reform MINNESOTA
HCH | Health Care Homes

Minnesota Department of **Human Services**

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Executive Summary

Minnesota's health care home (HCH) initiative has reached a five year milestone in its efforts to transform primary care and improve health for all Minnesotans. Health care homes are foundational to Minnesota's efforts to achieve the Institute for Healthcare Improvement's (IHI) triple aim of improving the health of Minnesotans, improving the patient experience, and reducing the cost of health care. Health Care Homes, known nationally as Patient Centered Medical Homes, require a fundamental redesign in the practice of primary care towards prevention and management of chronic disease, and serve as a critical element of health reform in Minnesota. Authorized by Minnesota's 2008 health reform law, the health care homes initiative is jointly administered by the Minnesota Department of Health and the Minnesota Department of Human Services.[1] This legislative report highlights progress towards meeting these goals in 2014.

HCH Implementation Progress

- As of December 31, 2014, 359 clinics have been certified as HCHs, representing 53% of clinics serving Minnesota, supporting the health care needs of 3.64 million people.
- Approximately 388,000 Minnesota health care program participants received care in a HCH.
- Ninety-nine percent of certified health care homes applied for recertification. Four clinics did not recertify.
- 58% percent of certified clinics/health systems are submitting claims for care coordination payments for Minnesota health care programs.
- The HCH program provided face to face and virtual learning collaborative activities to 990 participants.

Goals in 2015

- Continue to certify HCH's, address elements of the payment methodology, and seek opportunities to engage uncertified clinics throughout Minnesota.
- Act as an integral partner in the development of Medicaid Behavioral Health Homes through the creation of dual certification options for HCH's.
- Ensure inclusion of patient and family centered care concepts, and alignment with HCH principles, in the activities of the State Innovation Model (SIM) grant through continued expansion of HCH's, practice transformation strategies and implementation of Accountable Communities for Health.

[1] Health Reform Website

- Expand Learning Community grant programs by offering opportunities for broader HCH participation in a variety of transformation topic areas.
- Partner with DHS and SIM organizations to plan and implement combined learning days events. Integrate SIM practice transformation and facilitation activities into the current HCH learning collaborative framework.
- Support clinics through practice facilitation collaboration under the SIM grant to rapidly increase the number of certified HCH.
- Ensure health equity is reflected in HCH policies and processes.
- Implement activities to ensure active emphasis on the patient voice in the implementation of HCH at all levels.
- Emphasize and build community partnerships.

The HCH model, with its focus on whole person disease management and patient-centered care, is serving as the principal driver for focusing primary care on prevention and management of chronic disease. HCH has created the foundation for additional health care reforms that drive integration in the health care system and importantly, integration of health care with behavioral, community, social service, and public health systems.

Introduction

Minnesota's health care home (HCH) initiative has reached the five year milestone in its efforts to transform primary care and improve health for all Minnesotans. HCH puts patients and families at the center of their care, develops proactive approaches through care plans and offers more continuity of care through increased care coordination between providers and community resources.

- Minnesota's HCH initiative is a cornerstone of the state's 2008 health reform law[2]. HCHs both build on and benefit from other state and federal health reform and are well aligned with the state's other 2008 and 2010 health reforms.
- The 2008 law includes components focused on Population health, market transparency and enhanced quality and cost information
- HCH are the primary care foundation to building successful Accountable Care Organizations (ACOs) and is an integral partner in planning for Medicaid Behavioral Health Homes and Accountable Communities for Health through the SIM grant.

Minnesota's initiative showcases a redesign of both care delivery and payment through several components:

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

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

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

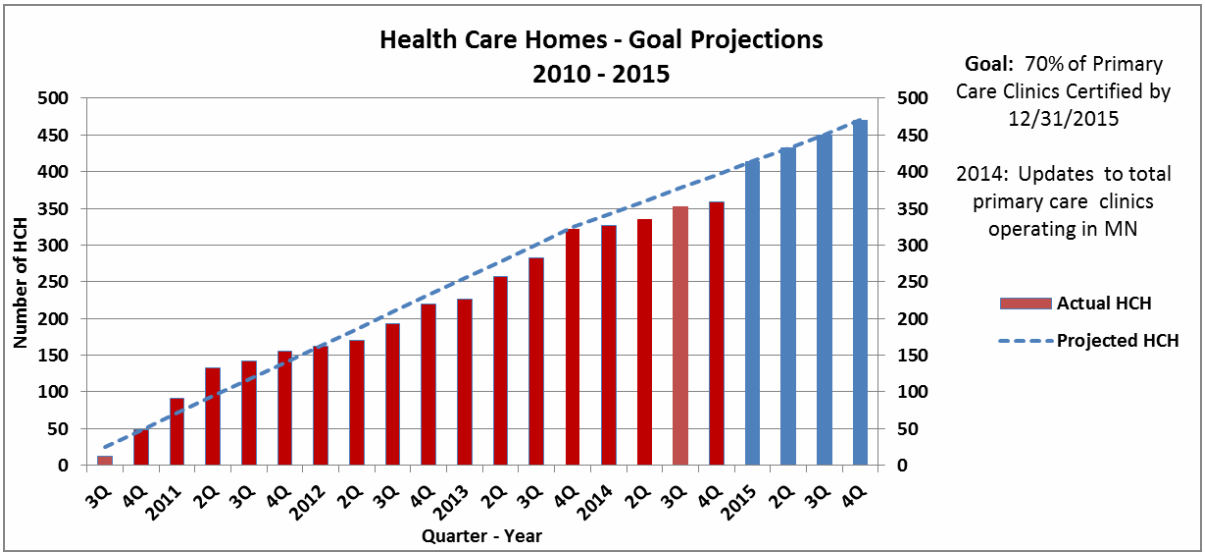
Program Development Updates

Health Care Home Certification

The standards for certification as a HCH were created to allow flexibility and the opportunity to achieve needed outcomes without being overly prescriptive. To be certified, a Health Care Home must meet standards in five domains:

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

MDH certifies clinics throughout the year with review and recommendation from the HCH Community Certification Committee. The enclosed maps show the distribution of HCH statewide in 2011, 2012, 2013 and 2014. [3]
In 2014, MDH certified 37 clinics, ending the year with a total of 359 certified clinics indicating a slowdown in the number of clinics ready for certification.



The HCH program expects to certify 70 percent of all Minnesota primary care clinics by the end of 2015. To date, progress towards that goal has been measured using a denominator of 735 clinics; in 2014, HCH staff worked to update the number of Minnesota primary care clinics to reflect recent clinic closures, consolidations, and acquisitions. The revised number of primary

[3] HCH Maps: Appendix B

care clinics in the state is estimated at 671 with an additional 51 border state clinics serving Minnesota residents. Using this updated denominator of 722, 53 percent of primary care clinics serving Minnesota are currently certified. The HCH program will continue to update these figures as needed in the coming years.

2014 Minnesota Health Care Homes by Region and 2010 Population[4]

Region	Clinics	Certified HCH	Clinics to Reach 70% 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	310	201	217	64.8%	100%	10.88	7.05	2,849,567
Northeast	55	14	39	25.5%	43%	16.86	4.29	326,225
Northwest	37	8	26	21.6%	38%	18.35	3.97	201,618
Central	82	54	57	65.9%	79%	11.25	7.41	729,084
West Central	27	11	19	40.7%	63%	14.27	5.81	189,184
South Central	53	10	37	18.9%	36%	18.20	3.43	291,253
Southeast	52	19	36	36.5%	82%	10.51	3.84	494,684
Southwest	55	23	39	41.8%	63%	24.74	10.35	222,310
Total MN	**671**	**340**	**470**	**50.7%**	**62.1%**	12.65	6.41	5,303,925
Border States	51	19						
Total	**722**	**359**						

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

- Access to a HCH continues to vary across the state. The variation between regions ranges from 65.9 % of clinics certified in the central area to 18.9% certified in the south central region. In 2014, the metropolitan region, increased from 57% to 64.8% of clinics certified
- All regions of the state except the Northeast, Northwest, and South Central region have increased the number of certified HCH in 2014.
- In 2014, the percentage of counties with one or more certified clinics increased in the west central, southeast and southwest regions of the state.
- Certified clinics per 100,000 people increased in the metro, central, west central, south central, southeast and southwest region of the state.

Capacity Building

At the end of 2014, there are approximately 88 clinics receiving capacity-building assistance to help prepare them for the certification process and 30 of these clinics have submitted a letter of intent to become certified.

A continued focus of the HCH program is to build capacity throughout the state and to assure that every county has a certified HCH to transform primary care. The HCH team identified development of this infrastructure through community partnerships as a key strategic priority for 2012; this continued to be a focus in 2014. The HCH team developed initiatives that promoted these community partnerships to support implementation of HCH including:

HCH nurse community outreach activities

- **Educating community partners** and interested parties throughout the state about

quality improvement initiatives and patient- and family-centered care models.

- **Actively participating in the implementation of the State Innovation Model Grant** through rapid expansion of HCHs, practice transformation strategies and implementation of Accountable Communities for Health

- **Supporting clinics through practice facilitation 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 in order to capitalize on existing resources and to contribute to the national core outcomes for Children and Youth with Special Health Needs.

Demographic Data for Certified Health Care Homes

Minnesota Health Care Homes Organizations Certified by Type*
% Total of Certified HCH Organizations

Year	Federally Qualified Health Center (FQHC)	Hospital Based Clinics	Independent Medical Group	Integrated Medical Group	Other
2012	5 (13%)	4 (11%)	12 (32%)	16 (42%)	1 (3%)
2013	10 (20%)	5 (10%)	18 (36%)	16 (32%)	1 (2%)
2014	14 (25%)	4 (7%)	18 (31%)	15 (26%)	6 (11%)

Data as of 11/19/2014

There are some significant changes in the types of clinic organizations that were certified in 2014 compared to 2013. Four additional FQHC organizations were certified which results in 73% of eligible FQHC's with certified clinics. Of the remaining two HCH eligible FQHC organizations, one is seeking HCH certification and the other is seeking National Committee for Quality Assurance Medical Home certification as part of a Health Resources and Services Administration grant program. While the integrated medical groups and independent medical groups remained constant, the overall number of certified clinics in Minnesota has increased.

Percentages & Number of Practice Types for Certified Primary Care Providers

Year	Family Physicians	Internal Medicine Physicians	Pediatricians	Nurse Practitioners & Certified Nurse Midwives	Physician Assistants	Other
2012 n= 2,353	1036	447	282	306	188	94
%	(44%)	(19%)	(12%)	(13%)	(8%)	(4%)
2013 n=3,429	1547	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%

Data as of 11/19/2014

Within a certified HCH, each clinician is certified as a HCH provider. In 2014, the number of unique clinicians within HCHs who had received certification increased from 3,429 in 2013 to 4,064 clinicians in 2014. Certified clinicians by practice type are listed in the chart above. A number of specialty clinics have achieved HCH certification because they also provide comprehensive primary care services for their patients. These specialties include geriatricians, women's health, pediatrics and HIV specialists.

Primary Language in Certified Clinics

Primary Language	2011	2012	2013	2014
Average % of English Speaking	**84%**	84%	86%	86%
Average % of Non-English Speaking	**16%**	16%	13%	14%

Data as of 11/19/2014

The overall average percentage of non-English speaking patients has remained steady over the past year. The number of clinics with a greater than 20% non-English speaking patient population has increased from 58 clinics in 2013 to 60 clinics in 2014.

Certification Process

Ninety-nine percent of certified health care homes applied for recertification. Four clinics did not recertify. One of these four clinics plans on HCH recertification in the future and the other three clinics are part of an international health care system that plans on seeking NCQA recognition.

Learning Collaborative

A HCH statewide learning collaborative is required by Minnesota Statute §256B.0751. This learning collaborative provides an opportunity for HCH to exchange information and enhance understanding related to quality improvement and best practices, using face-to-face and virtual learning opportunities. In addition to the required statewide learning collaborative, HCHs had a number of options in 2014 for participating in learning and sharing activities related to a variety of topics.

Learning Collaborative Activities and Topics During 2014

- MDH offered monthly webinars to HCHs on a variety of topics. Webinar topics included hypertension management and prevention, care coordination, care coordinator burnout, and Medicare behavioral counseling benefits. Attendance was 100-150 per webinar. Webinars are available on request.
- A centerpiece of learning collaborative activities is the annual in-person Learning Day, which was held in October 2014. The pre- conference workshop and day long seminars had 375 attendees. Sessions covered topics including care coordination, population management, culturally appropriate care and models of care. Evaluations indicated a high satisfaction with variety of topics and achievement of goals for the event overall.
- An "Introduction to Health Care Homes" webinar series is available on request. To date, MDH has responded to 73 requests for the recordings.
- A Hypertension Management Workshop was held in Fergus Falls in partnership with the Million Hearts Campaign and the Community Transformation Grant program. Thirty seven attendees from several local organizations attended.
- At the 2014 Fall Learning Day, 90% of respondents reported that the conference goal of improving understanding of disparities was met.
- In response to the Governor's report on Health Disparity http://www.health.state.mn.us/ommh/publications/legislativerpt2011.pdf, HCH incorporated integration of health disparities as a component of every learning opportunity.

The HCH Learning Collaborative incorporated multiple stakeholder inputs into the selection of topics and formats for 2014 activities:

- Nearly 50 certified HCHs completed a learning needs assessment in Spring 2014.
- A HCH Learning Collaborative Advisory Committee was expanded to include representatives from community groups for the Minnesota Accountable Health Model (SIM). The group met three times in 2014.
- The HCH program convened planning groups that included consumers, providers and HCH leaders.
- The HCH program used benchmarking and capacity building assessments to inform topic selection.
- Learning collaborative participants also completed evaluations, which help to shape future events.

Learning Collaborative: Alzheimer's

Legislation passed in 2011 directs the Commissioner of Health to develop a HCH learning collaborative curriculum that includes screening and education on best practices regarding identification and management of Alzheimer's and other dementia patients for providers, clinics, care coordinators, clinic administrators, patient partners and families and community resources including public health.[5].

The last of four learning sessions took place during the learning day event in October, 2014 and was attended by 33 people. The session covered the value of early screening, medication management, discussed caregiving best practices and provider/patient communication strategies. Ninety percent of respondents to the session evaluation stated the goals were well met. A provider focused webinar will be planned for 2015.

Learning Communities

In contrast to the mandatory statewide learning collaborative, a learning community is a smaller, more focused learning model in which a group of 5-10 clinics are brought together by a convening organization to focus on a specific topic of their choosing for a defined period of time. The HCH program funded four learning community grants during 2013/2014. Each $30,000 grant funded a sixth month implementation period. Details of grantees are as follows:

Topic	Grantee	Timeline	Participant characteristics
Prevention: using the EHR for population health management	National Rural Health Resource Center	Jan- July, 2014	Smaller clinics with a rural, urban/diverse population and FQHCs. Use Centricity EHR. Five teams (four members each) were recruited. Four completed the program
Transitions of care- focus on patient safety.	American Academy of Pediatrics, MN chapter	Jan- July, 2014	Pediatric clinics and hospital clinics to form a quality team. Four teams (5 members each) were recruited and completed the program
Prevention- quality improvement projects to share best practice in pediatric obesity identification and treatment.	American Academy of Pediatrics, MN chapter	June-Dec 2014	Pediatric teams from 6 clinics.
Community Focused Care Coordination	National Rural Health Resource Center	June-Dec, 2014	Five (six members each) clinical care teams from certified health care homes.

[5] MN Statutes Section 62U.15 Alzheimer's Disease: Prevalence and Screening

Learning Collaborative Next Steps

Learning days

In May, 2015 MDH/DHS will hold the first HCH/SIM Learning Day event, designed to bring together organizations that are working on implementing patient-centered, team based approaches to care and collaborating with a broad range of partners to transform care delivery. The HCH/SIM learning day will be open not only to HCHs, but to a wide range of organizations engaged in this work. Planning is in process with advisory committee and stakeholder input and a meeting facilitator. General session/keynote, workshops specific to transformational topics (Accountable Communities of Health, Behavioral Health Home, Health Care Home and SIM) and breakout sessions will make up the two day conference. Planning will continue with the interagency SIM/HCH team and Advisory Committee and stakeholders to shape the topics and format for the event.

Introduction to Health Care Homes - webinar series

Plans are underway to reorganize this series to provide an option for online training opportunities that can accommodate varied schedules.

Learning communities

In 2015 and 2016, the HCH program will support up to five learning communities, in coordination with the SIM grant. Topics will be aligned with HCH certification standards, but also include options to focus on data analytics, health equity, and/or community care team implementation. Lessons learned will be incorporated into subsequent requests for proposal to enhance team learning

Regional trainings

The HCH/SIM learning collaborative will evaluate the need for regional approaches to training activities. These may be held in partnership with other funding and program areas to increase cost effectiveness and population served. Partnering with local public health to provide resources is a strategy the HCH will explore in 2015.

Community Partnerships

Capacity building in the context of the HCH program supports clinics to transform into certified HCH. It requires a variety of community partnerships and focused facilitation resources to support clinics to make significant changes that result in lasting improvements to their quality goals. The SIM grant, which was funded in early 2014, has allowed HCH to partner with a wide variety of community organizations. The expansion of HCH throughout the state is a goal for both SIM and the HCH program, with an emphasis on increasing access to HCH statewide.

There are several funding opportunities offered through SIM that help to provide the support for this transformation and partnerships with community care systems.

Accountable Communities for Health

One component of the Minnesota Accountable Health Model, SIM, is the funding of up to 15 Accountable Communities for Health (ACH). These grants are intended to support readiness to advance the Minnesota Accountable Health Model and expand active community participation with a broad range of stakeholders and providers in addressing local health needs.

The three early implementer ACH Community Care Teams (Essentia Ely, Mayo Clinic, Olmsted County, and HCMC, Brooklyn Park) are already functioning in Minnesota, and have been funded through SIM. The lessons learned through the development of Community Care Teams and the on-going support of their efforts was used as the basis for the ACH RFP process.

The participating ACH sites represent population and geographic diversity:

- New Ulm Medical Center, New Ulm
- Otter Tail County Public Health, Fergus Falls
- CentraCare Health Foundation, St. Cloud
- Southern Prairie Community Care, Marshall
- Unity Family Health Care, Little Falls
- North Country Community Health Services, Bagley
- UCare/Federally Qualified Health Center Urban Health Network (FUHN), Minneapolis
- Vail Place/North Memorial, Hopkins
- Hennepin County/Hennepin Health, Minneapolis
- Generations Health Care Initiatives, Duluth
- Allina Health Systems/Northwest Metro Alliance, Minneapolis
- Lutheran Social Service of Minnesota/Bluestone Physician Services, St. Paul

Practice Transformation Grants

Many providers, including small, independent, rural, and safety net providers face financial barriers to implementation of practice transformation. These development grants, $15,000-

20,000, will support models that integrate primary care, behavioral health, social services, training, and coordination. Transformation grants will support a range of providers and teams in primary care, social services, or behavioral health to allow team members to participate in practice transformation activities. The grant helps to supports the expansion of HCH in areas or populations that do not currently have access to a HCH. Funding for the first round of these grants is expected to begin in February 2015.

Practice Facilitation Contract

Qualified entities will be awarded a contract to provide practice facilitation services to primary care clinics, certified health care homes, integrated models of care and sites seeking to become integrated models of care including primary care, behavioral health, social services, long term and post-acute care services. The applicant will use a range of organizational development, project management, quality improvement (QI), and practice improvement approaches and methods to build the internal capacity of a practice to help it engage in improvement activities over time and support it in reaching incremental and transformative improvement goals.

It is anticipated that these activities will involve certified health care homes, and/or provide support for those seeking certification. Funding is expected to begin in February 2015.

Health Care Home Performance Measurement

Program Measurement Activities

As part of their recertification process, Health Care Homes are required to submit data into the statewide quality measurement system, and to participate in a benchmarking process that compares their results to those of other certified health care homes within a secure portal. The HCH program seeks input from a Performance Measurement Workgroup to advise the performance measurement and benchmarking processes.

Care Coordination Measures

In 2013, the HCH program worked with its Performance Measurement Workgroup and with its data collection vendor, Minnesota Community Measurement (MNCM), to develop two new potential Care Coordination Measures: Advanced Care Planning and Follow-up after Hospital Discharge. MNCM worked with HCHs to pilot the two measures in 2014, and reported its final recommendations to the HCH Performance Measurement Workgroup in May 2014. Both measures were recommended for quality improvement purposes within the HCH evaluation and recertification processes, but not for public reporting. In November 2014, the HCH Performance Measurement Workgroup recommended to delay the implementation of the care coordination measures until late 2015. Senior MDH leadership will be reviewing the workgroup recommendations and formulating an action plan in early 2015.

Patient Experience

As part of recent changes to the Statewide Quality Reporting and Measurement system, all Minnesota clinics will begin using the Clinician and Group Consumer Assessment of Health Care Providers and Systems (CG-CAHPS) 12-month survey to assess patient experience beginning in 2015. Health Care Homes will be required to include supplemental questions for Patient Centered Medical Homes (PCMH) for their pediatric and adult populations, and to implement child CG-CAHPS for children age 0 -12 years of age.

Performance Measurement Next Steps

In 2015, the Performance Measurement Workgroup will provide guidance on the following HCH performance measurement areas:

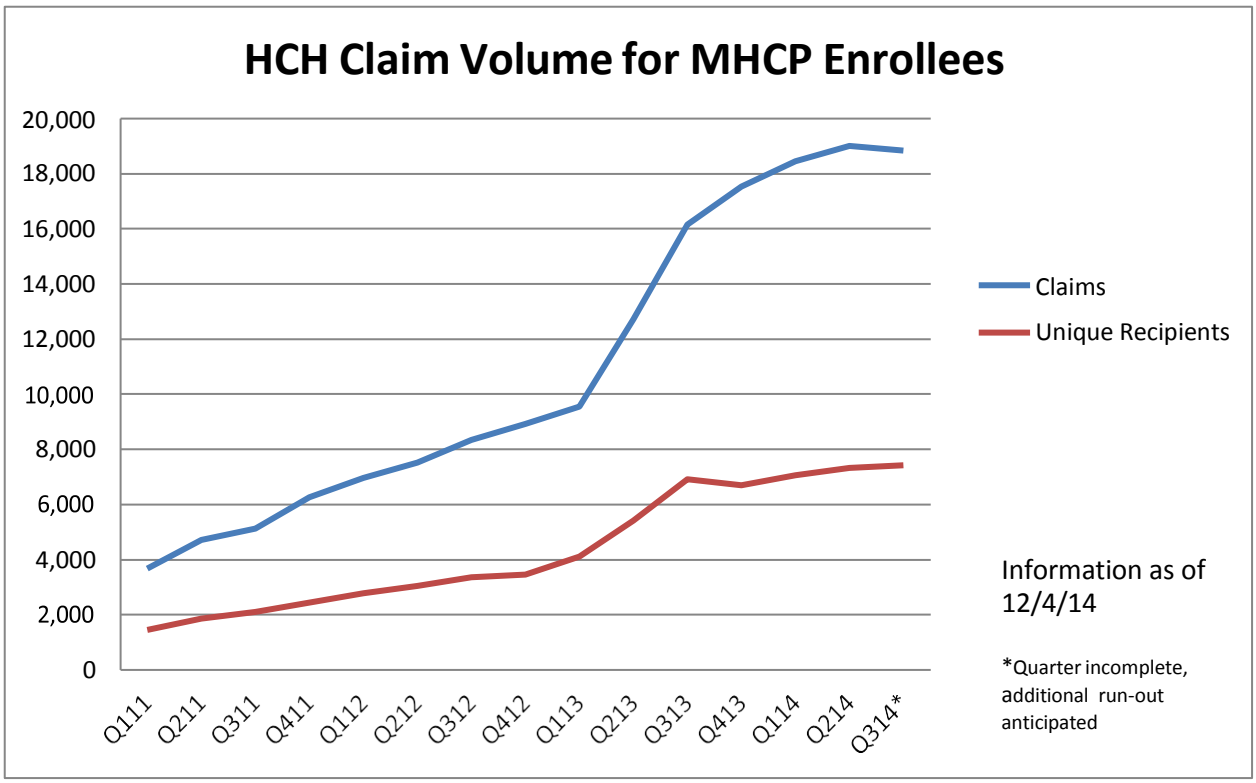
- 2015 University of Minnesota Evaluation Report
- Development of benchmarking methodology for recertification of medical groups with more than one clinic site.
- Care Coordination Measure Implementation Timeline

Financial Sustainability

The HCH payment methodology establishes a mechanism for certified providers to receive monthly per-person payments for care coordination activities which are tiered based on the complexity of the person's chronic health conditions. This methodology was developed as a multi-payer methodology for a HCHs patient population including both government and commercial payers. For Minnesota Health Care Programs (Medical Assistance and MinnesotaCare), the number of payments made to certified providers using Minnesota's HCH payment methodology continued to increase in 2014, a testament to the many clinics who have established processes to secure reimbursement for their care coordination activities. Nonetheless, after increasing in 2013, the proportion of clinics submitting claims for Minnesota Health Care Program enrollees flattened in 2014, and the overall volume of submitted claims remain lower than expected. There are many factors influencing the low submission rates (for both MHCP and other payers) including challenges with the administrative processes to tier, or submitting claims for non-face to face visits. Another key challenging is achieving continuity of payments across payers. Some health plans negotiate alternative payment arrangements with provider systems which are consistent with principles, though not the application, of the HCH payment methodology. The chart below does not reflect the volume in these alternative arrangements.

Payment Reform Building Block

When the HCH payment methodology was initially developed and predominately 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 toward value driven payment structures. Examples of these reforms include state and federal initiatives to establish Accountable Care Organizations, and Health Homes in Medicaid (section 2703 of the ACA). The transformational work done by Minnesota's Health Care Homes has positioned the state well for this important payment reform work. All current provider systems participating in Minnesota's Medicaid ACO, "Integrated Health Partnerships" (formerly Health Care Delivery System) demonstration project have HCH clinics among their participating provider locations. Many HCH clinics are also part of Minnesota Accountable Communities for Health State Innovation Model grant awards. These reform strategies recognize and prioritize the importance of primary care and patient-centered care, but also reflect new mechanisms such as shared savings payments to support and sustain provider's care coordination activities.



Financial Sustainability Next Steps

Minnesota's State Innovation Model grant provides a unique opportunity for the State to test current payment reform initiatives. This includes exploring options for modifying total cost of care payment models to capture a broader range of services and partners, as part of a statewide goal of promoting accountable care payment models. Feedback from stakeholders, including what is learned from the efforts of Accountable Communities for Health, will help inform evolvement of payment reforms to sufficiently support care for persons with chronic conditions. DHS and MDH will continue to engage and work with payers to align payment methodologies with the broader payment reform context in mind so as to give careful consideration to the impacts and interactions with other reform efforts. MDH and DHS will also continue to work with large employers, in partnership with the Minnesota Health Action Group, to better understand ways in which employers can use their benefit designs to support Health Care Homes and support their use.

CMS Advanced Primary Care Practice Demonstration

Minnesota was one of eight states selected by the CMS to participate in the Medicare Multi-payer Advanced Primary Care Practice (MAPCP) demonstration project. Over the past three years, MDH and DHS worked with CMS and their Medicare Part B contractor to implement payment to certified clinics. The demonstration project will end on December 31st, 2014. As of November, 2014, over $3 million in care coordination payments were made to Minnesota certified clinics for Medicare beneficiaries under the demonstration.

Starting January 1, 2015, practices may submit new Chronic Care Management (CCM) codes for beneficiaries covered under the traditional Medicare fee-for-service program.

Next Steps for Health Care Homes

Planning for the Future Implementation of Health Care Homes

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

Health Care Home Advisory Committee

During 2014 the legislature voted to establish a single Health Care Homes Advisory Committee to formally advise the commissioners of health and human services and guide the development of Health Care Homes in Minnesota in order to support the delivery of quality patient care, engage consumers and patients of primary care services, and meet the needs of communities. Recruitment of members began in December 2014. Meetings are expected to being in early 2015.

Consumer Engagement

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

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

Patient- and Family-Centered Care

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

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

Financial Sustainability

- Working to ensure successful use of the HCH payment tiering or claims process based on stakeholder input.
- Aligning payment methods across all payers, including self-insured employer purchasers.
- Collaborating with work under the SIM grant to explore options for modifying total cost of care payment models to capture a broader range of services and partners, as part of a statewide goal of promoting accountable care.

Certification

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

Performance Measurement and Evaluation

- Continuing collecting outcomes measures through the statewide quality reporting systems for use with recertification benchmarking and evaluation of HCH.
- Work with Performance Measurement Workgroup to develop and implement plans for data collection on care coordination measures
- Implementing Patient Experience survey tools for adult and pediatric patients that include questions that are specific to patient-centered medical homes.
- Collaborate with University of Minnesota on the legislatively required HCH evaluation report to be completed in 2015.

Learning Collaborative Plan

- Implementing a collaborative learning approach with the SIM grant to meet the needs of certified HCH, those working towards certification and other inter-professional providers.
- Continuing to evaluate the participant satisfaction with the learning collaborative and the amount of learning and plan for implementation with a variety of face to face and virtual learning methods.
- Provide HCH, ACH and SIM partners a variety of learning topics and modalities, exploring ways to provide flexible, meaningful ways to participate.

Linkages to Community Resources

- Continuing to implement practice facilitation resources (i.e., regional nurses, SIM grant practice facilitation) to assist clinics in developing enhanced partnerships with behavioral health, local public health and other community partners.
- Partnering with the SIM grant to implement Accountable Communities of Health (ACH) and encourage strong partnerships between HCHs and community resources.
- Focusing on reduction of health disparities through collaboration with communities and through the HCH evaluation.
- Recruiting and retaining community members as part of the HCH Advisory Committee.

Conclusion

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

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

Appendix A – Health Care Homes by County and Region

County	2010 Population	% of Population	Region	Total # of Clinics	# of Health Care Homes	% of Clinics Certified
Aitkin	16,202	0.3%	Northeast	2	0	0.0%
Anoka	330,844	6.2%	Metropolitan	20	18	90.0%
Becker	32,504	0.6%	Northwest	3	2	66.7%
Beltrami	44,442	0.8%	Northwest	3	2	66.7%
Benton	38,451	0.7%	Central	0	0	0.0%
Big Stone	5,269	0.1%	Southwest	3	0	0.0%
Blue Earth	64,013	1.2%	South Central	11	5	45.5%
Brown	25,893	0.5%	South Central	4	0	0.0%
Carlton	35,386	0.7%	Northeast	3	0	0.0%
Carver	91,042	1.7%	Metropolitan	15	5	33.3%
Cass	28,567	0.5%	Central	5	4	80.0%
Chippewa	12,441	0.2%	Southwest	3	0	0.0%
Chisago	53,887	1.0%	Central	5	5	100.0%
Clay	58,999	1.1%	West Central	6	4	66.7%
Clearwater	8,695	0.2%	Northwest	4	0	0.0%
Cook	5,176	0.1%	Northeast	1	1	100.0%
Cottonwood	11,687	0.2%	Southwest	6	4	66.7%
Crow Wing	62,500	1.2%	Central	10	5	50.0%
Dakota	398,552	7.5%	Metropolitan	36	21	58.3%
Dodge	20,087	0.4%	Southeast	1	1	100.0%
Douglas	36,009	0.7%	West Central	4	2	50.0%
Faribault	14,553	0.3%	South Central	3	1	33.3%
Fillmore	20,866	0.4%	Southeast	6	3	50.0%
Freeborn	31,255	0.6%	Southeast	2	1	50.0%
Goodhue	46,183	0.9%	Southeast	7	1	14.3%
Grant	6,018	0.1%	West Central	4	0	0.0%
Hennepin	1,152,425	21.7%	Metropolitan	142	94	66.2%
Houston	19,027	0.4%	Southeast	4	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	1	0	0.0%
Kandiyohi	42,239	0.8%	Southwest	4	2	50.0%
Kittson	4,552	0.1%	Northwest	2	0	0.0%
Koochiching	13,311	0.3%	Northeast	3	0	0.0%
Lac qui Parle	7,259	0.1%	Southwest	3	0	0.0%
Lake	10,866	0.2%	Northeast	2	0	0.0%
Lake of the Woods	4,045	0.1%	Northwest	1	0	0.0%
Le Sueur	27,703	0.5%	South Central	6	0	0.0%
Lincoln	5,896	0.1%	Southwest	4	0	0.0%

Lyon	25,857	0.5%	Southwest	5	5	100.0%
McLeod	36,651	0.7%	South Central	5	0	0.0%
Mahnomen	5,413	0.1%	Northwest	2	1	50.0%
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	5	2	40.0%
Mille Lacs	26,097	0.5%	Central	2	2	100.0%
Morrison	33,198	0.6%	Central	5	4	80.0%
Mower	39,163	0.7%	Southeast	5	1	20.0%
Murray	8,725	0.2%	Southwest	2	1	50.0%
Nicollet	32,727	0.6%	South Central	3	2	66.7%
Nobles	21,378	0.4%	Southwest	3	3	100.0%
Norman	6,852	0.1%	Northwest	3	0	0.0%
Olmsted	144,248	2.7%	Southeast	11	8	72.7%
Otter Tail	57,303	1.1%	West Central	7	3	42.9%
Pennington	13,930	0.3%	Northwest	1	1	100.0%
Pine	29,750	0.6%	Central	5	1	20.0%
Pipestone	9,596	0.2%	Southwest	3	0	0.0%
Polk	31,600	0.6%	Northwest	9	2	22.2%
Pope	10,995	0.2%	West Central	2	0	0.0%
Ramsey	508,640	9.6%	Metropolitan	67	42	62.7%
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	4	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	36	12	33.3%
Scott	129,928	2.4%	Metropolitan	11	7	63.6%
Sherburne	88,499	1.7%	Central	6	6	100.0%
Sibley	15,226	0.3%	South Central	5	0	0.0%
Stearns	150,642	2.8%	Central	24	14	58.3%
Steele	36,576	0.7%	Southeast	2	1	50.0%
Stevens	9,726	0.2%	West Central	2	1	50.0%
Swift	9,783	0.2%	Southwest	2	1	50.0%
Todd	24,895	0.5%	Central	6	4	66.7%
Traverse	3,558	0.1%	West Central	2	1	50.0%
Wabasha	21,676	0.4%	Southeast	5	0	0.0%
Wadena	13,843	0.3%	Central	2	0	0.0%
Waseca	19,136	0.4%	South Central	3	0	0.0%
Washington	238,136	4.5%	Metropolitan	19	14	73.7%
Watonwan	11,211	0.2%	South Central	2	0	0.0%
Wilkin	6,576	0.1%	West Central	0	0	0.0%
Winona	51,461	1.0%	Southeast	3	1	33.3%
Wright	124,700	2.4%	Central	10	8	80.0%
Yellow Medicine	10,438	0.2%	Southwest	4	2	50.0%

Health Care Homes by Region

Region	Clinics	Certified HCH	% Region's Clinics Certified
Metropolitan	310	201	65%
Northeast	55	14	25%
Northwest	37	8	22%
Central	82	54	66%
West Central	27	11	41%
South Central	53	10	19%
Southeast	52	19	37%
Southwest	55	23	42%
Total MN	671	340	51%

Appendix B

Health Care Homes - 2014