Health Care Homes

Minnesota's Journey toward Accountable Health

ANNUAL REPORT TO THE LEGISLATURE – JANUARY 2017

MDH Minnesota Department *of* Health
HEALTH CARE HOMES/STATE INNOVATION MODEL

Health Care Homes: Minnesota's Journey toward Accountable Health

Minnesota Department of Health
Health Care Homes
PO Box 64882
St. Paul, MN 55164-0882
(Phone) 651-201-3626

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

www.health.state.mn.us

As requested by Minnesota Statute 3.197: This report cost approximately $12,000 to prepare, including staff time, printing and mailing expenses.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

January 24, 2017

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

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

The Honorable Jim Abeler
Chair, Human Services Reform
Finance and Policy Committee
Minnesota Senate
3215 Minnesota Senate Building
95 University Ave. W.
St. Paul, MN 55155

The Honorable Joe Schomacker
Chair, Health and Human Services
Reform Committee
Minnesota House of Representative
509 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155

Dear Senator Abeler, Senator Benson, Representative Schomacker, and Representative Dean:

The Minnesota Department of Human Services (DHS) and the Minnesota Department of Health (MDH) jointly established the Health Care Homes (HCH) program as legislated in 2008. As required by statute, this report provides an overview of activities that took place during 2016.

The HCH program took important steps in 2016 to close the gap for Minnesotans living in rural counties – reducing the number of Minnesota counties without HCH clinics from 32 down to just 23 counties (see Appendix H for a full list). The program has worked to identify the financial sustainability needs of HCHs, while also beginning to explore the need for evolution of the certification standards. This includes ways to advance the HCH program to positively impact health equity for populations experiencing disparities. Work will continue in 2017 to expand the provision of patient-centered, team-based coordinated care.

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

Thank you for your commitment to improving the health of all Minnesotans. Questions or comments on the report may be directed to the Health Care Homes Program at (651) 201-3744.

Sincerely,

Edward P. Ehlinger, MD, MSPH
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975

An equal opportunity employer.

Contents

Executive Summary

"My care coordinator calls and listens to my concerns. I really like the calls and follow up, it keeps me accountable. My wife and I have been patients here with care coordination for two years after moving from Las Vegas upon our son's encouragement. He told us if we moved to Minnesota we would get wonderful care. The care coordinators have kept us going through a very difficult time for my wife, they came through with support for me. This lady (the care coordinator) is one lady who knows how to take care of people. We can call anytime, this is not just a clinic, but a family." (Buffalo, Montevideo, Albertville Patient)

The Minnesota Department of Health (MDH) Health Care Homes (HCH) program, known nationally as a Patient Centered Medical Home, is key to improving the quality of health care services delivered at primary care clinics. The Health Care Home approach shifts Minnesota providers from a purely medical model of health care to a focus on linking primary care with wellness, prevention, self-management and community services. A Health Care Home is best described as a model of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It is a widely accepted model for how primary care should be organized and delivered, and is a philosophy of health care delivery that encourages providers and care teams to meet patients where they are, from the simplest to the most complex conditions, and to provide the right care, at the right time, and in the right manner for each patient.

The implementation of the HCH standards of access, use of data for tracking clinical care and outcomes, care plan development, quality improvement and care coordination has built a strong foundation for improving cost, quality and the patient experience of care. An independent evaluation of the program's results in the first five years, released in early 2016, found that overall spending on medical services for Medicaid, Medicare and Dual Eligible beneficiaries in HCHs was approximately $1 billion less than if those patients had been attributed to a non-HCH settings during the study period, while results on a range of quality measures were also higher at HCH clinics. Currently, through their focus on re-design of care delivery, HCHs are providing high-quality patient-centered, coordinated, comprehensive primary care to *3.9 million Minnesotans* through the commitment of 3*,660 certified primary care clinicians and their teams*.

"An independent evaluation of the program's results in the first five years…found that overall spending on medical services for Medicaid, Medicare and Dual Eligible beneficiaries in [health care homes] was approximately $1 billion less…"

The goals of the HCH model are to:

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

The HCH program continued to take important steps towards these goals in 2016 by:

- Reducing the number of Minnesota counties without HCH clinics from 32 to 23.

- Certifying 22 clinics, ending the year with a total of 356 Minnesota clinics certified as HCHs.
- Offering capacity building support towards HCH certification to all uncertified Minnesota primary care clinics; 39 new clinics are currently working towards certification.
- Working with the Minnesota Department of Human Services (DHS) to certify Behavioral Health Homes.
- Seeking input for enhancing the HCH program's focus to increase community linkages, advance health equity, increase ability to impact social determinants of health, identify barriers and needed resources.
- Awarding 46 Practice Transformation grants totaling $734,398 in 22 counties.
- Bringing practice facilitation services to 23 urban and rural agencies with one third becoming Behavioral Health Home certified.
- Continuing development of 15 Accountable Communities for Health (ACH) through $5.5 million in grants, and supporting broader adoption of ACH models by completing an ACH White Paper[1].
- Funding two State Innovation Model (SIM) learning communities to allow providers and stakeholders to share common goals and best practices.
- Providing in person technical assistance, webinars and a two-day conference for 597 participants to support re-design of health care delivery.
- Working collaboratively with MDH programs such as Children and Youth with Special Health Needs, the Statewide Health Improvement Partnership program, and Public Health Practice.
- Highlighting the important work of HCH clinics through video storytelling, Minnesota and national presentations, and news media.
- Working with the Centers for Medicare and Medicaid Services to ensure that participating providers certified by the HCH program will receive full points in the 'Clinical Practice Improvement Activities' performance category under the Medicare Access and Children's Health Insurance Program Reauthorization Act's new Quality Payment Program, positioning them for increased payment rates.

MDH's seven years of experience working with clinics to transform how they deliver care – and the results from independent evaluations of the program – demonstrate that the HCH model of care delivery forms a strong foundation for improving quality of patient outcomes and positioning clinics for value based payment. It has proved to be an adaptable and successful model that continues to support Minnesota's primary care clinics as they strive for better care and better health in the midst of an ever-changing landscape of health care payment and delivery reform.

[1] http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs-290682.pdf

Introduction

Health Care Homes: A Foundation for the Future

> *"The HCH program at my clinic has helped to save me numerous hours as I manage my daughter's complex health care needs, and it has given me more of a peace of mind that my daughter is getting the support she needs." (Minneapolis/St. Paul area Parent)*

The HCH program is one of the centerpieces of Minnesota's multi-agency efforts to improve the delivery of primary care. Through a focus on re-design of care delivery, this program provides patient-centered, coordinated, comprehensive primary care to *3.9 million Minnesotans through the commitment of 3,660 certified primary care clinicians and their teams*. Minnesota's model embraces the principles of a Patient-Centered Medical Home, the more common national term, but chose the name "Health Care Home" to acknowledge a shift from a purely medical model of health care to a focus on linking primary care to wellness, prevention, self-management and community services.

The practice standards of a certified HCH clinic are an important foundation to transforming primary care delivery to meet evolving payer and patient expectations. The implementation of the HCH standards of access, effective use of data for closing gaps in care and managing patient's preventive and chronic health needs, care plan development, quality improvement and care coordination are critical for improving cost, quality and the patient experience of care. The goals of the HCH model are to:

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

Health Care Homes Certification

The HCH statute provides voluntary certification criteria that are intended to be challenging while also allowing clinics to be flexible and innovative. The certification criteria require clinics to meet standards in five domains:

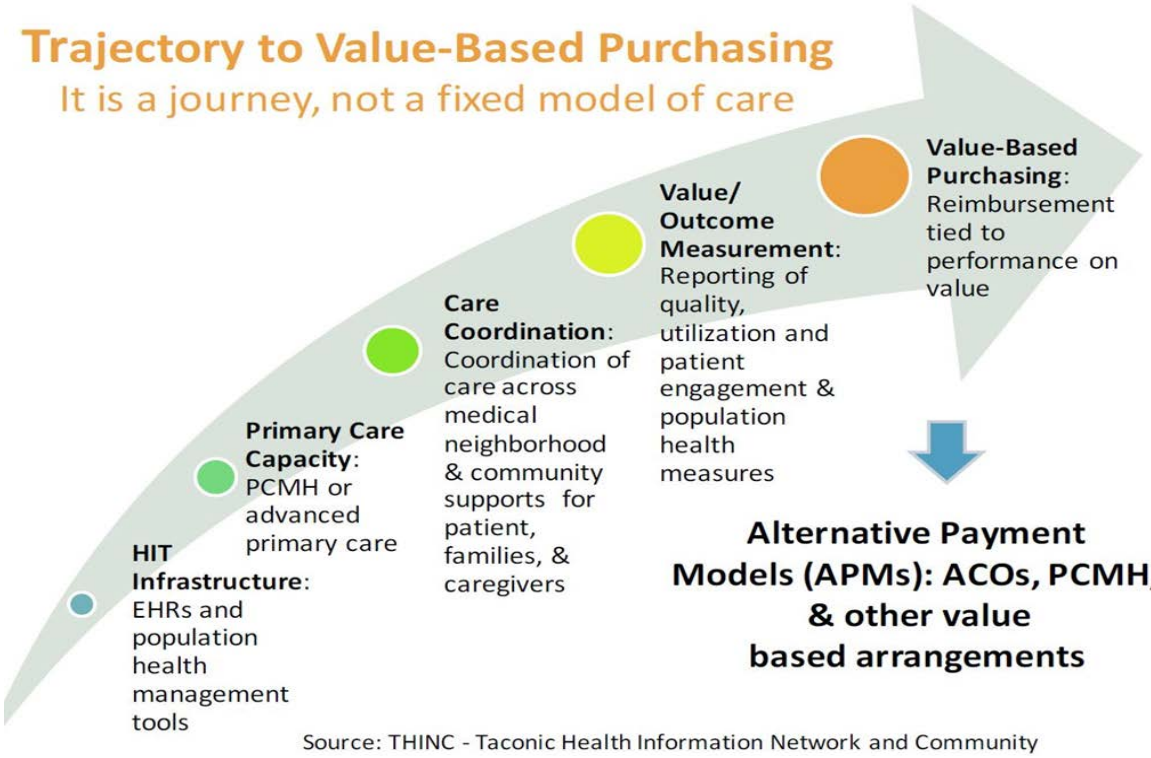
- Access and communication
- Participant registry and tracking participant care activity
- Care coordination
- Care planning
- Performance reporting and quality improvement

HCH Program Evolution

"Patients have a whole team of staff they are connected with. It doesn't matter who on the team they call or talk to, they will be taken care of. Patients seem to notice that we are taking additional steps to help them get healthy." (St. Paul Clinician)

Currently, 356 Minnesota clinics are certified, representing more than 50 % of Minnesota's primary care clinics. There are an additional 20 HCH border state primary care clinics that reach into North Dakota, Wisconsin and Iowa. The HCH legislation provides certification criteria that are intended to be challenging but also flexible and innovative. The program is not prescriptive and clinics are encouraged to evaluate the population they serve and develop proactive strategies to meet those needs. Certification is obtained through a rigorous process including a site visit by program staff and community site evaluators to ensure the certification criteria has been met.

Figure 1: Trajectory to Value-Based Purchasing



Source: THINC - Taconic Health Information Network and Community

By pushing primary care clinics to deliver care, and partner with patients/families, differently, the HCH program has laid a strong foundation for the next phase of health reform. The health care landscape in Minnesota, and nationally, continues to evolve with a continuing emphasis on payment system reform (including accountable care and bundled payments) and practice transformation. At the same time, we know that the health care system alone impacts only 20% of what creates health, whereas a larger percentage of health is influenced by social determinants such as education, income, housing and transportation. These trends have driven an increasing awareness that collaborative partnerships between health care providers,

local public health, social service, and community organizations are essential for improving health equity, improving the health of Minnesotans and succeeding under value based reimbursement.

Figure 1 shows the elements required for transformation to value based payment; both a robust health information technology infrastructure and the ability to function as a Patient-Centered Medical Home or HCH are considered foundational capabilities for success. For organizations that are interested in participating in state or federal payment reform activities, including the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA), the ability to meet these standards will be critical.

In 2016, the Centers for Medicare & Medicaid Services confirmed that participating providers certified by the HCH program will receive full points in the 'Clinical Practice Improvement Activities' performance category under the Merit-Based Incentive Payment System in MACRA's new Quality Payment Program, a strong endorsement of both the robustness of the HCH program and its importance for organizations wishing to benefit from the enhanced payments offered under MACRA. While MACRA itself is likely to continue to evolve under the new federal administration, future HCH certification standards will continue to align with these elements, and with MDH's mission to advance health equity through "expanding our understanding of what creates health" and "strengthening the capacity of communities to create their own healthy futures."

Learning from HCH Stakeholders

"The quality of life for physicians has improved with the implementation of care management." (Mankato Physician)

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

The advisory committee over the past year addressed the key priority areas of:

- Practice transformation
- Financial sustainability
- Learning
- Communication

Key aims include discussing the financial sustainability needs of HCHs, advancing the HCH certification standards and processes, developing a Request for Information to identify clinic barriers to certification and advancement of program standards, and exploring ways to continue to build community partnerships so that the program can successfully expand and grow, and its benefits can extend to all Minnesotans in all counties.

The HCH Advisory Committee met quarterly in 2016. More information about the committee and its upcoming meetings is available here: http://www.health.state.mn.us/healthreform/homes/hchadviscomm/index.html

Request for Information

"All staff are doing more, the care of the patient is done by the team, so a big culture change has been to ensure all are working at the top of their license. That was difficult at first, there was concern related to scope of practice and licensure, but this is occurring and working well. Increasing support and staffing of the social workers and pharmacy departments laid the foundation." (Hinckley, Mora, and Pine City area physician/ clinic champion)

In 2016, the HCH Advisory Committee and its workgroups were instrumental in helping MDH clarify its vision for how the program could continue to evolve to meet changing needs and expectations related to state and federal health reform initiatives and health equity priorities. As part of that process, the HCH Advisory Committee worked with MDH to develop a Request for Information for the purpose of obtaining broad community and stakeholder feedback from key stakeholders on potential enhancements to Minnesota's HCH program.

The Request for Information was sent out to certified and non-certified clinics, state and federal policymakers, community organizations, public health stakeholders, and consumers. It was broken into sections that included:

- Social determinants of health/health equity
- Partnerships and Data Exchange
- Financial Sustainability
- Learning Collaborative
- Communication and Evaluation
- Patient Engagement
- Longer term vision – Accountable Communities for Health

There were 42 responses submitted representing a wide array of organizations interested in program improvements (see Appendix F for a list of respondents). Additionally, MDH held three public meetings in Mankato, Bemidji and St. Paul. Attendance included 31 participants including patients, providers, administrators, public health representatives, and payers.

In general, responses have shown that the program is headed in the right direction in the way it is strategizing about future goals and potential changes that can be made to strengthen support to primary care providers and build more collaborative partnerships with community services. The responses, from a wide range of stakeholders, support the advancement of the HCH program towards stronger care coordination processes inclusive of community and regional organizations such as social services, local public health and behavioral health. This redesign of care can bring together community resources to lessen fragmentation of services, moves towards a more holistic approach to health, and forms a community care coordination system that addresses whole person needs including the social determinants of health.

The Request for Information responses also indicate significant variation across clinics in terms of their current ability to meet potentially stronger requirements in the future, and the types of support they may need in the future:

- The majority of respondents reported collecting race, ethnicity, and language data via an electronic health record system.
- The majority of respondents thought they would be able to conduct health inequity analyses.
- Over half of all respondents are including socio-economic factors in risk stratification of their patient population. However, fewer than half of respondents use data on social determinants of health to assess patient care needs.
- Over half of all respondents participate with local public health and/or hospitals and other partners when conducting Community Health Needs Assessments.
- Health information exchange remains challenging due to redundancies in data collection, lack of knowledge in use of collected data, and the high costs for small and rural providers.

Additionally, their responses point to areas where program improvement should take place by:

- Providing more learning resources and technical assistance for organizational leaders and clinicians.
- Investigating financial sustainability concerns and aligning incentives to support value-based payment and community partnerships.
- Providing additional support to clinics to increase patient outreach and develop individual care plans.

Next Steps

The input obtained through this Request for Information is helping to inform discussions related to potential enhancements, opportunities and barriers for implementation, and resource and support considerations to help HCHs meet program goals. Additionally, the program is using these responses to inform a strategic plan for the future that focuses on the continued transformation of primary care based on the needs of certified clinics, the patient population, and overall advancement of the program.

Practice Transformation

"We are building a bridge of trust with the patients as we work with them on their emotional health as well as their physical health." (St. Paul Clinic team member)

Health Care Homes: Leadership for Primary Care Transformation

Becoming a HCH isn't just about meeting certification criteria and checking a box; it's about transforming how care is delivered, how a care team collaborates with the patient and their family to meet needs, and how information is shared and used. Certification offers assurance to both patients and health care purchasers that these standards have been effectively implemented, and that the clinic has made a significant commitment to transforming and continually improving how it delivers care. Clinics that start down the HCH path are committing to changing their culture as well as their infrastructure. The HCH voluntary certification and recertification process requires a balance between fidelity to the model and flexibility for innovation. The program is not prescriptive, and clinics are encouraged to evaluate the population they serve and develop strategies to meet those needs.

In 2016, the HCH recertification time frame was legislatively changed from an annual to a three year cycle, as a way of reducing burden on providers associated with the recertification process. At initial certification through the second recertification cycle, clinics establish foundational processes to build the needed infrastructure to deliver patient centered quality care. At subsequent cycles the certified clinic begins using quality outcomes as a major component for their recertification. MDH certifies clinics throughout the year, with review and recommendation from the HCH Certification Committee. Regional HCH Nurse Planners check in annually with each certified clinic to offer support and technical assistance to ensure foundational HCH components are in place and the clinic is ready for the next certification cycle.

Certification by the Numbers

In 2016, the HCH program continued its work to improve the health of all Minnesotans by progressively expanding a foundation of primary care transformation across the state that is based on the provision of patient-centered, team-based, coordinated care through certified HCH clinics. During the year, MDH certified 22 new clinics, ending the year with a total of 356 certified clinics, representing over half of Minnesota primary care clinics (see Appendix I). An additional 20 border state clinics are certified as a HCH since they are part of a Minnesota healthcare system.

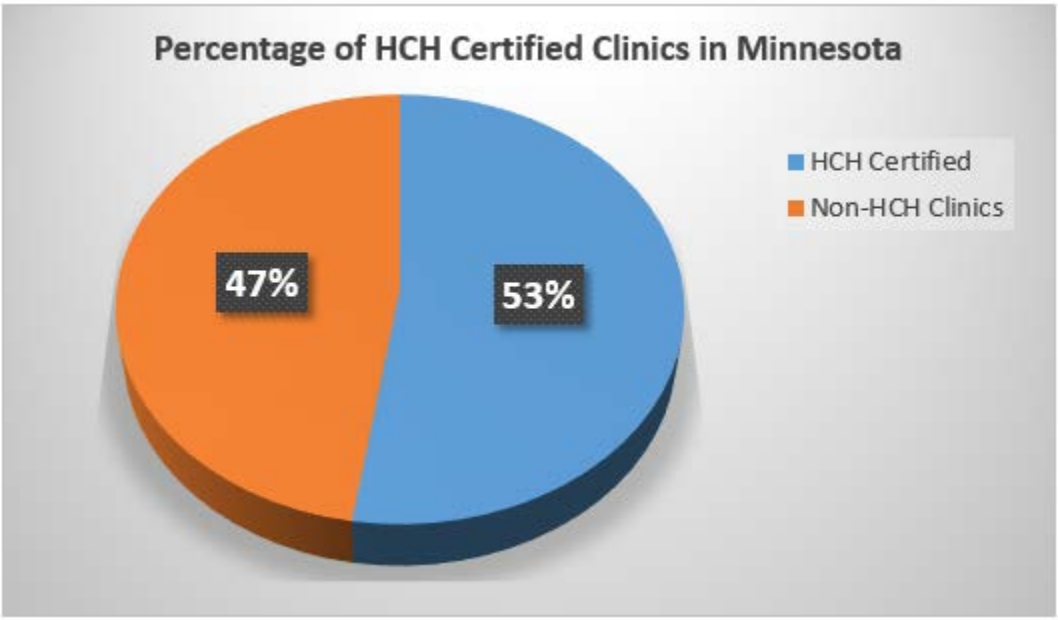
"The 22 clinics certified through [health care home] in 2016 has reduced the number of Minnesota counties without HCH clinics from 32 to 23 counties…"

Overall, since 2010, when the first HCH clinics became certified, 415 clinics have certified as a HCH with 37 clinics not recertifying. Of those, four clinics closed, while others cited lack of resources including time, money and staff. One plans on recertification at a later time, and some have sought national Patient Centered Medical Home certification due to multi-state location of clinics. In 2016, 26 certified clinics did not apply for

recertification, 22 of which belong to a large Minnesota organization that has multi-state locations and chose to be certified by a national certifying body.

In addition to Minnesota's HCH model, there are national bodies, such as the National Committee for Quality Assurance and the Joint Commission, that offer recognition to clinics that have met certain criteria. These programs are established based on core Patient Centered Medical Home concepts but vary with regard to site visits and requirements for renewal of recognition. In comparison, Minnesota's program is more closely aligned with state-specific initiatives and goals, requires on-site certification and recertification visits to more fully evaluate implementation of the model, and includes a strong technical assistance and shared learning/learning collaborative component to promote flexibility and innovation at the clinic level.

Figure 2: Percentage of Health Care Homes Clinics Certified in Minnesota by 2016



The 22 clinics certified through HCH in 2016 has reduced the number of Minnesota counties without HCH clinics from 32 to 23 counties (reference Appendix H). Generally, clinics that are not certified are rural, smaller practices and pediatric clinics. In addition, some larger organizations have not spread HCH certification to their satellite clinics due to the time required to do so as well as participation in other competing initiatives in which requirements do not align with HCH.

Alignment and provider burden have been an additional focus of the HCH's work this past year in planning and considering the advancement of the HCH standards. In considering provider burden, MDH is giving careful thought to requirements of other initiatives such as the Center for Medicare and Medicaid Innovation models of care delivery, Medicare Access and Children's Health Insurance Program Reauthorization Act requirements for qualifying under certain payment arrangements, Integrated Health Partnerships, an Accountable Care Organization type model, and other certifying programs to potentially alleviate provider burden.

Capacity Building

One of the strengths of the HCH program is the intensive support it provides to clinics considering, or preparing for, certification. This assistance ensures they are well positioned to succeed. At the end of 2016, 39 clinics are receiving capacity-building assistance to help prepare them for the certification process.

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

Figure 3: Certification by Program and Clinics Moving Towards Certification for 2016

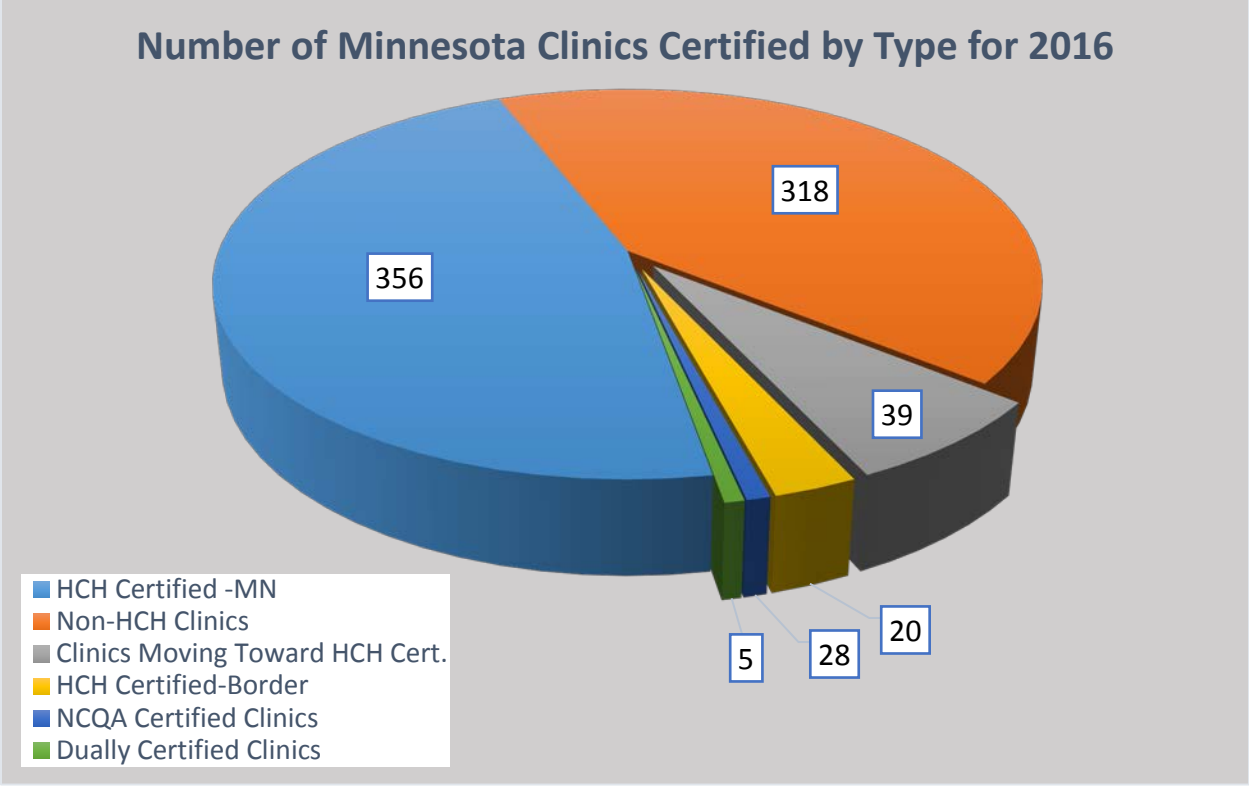


Table 1 shows HCH certification throughout the state, with the majority of HCH clinics located in the Metropolitan and Central areas of the state.

Table 1: Regions and HCH Certification Information, 2016

Region	Clinics	Certified HCH	Clinics to Reach 67% Goal	% Region's Clinics Certified	% Counties with One Or More Certified Clinic	Clinics per 100,000 People	Certified Clinics per 100,000 People	2010 Population
Metropolitan	311	199	Goal met	64%	100%	10.91	7.55	2,849,567
Northeast	55	21	15	38.1%	57%	16.86	7.66	326,225
Northwest	37	8	16	21.6%	38%	18.35	3.97	201,618
Central	82	55	Goal met	67%	93%	11.25	8.50	729,084
West Central	27	14	7	51.9%	75%	14.27	7.40	189,184
South Central	54	16	23	29.6%	64%	18.54	5.49	291,253
Southeast	52	20	13	38.6%	91%	10.51	5.05	494,684
Southwest	55	23	13	41.8%	75%	24.74	12.60	222,310
Total MN	**671**	**356**	**88**	**53%**	**73.6%**	12.69	7.41	5,303,925
Border States	0	20						
Total	**671**	**376**						

The majority of the certified HCH providers that offer comprehensive primary care are composed of Family Medicine, Internal Medicine, Pediatricians, Nurse Practitioners and Physician Assistants. Specialty providers, who provide comprehensive primary care make up two percent of the certified HCH providers. These specialties include geriatricians, women's health, pediatricians and HIV specialists.

Behavioral Health Home (BHH) Services

Recognizing the successes and positive outcomes of HCH in Minnesota, DHS identified a need for more intense, comprehensive services for those experiencing mental illness. In Minnesota, the comparison between the general population on medical assistance and adults with Serious Mental Illness (SMI), or Serious and Persistent Mental Illness (SPMI), and children with Emotional Disturbance (ED) or Severe Emotional Disturbance (SED) shows significantly greater numbers of co-occurring chronic conditions and use of more inpatient services. DHS launched BHH Services on July 1, 2016 and has certified 19 locations to date. This model used HCH as a foundation for their work, building on the successes of the HCH model with the following differences as listed in Table 2.

Table 2: HCH/BHH Comparison

Health Care Home (HCH)	Behavioral Health Home Services (BHH)
Inclusive of the whole population	Adults with SMI or SPMI and children/youth with ED or SED
All payer system, including commercial	Medicaid only
Care delivery model implemented in a primary care setting	A team based service delivery model that can be implemented in a variety of settings, including primary care and mental health centers

Implementation of BHH has been in collaboration with HCH, with a mutual commitment towards behavioral health/primary care integration efforts. To date, HCH nurse planners have participated alongside the BHH staff at site visits for 25 organizations, 19 of whom have finalized all requirements and become officially certified.

Specific collaborative work includes:

- DHS funding a Behavioral Health Integration Nurse Coordinator at MDH to coordinate activities between HCH, BHH, and behavioral health integration activities related to state health reform efforts and the Minnesota Accountable Health Model.
- Developing a cross-agency team with the Behavioral Health Integration Nurse Coordinator serving as a liaison between DHS and MDH.
- Recognizing there are certified HCH clinics seeking BHH certification and working to reduce duplicative efforts for both.
- Alignment of the respective program's certification standards where applicable.
- Involving HCH nurse planners in the BHH certification site visit process to serve as a resource to the team on the physical health and primary care integration requirements, including any applicable HCH certification items.

Zumbro Valley Health Center – Integrating Behavioral Health and Primary Care

"A key aspect of the care model is coordinating the various services for clients," says the CEO. "Through this approach, the report concluded that the integration of services within a 30-day period results in a significant reduction in charges when compared to providing the two services separately."

Zumbro Valley Health Center, a fully integrated community mental health center with certified HCH primary care on site, was able to achieve HCH recertification during their BHH certification site visit by working with their HCH nurse planner to align these two processes. Integrated care at this organization has resulted in nearly $2.25 million in savings based upon Minnesota DHS claims data between December 2013 and August 2015 in an evaluation done by Wilder Research. The majority of savings are from reduced hospitalizations, use of emergency rooms and in-patient mental health facilities.

Next Steps

A key focus of the HCH program has been to build capacity for practice transformation and integration throughout the state. The HCH team, with input from the advisory committee and the community, has identified these strategic priorities for 2017.

These priorities include:

- Educating and providing technical assistance to primary care clinics, community partners and interested parties throughout the state about the HCH model of care delivery.
- Supporting clinics through practice transformation to increase the number of certified HCH.
- Continuing to partner with DHS on certifying BHH.
- Continuing to partner and support joint strategies with other MDH programs to promote healthy lifestyles, improve care for children with complex needs and care of individuals with chronic conditions.
- Advancing HCH certification standards and processes to positively impact health equity through expansion to the community and the creation of partnerships outside of the traditional health care system.

Minnesota Accountable Health Model: Innovation in Care

"The care coordination approach has evolved throughout the first [period] of this grant. From the original vision which was then initiated and evolved into a process that has proven such significant value, it is planned to be replicated to other patient populations and integrated as the care coordinated approach for the entire medical home community it serves." (Rochester, Care Coordinator)

In February 2013, the Center for Medicare and Medicaid Innovation awarded Minnesota a State Innovation Model testing grant of over $45 million for use across a four and a half year period ending December 2017. MDH and DHS are collaborating to test new ways of delivering and paying for health care using the Minnesota Accountable Health Model framework. The Accountable Communities for Health model addresses a critical gap between clinical care and community services in the current health care delivery system by expanding the idea of team-based, integrated coordinated care from the clinic (HCH) to the community and including a community health focus.

Minnesota has made significant progress toward the aim of improved health, better patient experience, and lower costs building on practice transformation efforts such as accountable care organizations, HCH, and community care teams. However, millions of Minnesotans continue to experience fragmented, uncoordinated care. The Minnesota Accountable Health Model seeks to address this problem by changing how care is delivered and paid for in Minnesota.

The Minnesota Accountable Health Model provides grants throughout the state in these key areas: practice facilitation, practice transformation, learning communities, and accountable communities for health (reference Appendix I). For more information about the grants please see:
http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16_188792.pdf
These grants promote and support team-based care models such as HCH and BHH, integration and coordination across the continuum of care, use of community supports and services, peer-to peer learning and sharing best practices, and integrating new emerging professions into the care team.

Practice Facilitation Grants

Two organizations were awarded funds to provide practice facilitation services to 23 agencies in both urban and rural settings throughout Minnesota. The goals for the practice facilitation services are to accelerate behavioral health and primary care integration, increase use of data analytics and health information technology, improve care management, and support HCH certification. Coaching, bi-monthly webinars, training sessions, and site visits have provided the needed support to help agencies address the agreed upon goals.

Agencies receiving practice facilitation services report these practice based and structural improvements:

- Helped to advance quality improvement efforts within their organizations.
- Set transformation goals that support understanding of progress, and increase their capacity for future improvement efforts.
- Facilitated commitment and involvement from key leadership in each agency in the project teams' goals for transformation.
- Accelerated change through coaching on change management and leadership.
- The opportunity to set and successfully meet team goals energizes the team.

Practice Transformation Grant

Practice transformation to create an integrated approach to providing care delivery requires staff time and dedication. The practice transformation grants provide funds to support staff participation in activities such as increasing interdisciplinary team efforts through improved communication between departments, advancing performance-based accountable care payment arrangements, enhancing service delivery through Health Information Technology/Health Information Exchange improvements, conducting patient surveys to improve patient outcomes, and increasing community partnerships.

The practice transformation grant program has provided 36 grants to organizations around the state in 2016, with an additional 10 starting in 2017. Twelve organizations receiving practice transformation grants are certified HCH clinics, and four clinics have become certified or have site visits scheduled to become certified HCH clinics. All of the areas of work under this grant program support movement to HCH certification or recertification.

Sanford Luverne Clinic – Advancing Team Based Care

As a result of the Practice Transformation award, Sanford Luverne Clinic added a part time care coordination assistant to their staff. They assist with registry management, referral follow up, data entry into the electronic medical record and other clerical tasks to help maximize the RN health coach's time. This position has increased the coordination between patients, physicians and RN health coach, improving integration of care responsive to the population health needs of the Luverne area. The clinic has seen improved outcomes for patients with diabetes and depression, which has created the evidence needed to permanently add a care coordination assistant as part of the care team.

Learning Communities

Learning Communities bring together groups of providers and stakeholders who share common goals or interests to actively learn best practices from experts and each other. Learning Communities build on the wide array of learning collaborative expertise within the state, such as the HCH Learning Collaborative mandated for certified HCH teams, the education collaborative developed by Minnesota's Health Information Technology Regional Extension Center, Statewide Health Improvement Partnership, and chronic disease education activities.

Learning Communities focus on these areas:

- Integrating the HCH and BHH model for the pediatric population.
- Improving coordination of care for refugee populations.
- Increasing use of emerging professions such as community health workers and community paramedics in a care team.
- Advancing care team development through quality improvement skill building in the use of race, ethnicity, and language data for small, independent health care organizations in rural areas.
- Providing technical assistance for Accountable Communities for Health Grantees.

Accountable Communities for Health (ACH)

Minnesota's State Innovation Model (SIM) funds were also invested in 15 community-led ACH projects focused on social needs and clinical care integration across a range of providers, guided by local leaders and community members with support of an accountable care organization. It is expected that ACH bring together a broad range of community partners, including local public health, behavioral health, social services, long term care, primary care and other organizations that address needs of the whole person including social determinants of health. [2] Through community engagement, these partnerships establish priorities for population health outcomes and plan activities to coordinate care with an accountable care organization. This partnership brings health care systems and community resources together to lessen fragmentation of services.

Multi-disciplinary teams use a variety of methods to integrate services and coordinate care through enhanced referrals, transition management and implementation of new practice guidelines. The participation of certified HCH clinics in ACH projects contributes to the capacity of an ACH to initiate the care coordination process more readily and provide comprehensive services (see Table 3). Among the certification standards, a HCH must be able to identify high-risk patients with complex needs, provide coordinated care services, use registry tools to track clients and improve transitions and referrals to outside services. This includes partnering and planning with community-based organizations and public health resources and ensuring participants are given the opportunity to fully engage in planning their health care and sharing in decisions about their care.

The care coordination efforts through ACHs have identified many needs in the community that are difficult to meet through the current funding, including social and environmental supports, oral health services, transportation, housing and behavioral health services. The ACHs that include a certified HCH have the experience and are better ready to connect to available options for getting the client needed services.

The ACH projects were initially funded for a two year period ending December 2016. As a result of a no-cost extension for the SIM grant, 11 ACH projects will be able to continue their work through the end of 2017. Additional grants were awarded to six existing ACH's to support building and strengthening infrastructure, continuing the development of services and supports that have a positive effect on health, and promoting sustainability (Appendix I: Map of SIM Awards).

In 2016, MDH staff identified key learnings from the first two years of the ACH grants, and developed recommendations for strategies to build on those learnings in the future, via a white paper that was broadly shared in Minnesota and nationally. More information about the ACH white paper is available here: http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs-290682.pdf.

[2] See Tipirneni et. al. (2015) for definition and purpose of an accountable community for health.

Table 3: Certified Health Care Home Clinic participation in ACH Projects

	Certified Health Care Home is Lead Organization	Certified Health Care Home is Central Service Provider	Certified Health Care Home is Peripheral Service Provider or not a Partner
ACH	CentraCare Essentia Ely* HCMC Mayo Unity/CHI St. Gabriel's	UCare Greater Fergus Vail Place Lutheran Social Service Southern Prairie Community Care Together for Health at Myers Wilkins	Allina Hennepin North Country New Ulm
Characteristics of care coordination approach	-Strong linkages between care coordinators -Advanced tools and protocols to share health information -Ability to track client health outcomes	-Improving linkage between care coordinators -Health information sharing process in developmental stages -Some ability to track client health outcomes	-Coordination limited to screening and referral -Limited or no health information sharing between partners -Data tracking limited to simple outputs

*Essentia Health has a Level 3 certification from the National Committee for Quality Assurance.

Next Steps

Preliminary analysis of results from evaluations of the HCH program and lessons learned from the ACH projects have helped form the strategies for the future direction of the HCH program. These strategies include the importance of strong patient centered primary care, community and primary care partnerships in conjunction with effective care coordination processes that reach into the community that has a focus on meaningful work to improve health at the local level, improving overall population health, and advancing health equity. That work will accelerate in 2017, as conversations with stakeholders related to both sustainability of SIM investments and HCH program evolution continue.

Financial Sustainability

> *"It has been a year of ongoing change management, as we find our way between the two worlds of quantity versus quality systems of reimbursement. It is much like one foot in the boat and the other on the dock. The transformation of care delivery is the right thing and our mission remains the same, 'To improve the health of the communities we serve'." (Wadena Care Coordinator)*

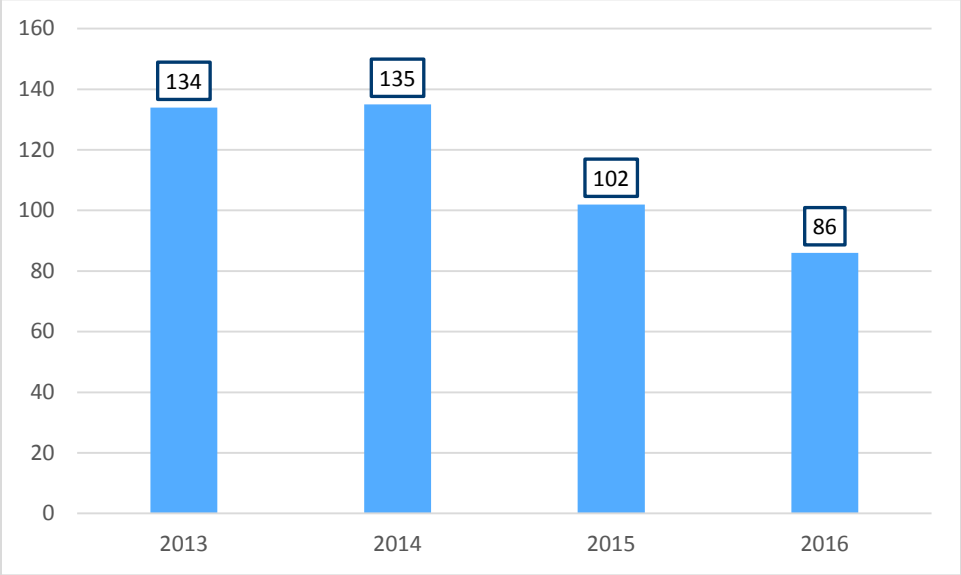
Financial sustainability is critical to the long-term success of the HCH program; feedback from HCH certified clinic providers indicate challenges around billing and reimbursement rank as a top barrier to successful implementation of the model. Making clinic level changes necessary to meet certification standards, and maintaining those changes, requires adequate levels of reimbursement and other means of support. Going forward, enhancements to HCH standards, promoting clinic-community partnerships and addressing social determinants of health will also need strong multi-payer support and adequate reimbursement for long-term viability.

A diverse set of challenges to financial sustainability have been identified through the work of the HCH Advisory Committee, stakeholder feedback, and program staff.

Care Coordination Payments

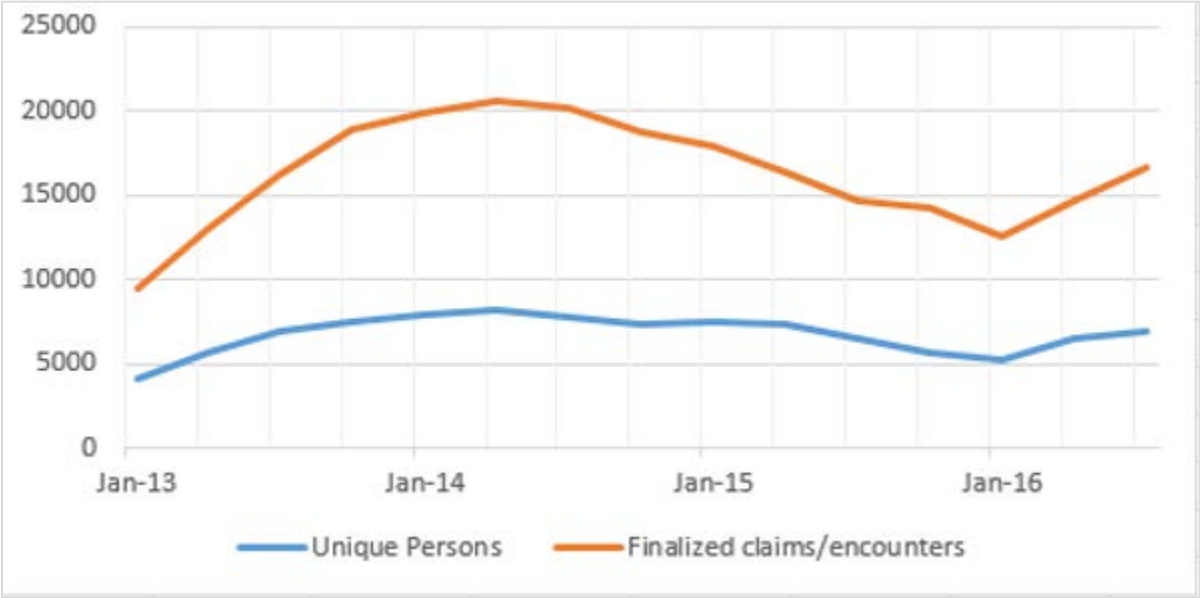
Submission of HCH claims peaked in 2014, with 180 clinics submitting claims. While there was a modest increase in the number of HCH claims submitted throughout 2016 (see Figure 4), these claims came from a smaller amount of billing clinics, with 86 clinics submitting claims to date (see Figure 5). So far in 2016 a total of 49,920 finalized claims for 9,364 Minnesota Health Care Program beneficiaries totaling $1,163,500 have been paid through HCH claims by DHS or the Medicaid Managed Care Organizations. Figure 4 reflects the quarterly trends of submitted and paid HCH claims for Minnesota Health Care Program members through the most recent quarter for which complete data is available.

Figure 4: Distinct National Provider Identifiers Billing Minnesota Health Care Programs for HCH



Despite the declining number of clinics submitting per-person HCH claims, the number of certified HCH clinics participating in alternative payment reform initiatives, such as the Integrated Health Partnerships (IHP) demonstration, has continued to increase. As of 2016, 163 HCHs are participating as part of an IHP and 17 of the 19 IHPs include certified HCH clinics. The IHP demonstration is one of a number of payment reform strategies underway at both the state and federal level which recognize and prioritize the importance of primary care and patient-centered care, but also reflect new mechanisms such as total cost of care shared savings payments that support providers' care coordination activities in different ways.

Figure 5: HCH Claims for Minnesota Health Care Program Members



Accomplishments in 2016

This past year, HCH staff began to examine the current state of reimbursement for HCH care coordination services and the payment systems being implemented by other states' Patient Centered Medical Home models. There has been a steady decrease in HCH certified providers billing for care coordination. While there are likely several factors leading to this decline, the complexity of the tiering system and other administrative burdens is a widely reported reason, including the view that obtaining reimbursement requires too much of an investment in time and effort relative to the returns. Three key opportunities identified by HCH program staff and external stakeholders to enhance the long-term financial sustainability of the HCH program include:

- Improving the reimbursement system for care coordination services including the development of incentives to assist clinics interested in certification but lacking the resources for initial infrastructure changes.
- Aligning payment approaches across public and private payers to reduce inefficiencies and provider burden as well as maximizing the capacity of clinics to implement the HCH model.
- Developing strategies to support the building and maintenance of clinic-community partnerships.

With these three subjects as the starting point, the HCH program took the following actions:

- Recommending the alignment of HCH with DHS's Integrated Health Partnerships (IHP) program, specifically with the next generation of the IHP demonstration in development by DHS with an anticipated implementation date of January 2018. The IHP model offers a mechanism by which participating clinics may receive a return on their care coordination/chronic disease management activities through shared savings. Future IHP models may additionally include prospective payments that could support providers' practice transformation efforts.

- HCH staff reached out to private payers as well as health care purchasers representing the self-insured population with the goal to increase understanding of how the HCH program is supported by various payers and to begin addressing the challenge of payment alignment.

- Staff completed a detailed analysis of the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) and created documents identifying points of concurrence as well as opportunities for future alignment of Minnesota's HCH program. In response to inquiries from staff, the Centers for Medicare and Medicaid Services has given notification that participating providers certified by the HCH program will receive full points in the Clinical Practice Improvement Activities performance category under MACRA's new Quality Payment Program.

- In partnership with the University of Minnesota, HCH staff designed an approach for quantifying the initial and ongoing costs of care coordination, using case studies of clinics around the state, so that future payment methods can more adequately account for these activities.

- HCH staff conducted research on best practices related to creating and sustaining clinic-community partnerships and addressing the social determinants of health. This included gathering information from focus groups and the Request for Information responses, as well as a review of current literature on the subject.

Next Steps

Some steps planned for 2017 to enhance the financial sustainability of a certified HCH include:

- Develop a white paper comparing various state-based patient centered medical home models and their strategies for financial sustainability, in relation to work being done in Minnesota.
- Facilitate discussions between health care payers and HCHs with the aim of building more cohesive approaches to reimbursement for care coordination.
- Develop and refine an approach to sustaining clinic-community partnerships.
- As a part of the State Innovation Model no-cost extension and in partnership with the University of Minnesota's State Health Access Data Assistance Center, implement the study on the components and cost of care coordination, to inform future payment approaches. The study will include in-depth case studies of five to eight clinics.
- Continue dialogue with the Centers for Medicare & Medicaid Services in order to better align the HCH program with the coming changes under the Medicare Access and Children's Health Insurance Program Reauthorization Act.

Learning

"The best learning is networking – sharing information with other clinics." (Stakeholder Feedback, Southern Minnesota Community Engagement Meetings, August 2016)

Learning Activities and Outcomes

Peer learning, support from HCH nurse planners and other clinical and quality improvement experts are critical components of Minnesota's HCH model. A HCH statewide learning collaborative is required by Minnesota Statutes, Section 256B.0751. The learning collaborative was established in 2008 and is jointly sponsored by the HCH program and the State Innovation Model (SIM) testing grant to provide resources for primary care clinics engaged in HCH certification and recertification and SIM grantees. Through the learning collaborative, participants exchange information and enhance understanding of quality improvement and best practices for health system redesign, using face-to-face and virtual learning opportunities.

Since 2008, the scope of the learning collaborative has expanded. Over half of Minnesota clinics are now certified and have advanced learning needs while others are still building a foundation for health redesign. As our definition of health has expanded beyond the clinic walls, clinics are working with a continuum of care providers, including behavioral health, specialty care, local public health, and community institutions addressing a variety of health and human service needs. With the release of the MDH report on Advancing Health Equity in Minnesota in 2014, awareness increased around health disparities that is changing the way we think about health. These factors have expanded the scope of stakeholders and learning needs addressed through the learning collaborative.

In 2016, the HCH/SIM learning collaborative sponsored a number of activities and innovations to help health providers and community partners at beginning, intermediate and advanced stages of development enhance knowledge and capacity for practice transformation. Building on prior years, the learning collaborative once again sponsored an annual statewide conference in April and a monthly webinar series on topics of interest to our stakeholders (see Table 4).

Staff also began work to acquire a Learning Management System which will provide a structured platform for designing and delivering educational resources to a complex stakeholder base. At the same time, staff worked to develop improved online learning modules on HCH certification as a foundation for health care redesign, including modules on community partnerships, population health and value based payment.

This work will continue into 2017.The HCH program worked closely with DHS as it developed, launched and provided learning opportunities for Behavioral Health Home certification and Integrated Health Partnerships. HCH also partnered with the MDH Statewide Health Improvement Program and Public Health Partnerships division to design and implement learning activities focused on primary care partnerships with local public health and an expanded scope of community partners.

Table 4: Learning Collaborative Activities 2016

Activity	Number of Activities	Attendance	Theme/Topics
2016 HCH/SIM Learning Days Conference	1	597	On the Road: Patient Centered Care to Healthy Populations
HCH/SIM Webinars	11	1067*	• Advancing Health Equity • The New Formula: Health Equity + Enhanced Community Partnerships = Improved Outcomes = Better Payment • Morrison County Community Based Care • Expanding the Care Coordination Team and Moving to Advanced Medical Home • I CAN Prevent Diabetes Program: Utilizing Community Partnerships To Address Health Disparities • Enhancing Care Coordination for Children and Youth with Special Health Needs • Medication Therapy Management: Preparing for Future Alternative Payment Models – A Care System Perspective • Under One Roof: Integrating Behavioral Health at Lake Superior Community Health Center • State Innovation Model Emerging Professions Learning Community • CMS Quality Payment Program 2017 • Integrating Behavioral Health for Refugee Populations

*Attendance based on numbers of people who signed in to the webinar. Attendance does not reflect staff groups who viewed webinars together or people who accessed webinar content from the website archive.

Next Steps

To improve the ways in which we deliver learning content to stakeholders, the HCH program will launch the Learning Management System for delivering and tracking educational resources in 2017. Other entities within MDH will be able to use the Learning Management System for their own stakeholder learning needs following the initial HCH rollout of the system in 2017. HCH will continue to develop learning modules and other related resources in 2017.

Communication

"Engaging our patients and families in this program has been a great opportunity and has helped us to adapt to the needs of the patient and family." (Lakewood Provider)

Outcomes

In the past year, the HCH program has taken on a number of tangible goals to advance the HCH message throughout the state. These goals have focused on a variety of audiences including providers, clinic staff, community organizations, local public health networks, and patients.

Strategies for engaging these audiences include:

- Producing a HCH window cling that certified clinics can put in their windows to show patients they are HCH certified. Approximately 300 window clings have been distributed thus far.
- Creating a business case that demonstrates how the program has contributed to improving the Triple Aim.
- Reaching rural radio listeners, who may not have been reached through previous communication channels, through an interview on the Healthy Matters radio program.
- Creating a "Spotlight" page on the HCH website that showcases four clinics at a time that represent the wide array of sizes, geographic areas and populations represented in the program. Thus far eight clinics have been spotlighted, showing an array of innovative tools, creative strategies, and community partnerships that have improved the health and well-being of the population they serve.
- Developing a Twitter hashtag (#MNHealthCareHomes), and posting to social media sites 53 times, and connecting to 32 other health related hashtags to enhance communication to diverse audiences, track who has responded to the posts and how these trends impact the format of future posts, and how these posts target key audiences.
- Interviewing HCH clinic providers and staff for a series of videos showcasing the important elements of the program related to care coordination, community partnerships and individual successes.

Spotlight Story: Murray County Medical "Big Blue Bus" Program

Murray County Medical Center, located in the southwestern part of the state, is a county owned organization that has been serving Murray County since 1951. Murray County Medical Center offers a multitude of visiting specialty services to provide convenient and accessible healthcare for their patients.

An innovative approach to health improvement is their "Big Blue Bus" program that travels to outlying communities, providing health education and support for the remote populations. Visitors of the bus were recipients of blood pressure readings, blood glucose monitoring and diabetic foot assessments. Each month different health spotlights were offered such as diabetic education, heart healthy snacks, pulmonary assessments, reviewing of medications by a pharmacist and seasonal flu vaccinations.

Next Steps

As 2016 comes to a close, a major objective for 2017 is to develop an overall communication plan for the HCH program that aligns with the program's strategic plan, as well as the department wide strategic plan for 2015-2019. Additionally, the Request for Information results provide a rich source of information that will guide the program's strategic goals for 2017.

These goals, in combination with a communication plan, have identified the following primary audiences:

- Providers and their teams
- Payers
- Community organizations
- Patients

In continued efforts through social media, radio and new publications, and direct contact with certified clinics and their community partners, the HCH program will be able to amplify the important work it has done throughout the state to improve primary care for all Minnesotans.

Figure 6: Certified Health Care Home window cling

Conclusion

> *"Once you focus on people's barriers, such as insurance, housing, transportation and others, helping folks deal with their healthcare needs becomes easier, even though their other challenges may stay somewhat the same. For many, if basic needs aren't met, we cannot impact other health issues. We must address the whole patient by looking at social determinants of health and people's health together." (Mankato Community Health Coordinator)*

In the first seven years of the program the HCH program has built a strong foundation of success. Minnesota's HCHs are well-positioned to continue to improve patients' experience of care, reduce the cost of care, improve the quality of care outcomes and enhance the current standards to improve health equity in Minnesota.

In late 2016, the Centers for Medicare and Medicaid Services confirmed that Minnesota clinics that are certified as HCHs will receive full credit in the 'Clinical Practice Improvement Activities' performance category under the Merit-Based Incentive Payment System of the Medicare Access and Children's Health Insurance Program Reauthorization Act. With this announcement, these certified HCH clinics are positioned to benefit from new federal payment reform initiatives without having to seek an alternative certification approach.

In 2016, the program took important steps to identify financial sustainability needs of HCHs, while also beginning to explore the need for evolution of the certification standards, and ways to improve the HCH program to positively impact health equity for populations experiencing disparities. This work will continue in 2017, as the HCH program continues its work to improve the health of all Minnesotans by progressively laying a foundation of primary care transformation across the state that expands the provision of patient-centered, team-based coordinated care.

Appendices

Appendix A: List of HCH Advisory Committee Members

First	Last	Category of Representation	Affiliations
Dana	Brandenburg	Health Care Professional	Psychiatrist, UMN
Rhonda	Cady	Academic Researcher	Nursing Research Specialist, Gillette Children's
Dustin	Chapman	Behavioral Health	Behavioral Health Liaison, Fairview
Dale	Dobrin	Statewide Representative HCH Clinic	MD, South Lake Pediatric Clinic
Emily	Goetzke	Statewide Representative HCH Clinic	RN, Mankato Clinic
Elizabeth	Goldstein	Consumer/Patient in a Health Care Home	Consumer
Andrea	Hillerud	Health Plan Representative	MD, Blue Cross/Blue Shield Health Plan
Michelle	Hodurski	Consumer/Patient in a Health Care Home	Consumer
Mary	Kautto	Learning Collaborative Work Group Co-Chair	RN, Gillette Children's
Rahul	Koranne	Health Care Professional	MD, MN Hospital Assocation (2 year term)
Bonnie	LaPlante	Project Manager, HCH Advisory Committee	Director, Health Care Homes Program
Susan	Mitchell	Consumer/Patient in a Health Care Home	Consumer
Lucas	Nesse	Employer	Minnesota Business Partnership
Kelly	Rheingans	Health Care Professional	RN, Allina Health Care
Jeff	Schiff	Health Care Professional	Medical Specialist, DHS
Nathan	Shippee	Communication & Evaluation Work Group Co-Chair	Researcher, UMN
Julie	Sonier	State Agency	Division Director, MMB
David	Thorson	Health Care Professional	MD, Enitra Clinic
Cally	Vinz	Quality Improvement Organization	ICSI
Melissa	Winger	Consumer/Patient in a Health Care Home	HCH Site Evaluator (2 year term)
Khalea	Zobel	Statewide Representative HCH Clinic	Social Worker, Vail Place

Appendix B: List of Communication & Evaluation Work Group Members

First	Last	Category of Representation	Affiliations
Mark	Caldwell	MDH Project Manager	Research Analyst Sr, MDH
Deborah	Carter McCoy	Marketing or Communication Expert	Public Communications Manager, Ramsey County Regional Railroad Authority
Karla	Dross	Quality Improvement Organization	Finance Manager, ICSI
Nancy	Hartzler	Communications Manager	Wilder Research
Casey	Langworthy	Newly Certified Clinic	RN, Zumbro Valley Mental Health
Scott	Robertson	Health Plan	Senior Director, Delta Dental of Minnesota
Jeff	Schiff	Health Care Professional	Medical Specialist, DHS
Nathan	Shippee	Communication & Evaluation Work Group Co-Chair	Researcher, UMN
Scott	Smith	Marketing or Communication Expert	Public Information Officer, MDH
Angie	Vasquez	Researcher	Management Consultant, Vasquez Consulting

Appendix C: List of Financial Sustainability Work Group Members

First	Last	Category of Representation	Affiliations
Charles	Abrahamson	Health Plan Representative	Vice President, HealthPartners
Aaron	Bloomquist	Finance	Vice President, North Memorial
Dale	Dobrin	Statewide Representative	MD, South Lake Pediatric Clinic
Lori	Doehne	Newly Certified Clinics	Chief Financial Officer, NorthPoint Health & Wellness Center
David	Kurtzon	MDH Project Manager	Planner Principal, MDH
Jeff	Schiff	Department of Human Services	MD, DHS
Jan	Schuerman	Quality Improvement Organization	Senior Director, ICSI
Julie	Sonier	SEGIP	Director, SEGIP
Jill	Swenson	Recertified Clinic	Medical Home Program Coordinator, Sanford Health
David	Thorson	HCH Provider and Financial Sustainability Work Group Co-Chair	MD, Entira Family Clinics

Appendix D: List of Learning Collaborative Work Group Members

First	Last	Category of Representation	Affiliations
Carolyn	Allshouse	ACH/SIM Community/Social Services	Executive Director, Family Voices
Carol	Bauer	MDH Project Manager	Planner Principal, MDH
Julie	Bluhm	Health Plan	Interim Director of Medical Administration, Metropolitan Health Plan
Dustin	Chapman	Behavioral Health and Learning Collaborative Work Group Co-Chair	Behavioral Health Services Liaison, Fairview Health Services
Laura	Ehrlich Sanka	Emerging Professions	International Program Director, WellShare International
Kristin	Erickson	Public Health/SIM Grantee	Evaluator and Healthcare Initiative Coordinator, Otter Tail County
Joanne	Foremann	Quality Improvement Organization	Team Director, ICSI
Ken	Joslyn	Patient/Consumer	Retired Physician, University of Minnesota
Mary	Kautto	Specialty Care Provider-Pediatrics Learning Collaborative Work Group Co-Chair	RN, Gillette Children's
Mathew	Keller	Professional Organizations	Policy, Regulatory and Nurse Practice Specialist, Minnesota Nursing Association
Dennis	Maurer	Recertified HCH/Newly Certified BHH/Physician Provider	Assistant Department Director, Community University Community Health Center
Kate	Onyeneho	Patient/Consumer	President and CEO, Center for Africans Now in America
Sue	Severson	IT/E-Health	Vice President, Health Information Technology, Stratis Health
Marie	Stevens	Patient/Consumer	Private Citizen
Eileen	Weber	Academia	Clinical Assistant Professor, Population Health and Systems, University of Minnesota, School of Nursing

Appendix E: List of Practice Transformation Work Group Members

First	Last	Category of Representation	Affiliations
Jennifer	Blanchard	Behavioral Health Care	Interim Health Care Policy Director, DHS
Rhonda	Cady	HCH Administrator or QI Leader and Practice Transformation Work Group Co-Chair	Nursing Research Specialist, Gillette Children's
Peter	Carlson	Hospital	Community Paramedic Supervisor, North Memorial Medical Center
Susan	Casey	Clinic	General Counsel/Chief Compliance Officer, Planned Parenthood, MN, ND, SD
Amano	Dube	Patient/Consumer	Director of Brian Coyle Center, Pillsbury United Communities
Akisha	Everett	Patient/Consumer	Executive Director, Neighborhood Hub
Scott	Gerdes	Newly Certified Clinic	CFO, Zumbro Valley Health Center
Kristen	Godfrey Walters	Local Public Health	Community Care Coordination Manager and Interim Director of Transition Care, HCMC
Emily	Goetzke	Health Care Home Clinic	Care Management Manager, Mankato Clinic
Rahul	Koranne	Medical Associations, Practice Transformation Work Group Co-Chair	Senior Vice President of Clinical Affairs and Chief Medical Officer, MN Hospital Association
Shirlynn	LaChapelle	Medical Association	President, Minnesota Black Nurses Association
Catherine	Larson	Site Visit Evaluator	Clinical Project Manager, HealthEast
Roxanna	Linares	Patient/Consumer	Executive Director, Centro Tyrone Guzman
Charlie	Mandile	Safety Net Clinic	Executive Director, Health Finders Collaborative
Denise	McCabe	SQRMS	Supervisor, Quality Reform Implementation Unit, MDH
Nancy	Miller	Quality Improvement Organization	Program Manager & Consultant. Health IT/Care Coordination
Claire	Neely	Quality Improvement Organization	Medical Director, ICSI
Melissa	Parker	Certified Clinic	Chief Operating Office, United Family Medicine
Judine	Pattinson	Emerging Professions	Faculty-Community Health Worker Certificate Program, Minneapolis Community and Technical College
Barbara	Schubring	Patient/Consumer	Associate Director of Advancement, YWCA of Minneapolis
Whitney	Terrill	MDH Project Manager	Planner Principal, MDH
Gwendolyn	Velez	Patient/Consumer	Executive Director, African American AIDS Task Force
Shelly	Zuzek	Mental Health Provider	Clinical Services Director, Vail Place

Appendix F: RFI Respondent List

Type of Organization	Total Responses	Examples (Not All Respondents are Listed)
Assisted Living/ Home Health	4	Central Minnesota Senior Care, In-Home Lab Connection
Community Based Organizations	7	MN-American College of Physicians, CANA, Planned Parenthood of MN/SD/ND, MN Safety Net Coalition, MN Association of Community Health Centers
FQHC	3	CUHCC, WSCHS, MACHC
Government Entity	1	MSCOD
Independent Clinic or Hospital	12	HCMC, St. Luke's, St. Cloud Medical Group, ACMC, Gillette Children's
Individual Patient/Consumer	5	
Integrated Health System	3	U of Minnesota Physicians, Employee and & Community Health Mayo
Local Public Health	3	Brown County, Otter Tail County, St. Paul/Ramsey County
Other	8	National Committee for Quality Assurance, MN- American Academy of Pediatrics
Patient/Consumer Advisory Group	2	MN Rural Health Advisory Committee, Community Health Awareness Team - Roseville
School or educational institution	1	University of St. Thomas

Appendix G: Health Care Homes by County and Region (As of 11/10/16)

County	Census 2010 Population	% of Population	Region	Total # of Clinics	# of Health Homes	% of Clinics Certified	County has at least One HCH	County with at least one clinic
Aitkin	16,202	0.3%	Northeast	2	0	0.0%	0	1
Anoka	330,844	6.2%	Metropolitan	20	18	90.0%	1	1
Becker	32,504	0.6%	Northwest	3	2	66.7%	1	1
Beltrami	44,442	0.8%	Northwest	3	2	66.7%	1	1
Benton	38,451	0.7%	Central	0	0	0.0%	0	0
Big Stone	5,269	0.1%	Southwest	3	2	66.7%	1	1
Blue Earth	64,013	1.2%	South Central	12	6	50.0%	1	1
Brown	25,893	0.5%	South Central	4	1	25.0%	1	1
Carlton	35,386	0.7%	Northeast	3	0	0.0%	0	1
Carver	91,042	1.7%	Metropolitan	15	5	33.3%	1	1
Cass	28,567	0.5%	Central	5	4	80.0%	1	1
Chippewa	12,441	0.2%	Southwest	3	0	0.0%	0	1
Chisago	53,887	1.0%	Central	5	5	100.0%	1	1
Clay	58,999	1.1%	West Central	6	5	83.3%	1	1
Clearwater	8,695	0.2%	Northwest	4	0	0.0%	0	1
Cook	5,176	0.1%	Northeast	1	1	100.0%	1	1
Cottonwood	11,687	0.2%	Southwest	6	5	83.3%	1	1
Crow Wing	62,500	1.2%	Central	10	5	50.0%	1	1
Dakota	398,552	7.5%	Metropolitan	36	21	58.3%	1	1
Dodge	20,087	0.4%	Southeast	1	1	100.0%	1	1
Douglas	36,009	0.7%	West Central	4	2	50.0%	1	1
Faribault	14,553	0.3%	South Central	3	1	33.3%	1	1
Fillmore	20,866	0.4%	Southeast	6	3	50.0%	1	1
Freeborn	31,255	0.6%	Southeast	2	1	50.0%	1	1
Goodhue	46,183	0.9%	Southeast	7	3	42.9%	1	1
Grant	6,018	0.1%	West Central	4	1	25.0%	1	1
Hennepin	1,152,425	21.7%	Metropolitan	142	98	69.0%	1	1
Houston	19,027	0.4%	Southeast	4	0	0.0%	0	1
Hubbard	20,428	0.4%	Northwest	2	0	0.0%	0	1
Isanti	37,816	0.7%	Central	1	1	100.0%	1	1
Itasca	45,058	0.8%	Northeast	8	2	25.0%	1	1
Jackson	10,266	0.2%	Southwest	4	2	50.0%	1	1
Kanabec	16,239	0.3%	Central	1	1	100.0%	1	1
Kandiyohi	42,239	0.8%	Southwest	4	2	50.0%	1	1
Kittson	4,552	0.1%	Northwest	2	0	0.0%	0	1
Koochiching	13,311	0.3%	Northeast	3	0	0.0%	0	1
Lac qui Parle	7,259	0.1%	Southwest	3	1	33.3%	1	1
Lake	10,866	0.2%	Northeast	2	2	100.0%	1	1
Lake of the Woods	4,045	0.1%	Northwest	1	0	0.0%	0	1
Le Sueur	27,703	0.5%	South Central	6	0	0.0%	0	1
Lincoln	5,896	0.1%	Southwest	4	0	0.0%	0	1

County	Census 2010 Population	% of Population	Region	Total # of Clinics	# of Health Homes	% of Clinics Certified	County has at least One HCH	County with at least one clinic
Lyon	25,857	0.5%	Southwest	5	5	100.0%	1	1
McLeod	36,651	0.7%	South Central	5	1	20.0%	1	1
Mahnomen	5,413	0.1%	Northwest	2	1	50.0%	1	1
Marshall	9,439	0.2%	Northwest	1	0	0.0%	0	1
Martin	20,840	0.4%	South Central	6	1	16.7%	1	1
Meeker	23,300	0.4%	South Central	5	4	80.0%	1	1
Mille Lacs	26,097	0.5%	Central	2	2	100.0%	1	1
Morrison	33,198	0.6%	Central	5	4	80.0%	1	1
Mower	39,163	0.7%	Southeast	5	1	20.0%	1	1
Murray	8,725	0.2%	Southwest	2	1	50.0%	1	1
Nicollet	32,727	0.6%	South Central	3	2	66.7%	1	1
Nobles	21,378	0.4%	Southwest	3	3	100.0%	1	1
Norman	6,852	0.1%	Northwest	3	0	0.0%	0	1
Olmsted	144,248	2.7%	Southeast	11	11	100.0%	1	1
Otter Tail	57,303	1.1%	West Central	7	4	57.1%	1	1
Pennington	13,930	0.3%	Northwest	1	1	100.0%	1	1
Pine	29,750	0.6%	Central	5	3	60.0%	1	1
Pipestone	9,596	0.2%	Southwest	3	0	0.0%	0	1
Polk	31,600	0.6%	Northwest	9	2	22.2%	1	1
Pope	10,995	0.2%	West Central	2	0	0.0%	0	1
Ramsey	508,640	9.6%	Metropolitan	68	48	70.6%	1	1
Red Lake	4,089	0.1%	Northwest	3	0	0.0%	0	1
Redwood	16,059	0.3%	Southwest	4	3	75.0%	1	1
Renville	15,730	0.3%	Southwest	4	0	0.0%	0	1
Rice	64,142	1.2%	Southeast	6	2	33.3%	1	1
Rock	9,687	0.2%	Southwest	1	1	100.0%	1	1
Roseau	15,629	0.3%	Northwest	3	0	0.0%	0	1
St. Louis	200,226	3.8%	Northeast	36	20	55.6%	1	1
Scott	129,928	2.4%	Metropolitan	11	7	63.6%	1	1
Sherburne	88,499	1.7%	Central	6	6	100.0%	1	1
Sibley	15,226	0.3%	South Central	5	0	0.0%	0	1
Stearns	150,642	2.8%	Central	24	18	75.0%	1	1
Steele	36,576	0.7%	Southeast	2	1	50.0%	1	1
Stevens	9,726	0.2%	West Central	2	1	50.0%	1	1
Swift	9,783	0.2%	Southwest	2	1	50.0%	1	1
Todd	24,895	0.5%	Central	6	4	66.7%	1	1
Traverse	3,558	0.1%	West Central	2	1	50.0%	1	1
Wabasha	21,676	0.4%	Southeast	5	1	20.0%	1	1
Wadena	13,843	0.3%	Central	2	1	50.0%	1	1
Waseca	19,136	0.4%	South Central	3	0	0.0%	0	1
Washington	238,136	4.5%	Metropolitan	19	18	94.7%	1	1
Watonwan	11,211	0.2%	South Central	2	0	0.0%	0	1
Wilkin	6,576	0.1%	West Central	0	0	0.0%	0	0

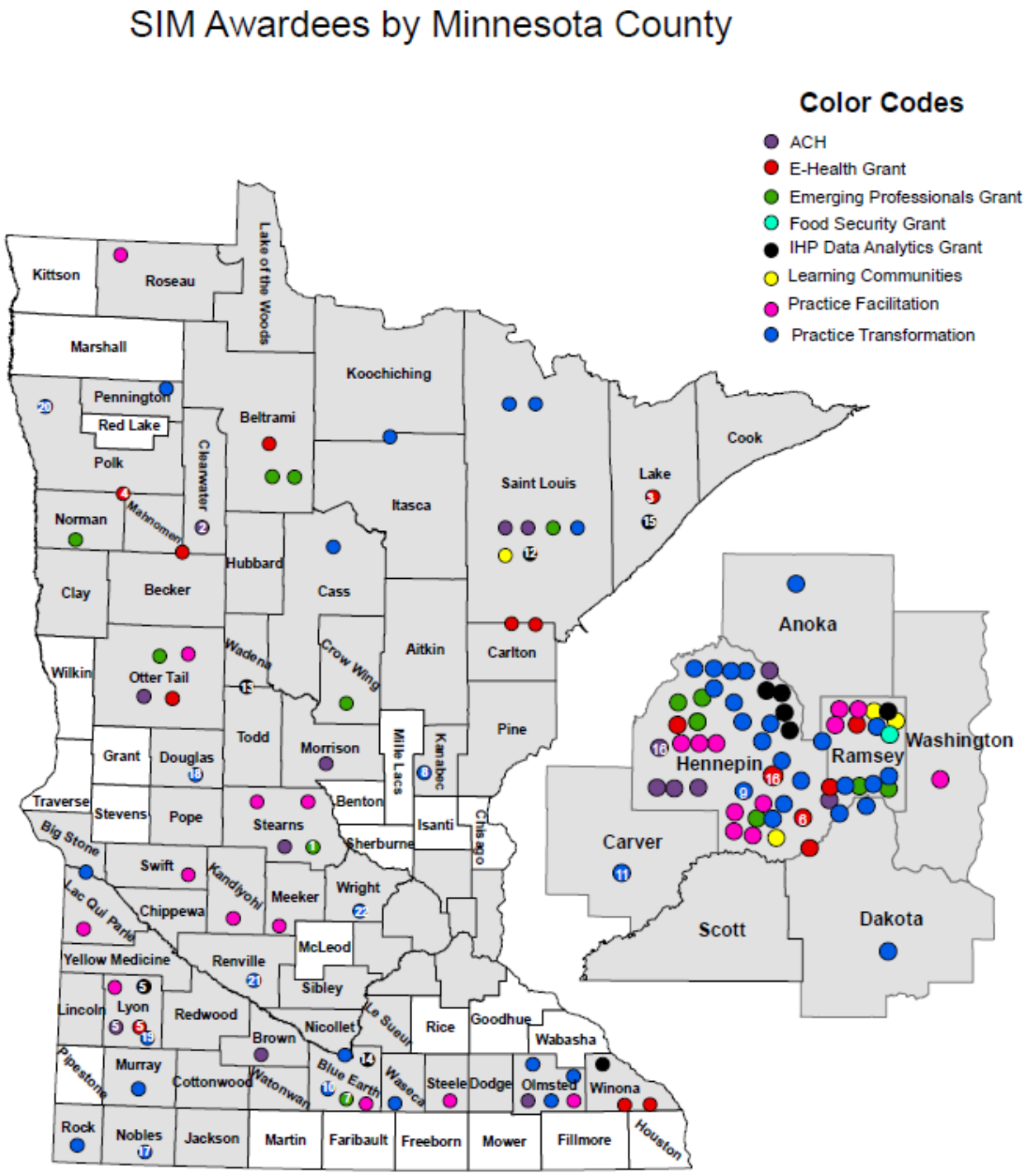
County	Census 2010 Population	% of Population	Region	Total # of Clinics	# of Health Homes	% of Clinics Certified	County has at least One HCH	County with at least one clinic
Winona	51,461	1.0%	Southeast	3	1	33.3%	1	1
Wright	124,700	2.4%	Central	10	8	80.0%	1	1
Yellow Medicine	10,438	0.2%	Southwest	4	2	50.0%	1	1

Appendix H: Counties with 0-1 Health Care Homes (As of 11/10/16)

County	2010 Population	% of Population	Region	Total # of Clinics	# of Health Homes	% of Clinics Certified	County has at least One HCH	County with at least one clinic
Aitkin	16,202	0.3%	Northeast	2	0	0.0%	0	1
Benton	38,451	0.7%	Central	0	0	0.0%	0	0
Brown	25,893	0.5%	South Central	4	1	25.0%	1	1
Carlton	35,386	0.7%	Northeast	3	0	0.0%	0	1
Chippewa	12,441	0.2%	Southwest	3	0	0.0%	0	1
Clearwater	8,695	0.2%	Northwest	4	0	0.0%	0	1
Cook	5,176	0.1%	Northeast	1	1	100.0%	1	1
Dodge	20,087	0.4%	Southeast	1	1	100.0%	1	1
Faribault	14,553	0.3%	South Central	3	1	33.3%	1	1
Freeborn	31,255	0.6%	Southeast	2	1	50.0%	1	1
Grant	6,018	0.1%	West Central	4	1	25.0%	1	1
Houston	19,027	0.4%	Southeast	4	0	0.0%	0	1
Hubbard	20,428	0.4%	Northwest	2	0	0.0%	0	1
Isanti	37,816	0.7%	Central	1	1	100.0%	1	1
Kanabec	16,239	0.3%	Central	1	1	100.0%	1	1
Kittson	4,552	0.1%	Northwest	2	0	0.0%	0	1
Koochiching	13,311	0.3%	Northeast	3	0	0.0%	0	1
Lac qui Parle	7,259	0.1%	Southwest	3	1	33.3%	1	1
Lake of the Woods	4,045	0.1%	Northwest	1	0	0.0%	0	1
Le Sueur	27,703	0.5%	South Central	6	0	0.0%	0	1
Lincoln	5,896	0.1%	Southwest	4	0	0.0%	0	1
McLeod	36,651	0.7%	South Central	5	1	20.0%	1	1
Mahnomen	5,413	0.1%	Northwest	2	1	50.0%	1	1
Marshall	9,439	0.2%	Northwest	1	0	0.0%	0	1
Martin	20,840	0.4%	South Central	6	1	16.7%	1	1
Mower	39,163	0.7%	Southeast	5	1	20.0%	1	1
Murray	8,725	0.2%	Southwest	2	1	50.0%	1	1
Norman	6,852	0.1%	Northwest	3	0	0.0%	0	1
Pennington	13,930	0.3%	Northwest	1	1	100.0%	1	1
Pipestone	9,596	0.2%	Southwest	3	0	0.0%	0	1
Pope	10,995	0.2%	West Central	2	0	0.0%	0	1
Red Lake	4,089	0.1%	Northwest	3	0	0.0%	0	1
Renville	15,730	0.3%	Southwest	4	0	0.0%	0	1
Rock	9,687	0.2%	Southwest	1	1	100.0%	1	1
Roseau	15,629	0.3%	Northwest	3	0	0.0%	0	1
Sibley	15,226	0.3%	South Central	5	0	0.0%	0	1
Steele	36,576	0.7%	Southeast	2	1	50.0%	1	1
Stevens	9,726	0.2%	West Central	2	1	50.0%	1	1
Swift	9,783	0.2%	Southwest	2	1	50.0%	1	1
Traverse	3,558	0.1%	West Central	2	1	50.0%	1	1
Wabasha	21,676	0.4%	Southeast	5	1	20.0%	1	1
Wadena	13,843	0.3%	Central	2	1	50.0%	1	1
Waseca	19,136	0.4%	South Central	3	0	0.0%	0	1
Watonwan	11,211	0.2%	South Central	2	0	0.0%	0	1
Wilkin	6,576	0.1%	West Central	0	0	0.0%	0	0
Winona	51,461	1.0%	Southeast	3	1	33.3%	1	1

There are 23 counties without HCH clinics.

Appendix I: Map of SIM Awards (As of 07/28/16)



This project is part of a $45 million State Innovation Model (SIM) cooperative agreement, awarded to the Minnesota Departments of Health and Human Services in 2013 by The Center for Medicare and Medicaid Innovation (CMMI) to help implement the Minnesota Accountable Health Model.

Note: Shaded counties represent areas served with SIM funded projects

Data as of July 28, 2016

Richard.Hermida@state.mn.us

Appendix J: Map of HCH Clinics 2016 (As of 11/10/16)