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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 2011

May 2012

Health Care Homes:
Annual Report on Implementation

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As requested by Minnesota Statute 3.197: This report cost approximately $2,000 to prepare, including staff time, printing and mailing expenses.

Upon request, this material will be made available in an alternative format such as large print, Braille or cassette tape. Printed on recycled paper.

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Executive Summary

Health care homes offer a significant redesign of health care in Minnesota. Also known nationally as "medical homes," health care homes focus on primary care and the development of strong partnerships between providers, patients and families to improve health – and, ultimately, contain or decrease health care costs.

Health care homes (HCHs) are an important component of the 2008 health reform law, a package of initiatives referred to as "Minnesota's Vision for a Better State of Health." This is a set of building blocks that move toward significant payment reforms and care redesign. Minnesota's Vision is driven by the Triple Aim, which focuses on simultaneously improving the health of the population, the patient experience of care and the affordability of health care by decreasing the per capita cost.

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

Activities and accomplishments

In 2011, the Minnesota Department of Health (MDH) and the Department of Human Services (DHS) have made significant progress toward the statewide transformation of primary care through health care homes.

2011 Highlights

- **As of December** 31, 2011, 22% of Minnesota clinics are certified as a HCH with 156 clinics certified. Approximately, **two million Minnesotans receive their health care in a certified HCH**
- Approximately 135,000 health program participants are enrolled in health care homes
- Continuation of collaborative learning/capacity building activities including 9 face-to-face half-day learning sessions, 14 webinars, 14 conference calls, quarterly meetings, and presentations at numerous statewide events
- Implementation and evaluation of the payment methodology
- Development of evaluation plans and addition of outcomes measures that reflect the holistic care of patients
- Development of a consumer communications plan about health care homes so that consumers gain a broad understanding of the health care home approach to care and become engaged in their health care
- Implementation of a Medicare demonstration project that complements and supports HCH activities through September 30, 2014

Certification of first health care homes

MDH has developed a patient and family focused process for certification with consumers on the certification teams and interviews of consumers/patients from the clinic. Through that process, MDH validates that clinics/clinicians meet the standards for certification. MDH certified the first set of health care homes in July 2010. As of December 2011, 156 health care homes have been certified. These include both urban and rural clinics that range from single-physician to large systems clinics and to Federally Qualified Health Care Centers, Safety Net Clinics and Rural Health Clinics and stretch across all regions of the state.

Enrollment of state health program participants in health care homes

Based on the proportion of clinics certified statewide, DHS estimates that roughly 135,000 Minnesota Health Care Program (MHCP) enrollees are being served by one of the state's 156 certified health care homes. This figure represents roughly 18 percent of total MHCP enrollees who use primary care. The number of MHCP enrollees served by a HCH will continue to increase over time in proportion to the number of certified clinics.

Continuation of capacity building/collaborative learning activities

MDH and DHS, in collaboration with a number of partners, have provided capacity-building opportunities for clinics and clinicians across the state. These activities included webinars, conference calls, regional workshops, financial support and the evolution of shared decision making concepts. MDH also realigned regionally based public health nursing staff to help build capacity for HCHs across the state. The Institute for Clinical Systems Improvement the HCH Learning Collaborative Vendor, implemented a regional HCH learning collaborative that was implemented in a phased approach.

Implementation of the payment methodology

Minnesota's HCH initiative includes a multi-payer payment methodology that reimburses certified practices for care coordination. DHS and MDH created an innovative payment methodology and tools that stratify reimbursement based on patient complexity. As required by law, the payment methodology was implemented on July 1, 2010. The payment methodology was evaluated in 2011 by a multi-stakeholder group and through a contract with the Institute for Clinical Systems Improvement, and MDH and DHS staff is currently evaluating options to improve the process for HCH reimbursement.

Development of evaluation plans and outcomes measures

The MDH-sponsored Performance Improvement Measurement Work Group (comprised of a number of community stakeholders including representatives from the provider community, health plans and government) has implemented a technical advisory group. The Commissioner of Health approved an expanded number of outcome measures for evaluation that focus on the areas of the IHI Triple Aim, including patient health, patient experience of care and cost-effectiveness for the total patient population.

Creation of tools to engage consumers

MDH engaged Tunheim Partners to lead a consumer engagement process to develop an overall consumer engagement communications plan. The consumer engagement plan includes messaging, tools and methods to communicate about the elements of health care homes to consumers statewide. The plan is expected to be implemented in 2012 / 2013.

Selection as Medicare demonstration project site

MDH and DHS jointly applied to the Centers for Medicare & Medicaid Services to be a demonstration site for the Multi-payer Advanced Primary Care Practice demonstration. Minnesota was selected as one of eight states to participate. This demonstration will add Medicare to Minnesota's existing multi-payer HCH initiative as a payer for certified HCHs. This is an additional incentive for providers to become certified and serve patients and families in Minnesota with the health care home model. The demonstration started October 1, 2011.

Challenges

Minnesota has made great strides toward the statewide transformation of primary care through health care homes. However, challenges remain as MDH and DHS continue the work to implement this initiative.

- **Implementation of payment methodology.** Despite the successful and timely launch of the HCH payment methodology, challenges remain to achieving the multi-payer "critical mass" necessary to support practice transformation. Developing the appropriate spectrum of payment models with new innovations such as "accountable care" models will be important so that primary care is enhanced, but there is not duplication of payment for coordination. State staff must continue to balance the need for flexibility that allows alternative payment models with the need for consistent implementation of the complexity-stratified care coordination payments described in statute.
- **Clinic transformation and readiness.** The transformation to a certified HCH requires whole-practice redesign in order to have a proactive, population-based approach to care. While many clinics and clinicians around the state are embracing these changes, the transformation takes time.

- **Focus on patient-centered care.** While many providers are moving toward this focus, care can still be in "silos" according to conditions, rather than focusing on a holistic, patient-centered approach that includes a whole-person orientation encompassing acute, chronic, preventive and end-of-life care.
- **Consumer engagement.** Patients who are engaged as active partners in their HCH are vital to achieving the IHI Triple Aim outcomes. Many patients move through the health care system as passive recipients of care, rather than as central members of the health care team.

Introduction

Health care homes offer a significant redesign of health care in Minnesota. Also known nationally as "medical homes," health care homes focus on primary care and the development of strong partnerships between providers, patients and families to improve health – and, ultimately, contain or decrease health care costs.

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

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

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

Minnesota's health care home initiative is a cornerstone of the state's 2008 health reform law, also called "Minnesota's Vision for a Better State of Health." This law includes components focused on:

- Population health,
- Market transparency and enhanced information, and
- Care redesign and payment reform.

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

HCHs both build on and benefit from other pieces of Minnesota's reform effort. For example, the focus on community linkages and preventive care allows HCHs to align with the Statewide Health Improvement Program (SHIP). SHIP, another important component of the 2008 health reform law, focuses on community-based approaches to reducing tobacco use and obesity in Minnesota, and thereby reducing the burden of chronic disease. By the same token, HCHs can benefit from the work of administrative simplification in Minnesota, where providers and payers are required to use the same standard electronic mechanisms for routine transactions, and from mandates that all prescriptions be electronically ordered by 2011 and all providers have interoperable electronic health records by 2015.

HCHs also align with the current momentum – among state government programs, community projects and national initiatives – to move toward a greater focus on patient- and family-centered care and shared decision making, to improve consumer engagement in health care and overall health outcomes.

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 commissioners on the implementation and administration of the health care home model, especially for state health care program enrollees in the fee-for-service, managed care and county-based purchasing sectors.

Program Development Updates

Certification

Becoming certified as a health care home is voluntary for providers. The standards for certification, developed through an extensive stakeholder process and incorporated in the health care homes rule, revolve around five main categories:

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

The standards for certification as a health care home have been created to allow flexibility among providers and give them an opportunity to achieve needed outcomes without being overly proscriptive. The goal in developing the standards was to enhance primary care without burdening providers with daunting expectations. For information on the development of certification standards and the certification process, please see the December 2009 health care homes legislative report athttp://www.health.state.mn.us/healthreform/homes/HCHLegReport.pdf.

In addition to developing the standards for certification, MDH has also created a patient and family centered process to certify providers as health care homes. This process includes a letter of intent, an application, an assessment and a site visit. It is worth noting, that MDH has taken extra steps to maintain a focus on the consumer throughout the certification process. MDH developed an innovative approach to site visits. Consumer representatives are included on the site visit teams and are also interviewed as part of the site visit evaluations. All recommendations for certification are reviewed by the HCH Community Certification Committee comprised of primary care physicians, nurse practitioner, consumer, payer, quality improvement organization and local public health representatives. The committee makes the final recommendation for certification to the Commissioner of Health.

As of December 31, 2011, 22% of Minnesota clinics are certified as a HCH with 156 clinics certified. Approximately **two million Minnesotans receive their health care in a certified HCH.**

Clinics are certified throughout the year. The goal was to certify 175 clinics by the end of the calendar year. Below is a quarterly view of how clinics are certified. In quarters one and two a number of larger systems certified their clinics at the systems level. The state shutdown had significant impact on the certification and recertification processes in third quarter of 2011 and in fourth quarter a number of smaller and independent clinics were certified as individuals or clinics, rather than by system. The ongoing goal is to certify on average 25 clinics per quarter. In 2011, on average 26 clinics were certified per quarter. MDH will continue with the goal of certifying 25 clinics per quarter in 2012. An application process including an assessment and site visit is not required for previously certified clinics that are adding HCH's and clinics. This is a process that has been implemented to ensure consistency and rigor, and also reduces administrative burden for clinics.

Quarterly Report of Certified Health Care Homes

MN Certified HCH Clinics	3Q2010	4Q2010	1Q2011	2Q2011	3Q2011	4Q2011
As of last quarter	0	12	47	90	133	143
Added this quarter	12	35	43	43	10	13
Total Certified Clinics	**12**	**47**	**90**	**133**	**143**	**156**

Certified clinics are currently located through-out the State in the following regions.

Metro	NE	NW	CE	CW	SE	SW
45%	9%	5%	14%	5%	12%	10%

Appendix A: **Health Care Home County / Clinic Report**

Reported Certified Clinic Types (some clinics report being more than one type)

Academic Practice	Community Health Center	Federally Qualified Health Center	Hospital -based clinics	Independent Medical Group	Medical Group Component of Integrated Delivery System	Rural Health Center	Critical Access Hospital
15%	5%	2%	15%	17%	46%	12%	2%

The status of the application process for clinics currently is:

- Clinics apply by application groups, as individual clinicians (31%), by clinic (60%) (where every clinician is certified) or by practice system (5%) where every clinician in every clinic is certified in the practice.
- 100% of certified clinics have applied to become recertified.
- At the end of 2011 there are 27 application groups pursuing HCH certification. This is approximately 150 clinics participating at some point in the certification process

The demographic makeup of certified clinics includes:

- 24% of patients are less than 18 years old, 60% are 18-64 years old and 16% are 65 years and older.
- The average percentage of English-speaking patients is 83% and Non-English speaking patients is 16%.
- 100% of certified clinics collect race, ethnicity and language information; however at present 92% of clinics report language information and 69% of clinics can report race or ethnicity information from their Electronic Medical Record (EMRs).
- 99% of certified clinics had an EMR at certification. The remaining one clinic has elements of an EMR and is working to implement the EMR.

There are currently 1,672 certified clinicians. Certified clinicians by practice type are listed in the chart below. Transformation to certified health care homes has been achieved in a number of specialty types including geriatricians, women's health and HIV specialists.

Percentages of practice types for primary care providers

Family Physicians	Internal Medicine Physicians	Pediatricians	Nurse Practitioners & Certified Nurse Midwives	Physician Assistants
45%	20%	16%	11%	8%

Consumers and payers can find lists of certified HCHs on the MDH health reform website at http://www.health.state.mn.us/healthreform/homes/certifiedhchs/index.html.

Recertification

Most clinics are on course for health care home recertification. Where clinics experienced hardships that delayed their implementation of the second set of standards, those clinics submitted a request for a hardship variance. Variances extended recertification dates depending on the clinic's needs. Variances were approved for things such as implementation of a new electronic health record, other regulatory or accreditation visits such as Joint Commission, and extensive changes in staffing in the clinic. All clinics that were due for recertification have applied for recertification and continue to maintain their certification. The recertification process is streamlined and includes a team meeting with the clinic's health care home team. No site visits were conducted in the recertification process.

2012 HCH Legislation Burden Wavier

The 2011 Legislative Special Session - HHS Bill Article 6, Sec. 54, Subdivision. 4 Alternative models and waivers of requirements - was implemented.

"The Commissioner of Health shall waive health care home certification requirements if an applicant demonstrates that compliance with a certification requirement will create a major financial hardship or is not feasible, and the applicant establishes an alternative way to accomplish the objectives of the certification requirements".

There is also language in Health Care Home rule 4764.0050 Variance Chapter, subpart B. If the commissioner finds that failure to grant the variance would result in hardship or injustice to the applicant, the variance would be consistent with the public interest, and the variance would not prejudice the substantial legal or economic rights of any person or entity, the commissioner may grant a variance.

Administrative procedures are in place for variances. Potential applicants can submit a request for a variance for a certification requirement at any time before or during the certification process. To date a number of variances have been submitted by certification applicants. But no clinic has applied for a variance using the rationale that achieving certification would be too much of a financial hardship.

Current state health care program enrollees

The Department of Human Services estimates that roughly 135,000 Minnesota Health Care Program (MHCP) enrollees are currently being served by a health care home. This figure represents 18 percent of total MHCP enrollees who use primary care. The number of MHCP enrollees served by a HCH will increase over time in proportion to the number of certified clinics.

Learning collaborative/capacity building activities

The continued goal of the statewide HCH learning collaborative is to develop and implement a statewide HCH learning collaborative that builds the capacity of primary care providers to meet the standards, criteria and expected outcomes of HCH certification and to provide an opportunity for health care homes and state agencies to exchange information related to quality improvement and best practices.

Statewide HCH learning collaborative

Although the state has been providing collaborative learning opportunities for clinics as they have been preparing for health care homes, one of the requirements of certification is that HCHs participate in a statewide learning collaborative that MDH implemented in 2011. The learning collaborative project included:

- **HCHs learning collaborative leadership committee.** This committee provided oversight for the project, established criteria required for certified clinics/clinicians to participate in the collaborative and reviewed the overall comprehensive evaluation plan. The committee included members from the public and private sectors, such as representatives from state health and medical professional organizations, clinics, consumer groups, local public health and MDH. Also included were education specialists and other knowledgeable individuals with experience in quality improvement learning collaboratives, medical home/HCH models, and patient- and family-centered care delivery and payment systems.

- **HCHs learning collaborative curriculum.** A curriculum appropriate for both pediatric and adult medicine was developed using best practices of existing national and state medical home curricula for providers, clinics, care coordinators, clinical administrative leaders, patient partners and families and community resources including public health.

- **The learning collaborative in 2011 was implemented in three phases.**
    - **Phase I - Preparation (pre-certification).** Voluntary for groups that have submitted a letter of intent to become certified as a HCH or are considering certification.
    - **Phase II - Certification and implementation.** Required for all HCH certified clinics/clinicians.
    - **Phase III - Ongoing improvement and maintenance.** Required for all health home certified clinics/clinicians after they complete Phase II.

The overall contract requirements for the HCH learning collaborative was to implement the following design elements:

- Regional approach for participants to limit travel and for participants to address issues that are regionally based,
- Implementation of a curriculum to support clinics to become recertified,
- An increased patient and family centered approach with patient partners as team members,
- A phased approach to allow new certified health care homes to enter the learning collaborative as they become certified, and
- Implementation of face to face and virtual learning methods to improve efficiencies for HCH's.

An evaluation of the learning collaborative was conducted throughout the year. Results and feedback from the first three phased groups indicated the following:

- Regional approach while convenient for some may not be the best shared learning approach,
- Engagement in a virtual learning can be difficult to commit to due lack of participation during the clinic teams busy day and impossible for patient participation,
- The regional approach was not as cost effective as there was small numbers, often one team representing an organization with an average of 25 people / session,
- Clinics desired a number of learning topics and approaches to learning, thus there was not learning curriculum to meet everyone's needs,
- Face to face sharing and learning was highly valued,
- Phase I participants had a high degree of value in phase one, and
- Phase II phase II participants were satisfied with the quality of the sessions, objectives were met and speakers were knowledgeable, although there were mixed feedback on whether the learning collaborative structure supported recertification needs for all participants.

As a result of the feedback from participants final virtual phase III was eliminated and an all-day learning collaborative event is scheduled for early 2012. Ongoing revisions to the learning collaborative format with a feedback loop and continued community leadership are planned for 2012.

Regionally based health care home consultant nurses

MDH aligned the work of the Minnesota Children and Youth with Special Health Needs program with the HealthCare Home initiative in November of 2010, in order to better utilize existing resources as HCHs expand across the state. The program's five district nurses were reassigned to the Health Care Home section to provide needed regional expertise and support in expanding health care homes throughout the state. This move aligns with their historical focus on building more effective health systems that can better serve children with special health needs and their families. The move also leveraged existing federal resources to help scale up health care homes across the state. The Health Care Health Regional Nurse Consultants provide technical support and project management consulting, educate clinics on whole-practice redesign, and facilitate and expand relationships in the community with groups such as local public health, social services, mental health and others.

The nurse consultants were active in their first year supporting capacity building in clinics. They worked with 87 clinics or clinics systems across the state of which 20% became certified Health Care Homes and another 16% are in process of becoming certified. The nurse consultants focus their capacity building efforts by providing the above mentioned support to small and medium sized rural and urban community and independent clinics. They have also worked with larger primary care systems that increasingly dominate greater MN health care delivery. They have hosted forums for education and discussion of Health Care Home standards and work with clinics that are recipients of the Health Care Home safety net grant and community care team grants (see below). The nurse consultants find that many clinics in greater MN are slower to adopt Health Care Home certification as they seek to implement electronic medical records or lack project assistance to develop new care models. Their outreach and support will continue in 2012.

The nurse consultants' community outreach activities included educating community partners about health care homes, quality improvement initiatives and patient and family centered care models to Local Public Health Directors, Regional School Health Coordinators, SHIP community leaders, MCH Coordinators, Schools of Nursing, Area Health Education Centers, the MN Rural Health Association, Child and Teen Checkup Coordinators, and Parish RNs throughout the state. They continued their participation in activities with community partners focused on children with special health needs in an effort to continue our goals in fostering growth of HCH for these children. That work included participation in the Interagency Early Childhood Intervention Committee (IEIC) regional transition planning, Assuring Better Child Health and Development ADCD III grant, Great Start, children's mental health initiatives as well the transition of the Maze training program. The nurse consultants also participated in outreach activities at a number of conference including the Rural Health Conference and conferences sponsored by primary care association provider groups.

Safety Net Primary Care Transformation:

Spring of 2011 The Minnesota Department of Health (MDH) requested proposals for the purpose of providing expert support and technical assistance to Safety Net Providers (Federally Qualified Health Centers (FQHCs), community clinics, rural health clinics) to facilitate their becoming certified Health Care Homes (HCHs). These clinics serve the patients that are most vulnerable to poor health outcomes and increased costs. It is the goal of this activity to provide expert facilitation for Safety Net Providers (FQHCs, community clinics, rural health clinics) to help them transform their practice to meet HCH standards and become certified health care homes and move towards meeting the triple aim of health care reform: improved patient experience, enhanced health status, and reduced costs.

The contract was awarded to Halleland Habicht Consulting LLC. The goal of the recruitment process was to select 3-5 safety net clinics to participate in the process. In an attempt to recruit a diverse group of clinics, a letter of invitation was sent to the safety net community through the following groups:

- Minnesota Association of Community Health Centers,
- Minnesota Association of Community Mental Health Centers,
- Safety Net Coalition,
- St. Mary's Duluth Clinic,
- Minnesota Rural Health Association,
- Minnesota Association of County Health Plans, and
- Neighborhood Health Network

In the invitation responders were asked to complete the following tools to identify their readiness for transformation:

- QUALIS Patient-Centered Medical Home Assessment (PCMH-A) to determine their level of maturity in the health care home development
- A Leadership Readiness Assessment to determine the level of commitment by leadership to this project

Four safety net clinics applied and were selected. During the grant clinics have received intensive project support including a gap analysis and assistance with implementation of their HCH team. Those clinics were all somewhere in the middle of the certification process. Once HCH teams were formed and the gap analysis was completed the next step was to lay out a work plan to support the clinics transformation. The consultant participates in team meetings, provides tools for process improvements, information and resources to the HCH team and support for quality improvement activities.

The HCH transformation process requires culture change for most providers and staff members. Bringing patients and family partners onto HCH quality teams was one of the challenges. One of the key learning's for clinic team members was about how the HCH standards and criteria and care coordination fits into day-to day activities. This was confusing at first thus initially there was a tendency to design two different workflow processes. Once teams understood that the HCH standards and criteria and workflows are population based and coordination of care is foundational to all the work of the clinic, it became much easier to implement new workflows to prevent gaps in care, identify patients that would benefit from broader care coordination and do care planning. All clinics are making substantial progress in their transformation and three of the four clinic participants have submitted a letter of intent for certification and the fourth plans to be the end of the fiscal year. An evaluation of transformation process will be completed at the end of the grant.

Health care home is well suited to address health care disparities. A requirement of the health care home is the collection of race, ethnicity and language data and using that data in care delivery activities. Health care homes also require patients and families to participate in the clinic's quality or advisory committee. Participants must be representative of the clinics demographics and must participate in a meaningful manner.

In 2011 the health care home team and Directors of the DHS Office for Equity and Agency Development and MDH Director, Office of Minority & Multicultural Health participated in a learning community conducted by NASHP (National Association of State Health Policy). One of the goals for the work is to provide a community workshop. That workshop will be held in February of 2012 and training will be delivered in partnership to health plans, health care home staff, certified HCH teams and others. A variety of methods will be used including experiential work from care coordinators working on clinic HCH teams and professionals who conducted learning collaboratives that focused on race, language and ethnicity.

Implementation of payment methodology

Minnesota's HCH initiative includes a multi-payer payment methodology that reimburses certified practices for care coordination. The law requires that, beginning July 1, 2010, certified HCHs be reimbursed for all eligible MHCP enrollees, and also requires that all private health plan companies reimburse HCHs "in a manner that is consistent with" the public programs for all state-regulated insurance products. DHS and MDH met this deadline, with payments beginning in July 2010.

The methodology is unique because it stratifies payment based on patient complexity and includes "supplemental" psychosocial complexity factors that extend beyond medical conditions. The rate structure places a value on the expected amount of time and work required to coordinate care for patients in each complexity tier. The methodology was designed with extensive stakeholder input and represents a statewide administrative standard for HCH reimbursement.

A central feature of the payment methodology is a system of patient complexity tiers. Stakeholders created five tiers of patient complexity that represent the amount of time and effort required to coordinate care in the primary care setting. HCHs place all participants in a complexity tier using a common clinic-based screening process that draws on all patient information in the provider records. The tiers are based on the count of provider-identified condition groups (such as "cardiovascular" and "endocrine") that are considered "major" by virtue of being chronic, severe and requiring a care team for optimal management.

In collaboration with the University of Minnesota, DHS developed a Medicaid fee-for-service rate methodology that reimburses certified practices for all patients in Tiers 1-4 (all patients with one or more major chronic condition) at per member per month (PMPM) rates ranging from $10.14 to $60.81. Rates increase by 15 percent if the patient (or caregiver of a dependent patient) has a "supplemental" complexity factor: either a non-English primary language or a severe and persistent mental illness diagnosis (rates increase by 30 percent if both factors apply). This rate structure was approved by CMS as a state plan service for Minnesota Medicaid.

Patient Complexity Tier	PMPM Rate
0 (No Major Chronic Conditions)	N/A
1 (1 – 3 Major Condition Groups)	$10.14
2 (4 – 6 Major Condition Groups)	$20.27
3 (7 – 9 Major Condition Groups)	$40.54
4 (10 or More Major Condition Groups)	$60.81

Although the HCH model will benefit the entire patient panel, the rate structure initially focuses higher payment on more complex participants that Minnesota stakeholders believe are most likely to produce a short-term return on investment.

Stakeholders continue to evaluate this first iteration of the payment methodology and identify opportunities for improvement. A steering committee of nominated representatives from health care and consumer organizations provides oversight, and separate work groups have actively assessed the complexity tier structure, payment processes, and consumer payment issues. As a result of this stakeholder input, DHS and MDH are implementing practical changes in 2012 aimed at simplifying the billing process and increasing provider participation in the payment methodology.

Evaluation

Robust evaluation and outcomes measurement is a critical part of the HCH initiative. As part of the 2008 statutory requirements, Minnesota will be evaluating and monitoring the impact of the HCH initiative for all populations, including Medicare beneficiaries. Statutory language requires that HCHs meet specific outcomes measures for the purposes of annual recertification. The language states that "for continued certification under this section, HCHs must meet process, outcome and quality standards as developed and specified by the commissioners. The

commissioners shall collect data from HCHs necessary for monitoring compliance with certification standards and for evaluating the impact of HCHs on health care quality, cost and outcomes."

Statutory language goes on to direct the commissioners to provide to the Legislature comprehensive evaluations of the HCH model three and five years after implementation.

The legislative report must include:

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

Outcome measure collection will be phased in over the next few years, with legislative reports evaluating the statewide program's effectiveness due three and five years after the initial certification of health care homes. In first quarter 2012 a Request for Information (RFI) with a stakeholder participant process will be held to seek input from researchers and evaluators of care delivery redesign throughout the State. A RFP process will be conducted to hire an independent evaluator by the end of the upcoming fiscal year 2012. A comprehensive evaluation of the State's Health Care Home implementation is also planned by the independent contractors from the Medicare demonstration.

Performance Measurement

Robust quality measurement is a cornerstone of the health care homes initiative, to improve population health, patient experience and affordability. Over the past year, the MDH-sponsored Health Care Homes Performance Measurement Advisory Work Group (comprised of a number of community stakeholders including representatives from the provider community, health plans and government) has been developing recommendations for measurement for this evaluation and for recertification of health care homes. The purpose of this work group (and its technical committee counterpart) is to recommend outcomes for measuring HCH improvement in the areas of patient health, patient experience and cost-effectiveness for the total patient population. Whenever possible, HCH evaluation will also coordinate with other health reform measurement efforts for alignment of quality reporting. This work group closely monitors the measurement and evaluation of HCHs. The group will continue to meet to follow the progress from implementation to evaluation for both recertification and outcomes measurement.

In 2011, the Health Care Homes Performance Measurement Advisory Work Group, has been meeting to make recommendations about the measurement strategy for recertification of health care homes. The goal for HCH recertification is to over time move from process verification to recertification based on outcome benchmarks. In order to establish benchmarks that reflect the work of the clinic systems redesign and the holistic care of patients additional measures are recommended that cross the continuum of care delivery and clinic systems. This should result in an accurate fair picture of the progress the certified health care home has made.

Per the Minnesota State Health Care Home Rule, 4764.0030, Certification and Recertification Procedures Subpart 6, Benchmarks, the commissioner must announce benchmarks for patient health, patient experience, and cost-effectiveness. The data submitted will be used for benchmarking for recertification and overall evaluation of the health care homes initiative.

Clinical measures are aligned with the direct data submission requirements for the Statewide Quality and Reporting Measurement Rule. A newly aligned process for submitting both health care home data and the statewide quality and reporting measurement rule data was implemented in 2011 and results in clinics submitting data to Minnesota Community Measurement (MNCM), the vendor for both data collection activities, one time. This reduced administrative burden for clinics and was well received.

The newly approved measures approved in 2012.

Patient Health

- Optimal Diabetes Care
- Depression Remission at 6 months
- Colorectal Cancer Screening

Cost: 30-day, All Cause Hospital Readmission
Initially claims data will be provided by Medicaid and Medicare. This measure will be specific to the ambulatory clinic. The 30-day all cause hospital readmission measure will be aligned with CMS national standards and where appropriate from the work of the Reducing Avoidable Readmissions Effectively (RARE) collaborative.

In 2010, the following measures were approved and data submission will continue for these health measures in 2012.

- Optimal Vascular Care
- Optimal Asthma Care

Patient Experience
In 2010 a test of equivalency for patient experience tools was approved by the Commissioner of Health. The equivalency test is being conducted in spring of 2012 using the CG-CAHPS visits survey (required by the Statewide Quality and Reporting Measurement System fall of 2012) and a modified version of the new CG CAHPS Patient Centered Medical Home (PCMH) survey. If equivalency is found, a recommendation will be made to the Statewide Quality and Reporting System at the annual rule review to modify the quality rule for certified clinics to use the CG CAHPS PCMH survey. Pediatric clinics are excluded from the use of the CG CAHPS tool in the statewide quality rule requirement, however are required to submit patient experience data for health care homes recertification in the HCH rule. A workgroup process will be implemented in 2012 to develop the data submission process for the PCMH CAHPS Child Version.

In addition, through its collaboration with MNCM, the well-established statewide performance measurement and public reporting entity sponsored by Minnesota's non-profit health plans, in 2011 other measurement work was also recommended and approved that includes to further evaluate care coordination the foundation to health care homes, an implementation of a care coordination measure was recommended. A measure development workgroup is currently established by MNCM to evaluate and develop a data collection process for a care coordination measure. Careful attention is being paid to work that is being done nationally on care coordination as this work progresses.

Measures Under Consideration
The Health Care Homes Performance Measurement Advisory Work Group and technical groups that support this work will continue in 2012 to address other measurement needs to provide for a fair and systems based approach to outcomes measurement for HCH recertification. Some of the measures that are being considered are:

- Depression 6-month follow-up already calculated from the depression remission measure.
- Pediatric preventive care (currently in development by a workgroup at MNCM)
- Prevention measures currently considered through the MDH Community Transformation Grant focusing on obesity and tobacco screening

- Coordination with DHS in the development of a measure for the frail elderly, a welcomed measure by some of our HCH's that focus on the care of the frail elderly.
- Functional status measure, integrated in the patient experience tools.

Beginning in 2012 those clinics first certified in 2010 will be recertified through benchmarking against their outcomes performance measures for the triple aim where data is available. Considerable work has been done to align benchmarking performance indicators with the statewide quality incentive system.

DHS will be evaluating the effectiveness of the HCH initiative through claims analysis and is leading a cross-payer work group that will encourage an aligned evaluation initiative outside of Medicaid. Data will be used both to feed actionable information back to HCH practices and to evaluate the overall HCH initiative on cost and quality dimensions.

Additional evaluation efforts

MDH and DHS have also established a partnership research study with investigators at the HealthPartners Research Foundation and MNCM funded by a $600,000 grant from the Agency for Healthcare Research and Quality to study the transformation of primary care clinics certified as HCHs. As part of this study, additional data will be collected from HCHs to establish comparison groups that are more and less effective in implementing systematic care coordination and improving quality performance. The study will then collect information on the organizational factors that distinguish these groups and the process used to achieve higher levels of performance. Finally, the study will compare these groups in terms of operating costs and total cost of care. These data, measured and analyzed in a scientifically sound way, will be available to MDH and DHS on an aggregate basis to add understanding of the process and outcomes of HCH transformation.

This AHRQ-funded evaluation will address the following questions:

1. Do clinics certified as HCHs have better quality, patient experience and costs than clinics not so certified?
2. Do clinics certified as HCHs demonstrate improvement over time in their measures of quality, patient experience and costs?
3. What organizational factors and change processes distinguish HCHs that achieve the highest levels of performance from those that do not?

Consumer awareness and engagement

In a HCH, patients and families are part of the care team and actively partner with their providers in making health care decisions. As HCHs become more prevalent in Minnesota, it is important that consumers/patients gain a broader understanding of this approach to care.

Consumers have already become involved in the HCH initiative in various ways. The Consumer/Family Council, made up of patients and family members, advises the state on HCH implementation and provides patient representation for broader work groups. Consumers have also served as site visit evaluators or on the quality improvement teams in certified HCHs.

MDH is working to expand consumer understanding and engagement in a number of ways:

- **Consumer-oriented brochure.** In conjunction with its partners, MDH has developed a brochure about HCHs that clinics can use with their patients. The brochure, to be used by clinics that are either certified HCHs or in the process of certification, is a mechanism for providers to begin initial conversations with patients about HCHs.
- **Consumer and provider surveys.** To better understand current levels of awareness among consumers and providers – and to glean themes that are important and resonate with these audiences – MDH is in the process of surveying a broad array of Minnesota consumers and providers about HCHs.
- **Consumer messaging and communications.** Based on survey results, MDH and its partners developed targeted messages about HCHs for consumers, as well as an overall communications plan to raise public

awareness about HCHs. This plan will highlight strategies, tactics and tools to best communicate with consumers. This communication plan will be rolled out in 2012.

- **Certification seal for certified HCHs.** In order to make it clear to consumers which clinics are certified as HCHs, MDH and its partners are developing a seal that certified HCHs can display.

CMS Advanced Primary Care Practice Demonstration

Minnesota is one of eight states selected by the Centers for Medicare and Medicaid Services (CMS) to participate in the Medicare Multi-payer Advanced Primary Care Practice (MAPCP) demonstration project. This demonstration added fee-for-service Medicare to Minnesota's existing multi-payer HCH initiative as a payer for certified HCHs.

The demonstration project is expected to last for three years. During this period, the state anticipates that more than 225,000 Medicare beneficiaries will be served by a certified HCH. This demonstration is particularly important to clinics and clinicians in rural Minnesota with large proportions of Medicare patients; it is a significant incentive for these providers to work toward becoming certified as a HCH.

CMS began paying MAPCP claims to health care homes in October, 2011. MDH and DHS continue to work with CMS and their Medicare Part B contractor (WPS) to monitor payment and provide technical support to practices on billing issues. A steering committee composed of a wide variety of stakeholders continues to meet quarterly to guide Minnesota's MAPCP efforts, and a Community Resources work group also meets regularly to foster linkages between health care homes and community services provided to Medicare beneficiaries.

The Minnesota team participates in regular planning conversations with CMS' evaluation contractors (The Urban Institute, The National Academy for State Health Policy [NASHP], and Research Triangle Institute [RTI]) to plan evaluation and provider data feedback efforts.

A Minnesota MAPCP Advisory Steering Committee was created to guide the implementation of the Medicare demonstration. Membership includes representation from key stakeholder groups including consumer members, certified health care homes, payers, providers, clinics, nursing homes / long term care, geriatricians, community resource professionals, quality and professional organizations

In the State's application to participate in the demonstration stakeholders identified that linkages to community resources and preventive services for Medicare recipients was a key challenge. The MAPCP Advisory Steering Committee has directed a MAPCP Resources Committee to meet to address key linkages to community. The MAPCP Resources Workgroup will introduce guidelines and strategies to the medical community that cares for seniors. Many of the elements crucial to managing comprehensive care for seniors have historically not been part of primary care providers' work, communication or records.

Focus areas include:

- Train HCH care teams via the HCH learning collaboratives regarding the use of screening resources such as Minnesota Board on Aging's Rapid Screen, medical care utilization risk assessments, and others to be determined.
- Develop role definitions for how and when community connections to support beneficiaries are clinically valuable or support higher quality of life and should occur.
- Identify primary care's role in transitions to and from the hospital to all settings with special focus on transitions in to sub-acute and long-term care facilities.
- Develop a longer-term view of the care plan, beginning with links for all beneficiaries to evidence-based wellness, health promotion activities in the community.

Challenges and Next Steps

In the past year, much progress has been made in implementing HCHs in Minnesota. Important challenges to consider as we move forward include:

Implementation of payment methodology

Despite the successful and timely launch of the HCH payment methodology, challenges remain to achieving the multi-payer "critical mass" necessary to support practice transformation. It is not clear precisely how private health plans are implementing the required HCH payments outside of MHCP. A variety of incentive and risk-based contracts are in place that may or may not include explicit payments to support care coordination. It is crucial that, absent mutually agreeable "alternative payment arrangements," health plans make the care coordination payments to certified HCHs required by law. In addition, developing the appropriate spectrum of payment models with new innovations such as "accountable care" models will also be important so that primary care is enhanced, but there is not duplication of payment for care coordination.

Overall, participation in the per-person monthly billing for care coordination has been lower than expected. It will be important going forward to ensure administrative simplicity so that all certified health care homes that wish to be reimbursed by the default standard payment methodology are able to do so in a cost-effective manner.

Next steps: The state is working to engage self-insured employer groups in the HCH initiative going forward. Although federally regulated groups are not required to participate by law, there is significant interest in voluntary participation. MDH and DHS will be working collaboratively with these purchaser groups to further expand the scope of participation in the initiative and make advanced primary care available to even more Minnesotans. These efforts can build on the current participation of the State Employee Group Insurance Program, for example.

Linkages to community resources

A HCH serves as the central point for coordinating care around the patient's needs and preferences. It also coordinates care between all of the various health care team members. This coordination should include the patient, family members, other caregivers, specialists, other health care services (public and private) and nonclinical services as needed and desired by the patient. HCH team implemented an RFP to test implementation of integrated community networks through community care teams. Three grantees were selected one urban, one suburban and one rural clinic and community team. Teams have identified a number of successful initiatives as well as challenges in creating needed connections between HCHs and community resources and preventive services. While this continues to be a challenge grantees are making significant progress and will be developing a sustainability plan as the outcome to the grant.

Next steps: MDH is working to align its current resources (i.e., regional nurse consultants) to assist clinics to develop enhanced partnerships with local public health and with other community partners. The HCH team is testing new models through the community care team grant and evaluating options for primary care and mental health integration through the implementation of Federal ACA Legislation 2703 Health Homes. A number of other initiatives to implement integrated health and community teams are being considered.

Clinic transformation and readiness

Transformation of primary care practices to meet HCH certification standards is more than a series of individual changes or adherence to clinical guidelines. It requires changes in infrastructure, culture and physician-patient relationships. Implementation costs can also be a challenge. This transformation to a certified HCH requires whole-practice redesign in order to have a proactive, population-based approach to care. While many clinics and clinicians around the state are embracing these changes, the transformation takes time.

Next steps: Building on the collaborative learning experience from the last few years, the expansion of knowledge transfer with the statewide learning collaborative in 2012 will provide important opportunities for

clinics and clinicians to share best practices and continue the transformation process. In 2012 the State will include structured, time phased learning communities based on a specific identified topic as an additional learning opportunity for clinics seeking certification and certified HCH's.

Focus on patient-centered care

One critical tenet of HCHs is a focus on patient- and family-centered care. While many providers are moving in this direction, care can still be in "silos" according to conditions, rather than focusing on a holistic, patient-centered approach that includes a whole-person orientation encompassing acute, chronic, preventive and end-of-life care.

Next steps: MDH is working to facilitate the alignment of population health management into the current disease management framework through the learning collaborative activities and networking with groups such as the Minnesota Shared Decision Making Collaborative. Our HCH regional consultants with their strong public health backgrounds are also well-positioned to educate clinics on population health in their ongoing outreach activities as certified clinics evolve and transform.

Consumer engagement

Patients who are engaged as active partners in their HCH are vital to achieving the Triple Aim outcomes. The HCH certification standards support consumer engagement by encouraging clinics to have patients as members of their HCH quality improvement team; mandating the use of care plans; and utilizing a patient experience survey for measurement. 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.

Next steps: MDH and DHS are working to develop partners and seek funding sources to implement the HCH communication plans through a variety of communications strategies.

Plans for 2012

- Focus capacity building for small and medium-sized clinics in both urban and rural settings.
- Continue recertification and implement the annual recertification process with outcomes benchmarks.
- Continue collecting outcomes measures through the statewide quality reporting system for use with recertification and evaluation; explore how to use provider peer grouping as outcome measures.
- Look for opportunities to align and build shared accountability in the community for the outcome measures being developed for health care homes.
- Implement a strategy to facilitate focused communication with community members such as home health, local public health, social services, mental health, physician specialists, pharmacy and others to build stronger community connections to support implementation of certified health care homes.
- Begin conducting the first evaluation report for the Legislature on the implementation of health care homes due three and five years from implementation, which formally began in July 2010. Provide annual reports to the Legislature on program progress.
- Implement consumer messaging plan.
- Launch the next phase of the statewide learning collaborative with a focus on establishing opportunities for clinics, clinicians, the state and others to share information in face-to-face and through structured learning communities.
- Implement the MAPCP demonstration project and participate with CMS in evaluation activities.
- Implement revisions to the current payment methodology and continue to explore flexible options for Health Care Home payments.
- Implement work of the Purchasers Payment Steering Committee contracted by MDH through the BHCAG with private payers to increase critical mass.
- Collaborate with other community stakeholders on exploration of the spectrum of accountability for redesign of care and redesign of payment models that will be needed for the continued transformation of care.

- Develop ACO models built upon HCH.
- Continue engagement with CMS to ensure that the unique contributions of the Minnesota model factor prominently in the primary care redesign being promoted by the new Center for Medicare & Medicaid Innovation.
- Continue to participate in the NASHP learning community to explore strategies to improve health disparities.
- Provide training to HCH team members on cultural competency, collection of race, ethnicity and language, use of data in clinical practice, how to develop systems to measure effectiveness of quality work for measures, and patient-family-centered care coordination for minority populations.

Health Care Home Clinic / County Report 2012

County	Total Population	Percent of Total Po	Region	Total # of Clinics	# of Health Homes	% of Clinics Certified
Aitkin	16,202	0.3	NE	3	0	0.0%
Anoka	330,844	6.2	METRO	19	9	47.4%
Becker	32,504	0.6	CE	7	0	0.0%
Beltrami	44,442	0.8	NW	3	0	0.0%
Benton	38,451	0.7	CE	1	0	0.0%
Big Stone	5,269	0.1	SW	3	0	0.0%
Blue Earth	64,013	1.2	SE	11	1	9.1%
Brown	25,893	0.5	SW	3	0	0.0%
Carlton	35,386	0.7	NE	4	0	0.0%
Carver	91,042	1.7	METRO	11	2	18.2%
Cass	28,567	0.5	CE	9	1	11.1%
Chippewa	12,441	0.2	SW	4	0	0.0%
Chisago	53,887	1.0	CE	7	5	71.4%
Clay	58,999	1.1	CW	7	1	14.3%
Clearwater	8,695	0.2	NW	3	0	0.0%
Cook	5,176	0.1	NE	3	0	0.0%
Cottonwood	11,687	0.2	SE	6	0	0.0%
Crow Wing	62,500	1.2	CE	6	0	0.0%
Dakota	398,552	7.5	METRO	38	14	36.8%
Dodge	20,087	0.4	SE	1	0	0.0%
Douglas	36,009	0.7	CW	5	0	0.0%
Faribault	14,553	0.3	SE	4	1	25.0%
Fillmore	20,866	0.4	SE	5	0	0.0%
Freeborn	31,255	0.6	SE	2	0	0.0%
Goodhue	46,183	0.9	SE	5	0	0.0%
Grant	6,018	0.1	CW	5	0	0.0%
Hennepin	1,152,425	21.7	METRO	152	66	43.4%
Houston	19,027	0.4	SE	4	0	0.0%
Hubbard	20,428	0.4	NW	2	0	0.0%
Isanti	37,816	0.7	CE	1	1	100.0%
Itasca	45,058	0.8	NE	8	0	0.0%
Jackson	10,266	0.2	SW	4	0	0.0%
Kanabec	16,239	0.3	CE	1	0	0.0%
Kandiyohi	42,239	0.8	SW	6	0	0.0%
Kittson	4,552	0.1	NW	2	0	0.0%
Koochiching	13,311	0.3	NE	4	0	0.0%
Lac qui Parle	7,259	0.1	SW	4	0	0.0%
Lake	10,866	0.2	NE	3	0	0.0%
Lake of the	4,045	0.1	NW	1	0	0.0%
Le Sueur	27,703	0.5	SE	6	0	0.0%
Lincoln	5,896	0.1	SW	4	0	0.0%
Lyon	25,857	0.5	SW	5	0	0.0%
McLeod	36,651	0.7	SW	5	0	0.0%
Mahnomen	5,413	0.1	NW	3	0	0.0%
Marshall	9,439	0.2	NW	1	0	0.0%
Martin	20,840	0.4	SE	6	0	0.0%
Meeker	23,300	0.4	SW	6	0	0.0%
Mille Lacs	26,097	0.5	CE	6	2	33.3%

Morrison	33,198	0.6	CE	5	1	20.0%
Mower	39,163	0.7	SE	4	1	25.0%
Murray	8,725	0.2	SW	3	0	0.0%
Nicollet	32,727	0.6	SW	3	1	33.3%
Nobles	21,378	0.4	SW	4	0	0.0%
Norman	6,852	0.1	NW	3	0	0.0%
Olmsted	144,248	2.7	SE	12	4	33.3%
Otter Tail	57,303	1.1	CW	9	0	0.0%
Pennington	13,930	0.3	NW	1	1	100.0%
Pine	29,750	0.6	CE	7	1	14.3%
Pipestone	9,596	0.2	SW	5	0	0.0%
Polk	31,600	0.6	NW	10	1	10.0%
Pope	10,995	0.2	NW	2	0	0.0%
Ramsey	508,640	9.6	METRO	81	9	11.1%
Red Lake	4,089	0.1	NW	3	0	0.0%
Redwood	16,059	0.3	NW	4	0	0.0%
Renville	15,730	0.3	SW	5	0	0.0%
Rice	64,142	1.2	SE	6	2	33.3%
Rock	9,687	0.2	SW	1	0	0.0%
Roseau	15,629	0.3	NW	3	0	0.0%
St. Louis	200,226	3.8	NE	37	1	2.7%
Scott	129,928	2.4	METRO	8	3	37.5%
Sherburne	88,499	1.7	CE	7	4	57.1%
Sibley	15,226	0.3	SW	5	0	0.0%
Stearns	150,642	2.8	CE	22	9	40.9%
Steele	36,576	0.7	SE	3	1	33.3%
Stevens	9,726	0.2	CW	4	0	0.0%
Swift	9,783	0.2	SW	2	0	0.0%
Todd	24,895	0.5	CE	5	4	80.0%
Traverse	3,558	0.1	CW	4	0	0.0%
Wabasha	21,676	0.4	SE	4	0	0.0%
Wadena	13,843	0.3	CE	2	0	0.0%
Waseca	19,136	0.4	CE	4	0	0.0%
Washington	238,136	4.5	METRO	15	6	40.0%
Watonwan	11,211	0.2	SE	3	0	0.0%
Wilkin	6,576	0.1	CW	1	0	0.0%
Winona	51,461	1.0	SE	4	0	0.0%
Wright	124,700	2.4	CE	10	4	40.0%
Yellow Medicine	10,438	0.2	SW	3	0	0.0%
	5,303,925	**100.0%**		**723**	**156**	**21.6%**

	Total # of Clinics	**% of Clinics**
Metro	324	44.8%
NE	62	8.6%
NW	41	5.7%
CE	100	13.8%
CW	35	4.8%
SE	86	11.9%
SW	75	10.4%
Total	**723**	

County Data: 2010 Census Redistricting Data (Public Law 94-171) Summary File, Updated in 2012