MINNESOTA
HEALTH CARE HOMES

Health Care Homes: Improving Health for All

Annual Report to the Legislature
May 2018

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

May 12, 2018

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 2017.

The HCH program took important steps in 2017 to advance program effectiveness by increasing the number of certified primary care clinics, identifying financial sustainability needs of HCHs. We also began the process of advancing and strengthening the certification standards so that care teams can positively impact health equity for populations experiencing disparities and address the social determinants of health and population health, with minimal provider burden related to program requirements. This work will continue in 2018, as we build on our nearly 10-year history of successful practice transformation.

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

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

Sincerely,

Jan K. Malcolm
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975

Executive Summary

> *"I have told everyone how helpful [care coordination] is. It takes a load off of your mind. I know that I can get my husband into the clinic right away if I need to so I don't have to worry." "I don't know what I would do without it (care coordination). It is so great. You can get information faster. You can set goals and take it from there."*
>
> *- Patient, Winona*

For most Americans, primary care serves as the entry point and touchstone of the health care system, delivering care for patients and families, with an emphasis on promoting access and managing chronic illness (PCPCC)[1]. Many people have regular access to a health care provider through their primary care clinic but still feel lost in the system, especially if they have more complex needs.

A Health Care Home is an innovative approach a clinic uses to deliver advanced primary care to patients. The primary care practice changes their traditional approach to organizing and delivering care and puts into place procedures for achieving a patient centered, high-quality, accessible, and efficient care delivery system. The HCH transitions the culture of a clinic from a purely medical model with a focus on treating illness to an enhanced focus on primary care with wellness, prevention, self-management and linkages with community services. It provides care that is respectful of and responsive to individual patient preferences, needs, and values ensuring that patient values guide all clinical decisions.

The HCH model emphasizes teamwork between the care team and patients, care coordination, communication and continuous quality improvement. It is a place where patients and their health care needs are the focus. The Health Care Home clinic team listens to patient's questions and help them make the right choices. Clinic care team members help coordinate needed care and support patients in navigating a complex health care system. The primary care team includes a patient, a doctor, a nurse practitioner or physician assistant and their team members, but also extends to others involved in the patient's health, such as family, friends, and community organizations.

For clinics, becoming a HCH leads to improved patient outcomes and satisfaction. It also gives them access to training and technical assistance to transform how they care for patients. Becoming a HCH also improves provider satisfaction with their work. More than 90 percent of HCHs who responded to a 2017 survey indicated that satisfaction of care team members has increased since they became a HCH; this is key to ensuring high-quality care, reducing physician burnout, and decreasing turnover.

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[1] https://www.pcpcc.org/sites/default/files/resources/The%20Patient-Centered%20Medical%20Home%27s%20Impact%20on%20Cost%20and%20Quality%2C%20Annual%20Review%20of%20Evidence%2C%202014-2015.pdf

Making a Difference: 2017 Health Care Home Program Outcomes

The HCH Program continued to take important steps to advance program effectiveness in 2017 by:

- Certifying 14 new clinics, ending 2017 with 368 Minnesota clinics certified as HCHs.
- Increasing the number of Minnesota counties with HCH clinics to 61.
- Providing capacity-building support to all uncertified Minnesota primary care clinics: nurse planners are actively working with 29 clinics to achieve certification.
- Working with the Minnesota Department of Human Services to certify Behavioral Health Homes.
- Seeking input for enhancing the HCH program to increase community linkages, advance health equity, and increase ability to impact social determinants of health.
- Awarding 56 Practice Transformation grants totaling $988,569 in 22 counties.
- Bringing practice facilitation services to 23 urban and rural agencies, with one third becoming Behavioral Health Home certified.
- Continuing support of 15 Accountable Communities for Health (ACH) through $5.5 million in grants, and supporting broader adoption of ACH models.
- 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, 10 webinars and a two-day conference for 362 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.
- In collaboration with the University of Minnesota, conducting a study on costs of care coordination, to understand the impact of patient factors and care team structure on costs.

Benefits of a Health Care Home

Since the HCH program was established in 2010, Minnesota has made great strides towards universal adoption of this best-practice model. More than half of Minnesota clinics are now certified as HCHs, demonstrating that they meet rigorous standards for patient-centered, team-based care. The results from independent evaluations of the program, national research and the work accomplished through SIM demonstrate that the HCH model improves access, patient outcomes, and provider satisfaction, and positions clinics to succeed in value based payment arrangements and in addressing health equity. Health Care Homes are a model for achieving primary care excellence so that care is received in the right place, at the right time, and in the manner that best suits a patient's needs. In 2018, the HCH program will continue to work towards its goals of giving all Minnesotans access to this model through certifying additional clinics as HCHs, while advancing the HCH certification standards to reflect changing expectations and opportunities for community partnerships, health equity, and improved population health.

Introduction

Health Care Homes: A Foundation for the Future

> *"HCH is a safety net for our patients and we are seeing our quality metrics associated with our attributed patient panel for Minnesota Community Measures (MNCM) improve because of care coordination. Blood pressures and A1C's are going down and with that there is greater buy-in."*
>
> *~Physician, Riverview Crookston Clinic, Polk County*

Minnesota's Health Care Homes (HCH) program, known nationally as a Patient Centered Medical Home (PCMH), has laid a strong foundation for the future and provides benefits for patients of all ages. Through a focus on redesign of care delivery and meaningful engagement of patients in their care, Health Care Homes is transforming care - and lives - for millions of Minnesotans. The name "Health Care Homes" acknowledges a shift from a purely medical model of health care to a focus on linking primary care with wellness, prevention, self-management and community services.

In Minnesota, a robust statewide effort by 3,871 certified HCH primary care clinicians, along with their teams and community partners, has strengthened the primary care foundation serving an estimated 3.9 million people. The current HCH certification standards put systems into place to provide patient centered, team based, coordinated care and since 2010 have demonstrated improvement in primary care health outcomes and cost savings[2].

During this last year the HCH team, the HCH Advisory Committee and its workgroups have moved forward with advancing the HCH program in the key strategic areas of Program Innovation; Financial Sustainability; Evaluation and Measurement; Communication and Partnerships; and Learning and Technical Assistance. These strategic areas are discussed in this legislative report along with HCH certification, practice transformation and care delivery innovation at the clinic and the community level.

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, experience, and value of care.

[2] http://www.health.state.mn.us/healthreform/homes/legreport/docs/hch2016report.pdf

Learning from Stakeholders

A statewide HCH Advisory Committee guides the work of the HCH program. This group guides MDH and DHS on the evolution of the HCH program, participating in and learning from the State Innovation Model grant initiatives, and developing strategic goals for the future. Members of the Advisory Committee include consumers, health care professionals, employers, researchers, health plan representatives, 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 in Appendix A.

In 2017, the HCH Advisory Committee, the Advisory Committee Work Groups and the HCH team identified a strategic agenda for the future work of the HCH program to achieve desired positive outcomes. The Advisory Committee, Advisory Work Groups and HCH team over the past year addressed the key priority areas of:

- Program Innovation
- Financial sustainability
- Learning and Technical Assistance
- Partnerships and Communication
- Measurement and Evaluation

The HCH Advisory Committee met quarterly in 2017. More information about the committee and its upcoming meetings is available on the HCH website.
http://www.health.state.mn.us/healthreform/homes/hchadviscomm/index.html

Care Delivery Innovation

> *"They (the physician and care coordinator) tell me things about my conditions, then we all discuss what is best for me to do. I feel I'm part of that decision. I like that they take care of my spiritual health too. I have goals and they encourage me all the way."*
>
> *~Patient, Sacred Heart Mercy Health Care Center, Jackson County*

Health Care Homes: Leadership for Primary Care Transformation

Minnesota's HCH program is closely aligned with state-specific initiatives and goals, seeking ongoing input from the primary care provider community, payers, patients and family members, health systems, and others. HCH staff conduct onsite certification and recertification visits to more fully evaluate implementation of the model and provide in-person consultation and technical assistance. The program also facilitates and provides ongoing technical assistance, information, and peer-to-peer learning through its learning collaborative to promote flexibility and innovation at the clinic level.

As a way of providing value to clinics that have chosen to become certified as HCHs, all of these services are provided to clinics at no cost, with the exception of a nominal registration fee for the annual HCH learning days event. National accrediting organizations such as the National Committee for Quality Assurance (NCQA) and The Joint Commission (TJC) offer recognition to clinics, but vary on requirements for site visits and renewal of recognition as well as the cost for attaining recognition from the organization.

Health Care Homes Certification

The Health Care Homes program recognizes clinics and clinicians that demonstrate clinical practice transformation in five key standards of primary care delivery: access and communication, registry (patient data), care coordination, care planning, and performance reporting and quality improvement (see Figure 1). HCH standards ensure clinics deliver care using a medical home model that puts the patient and family at the center.

Figure 1: Five Standards of Health Care Homes Program

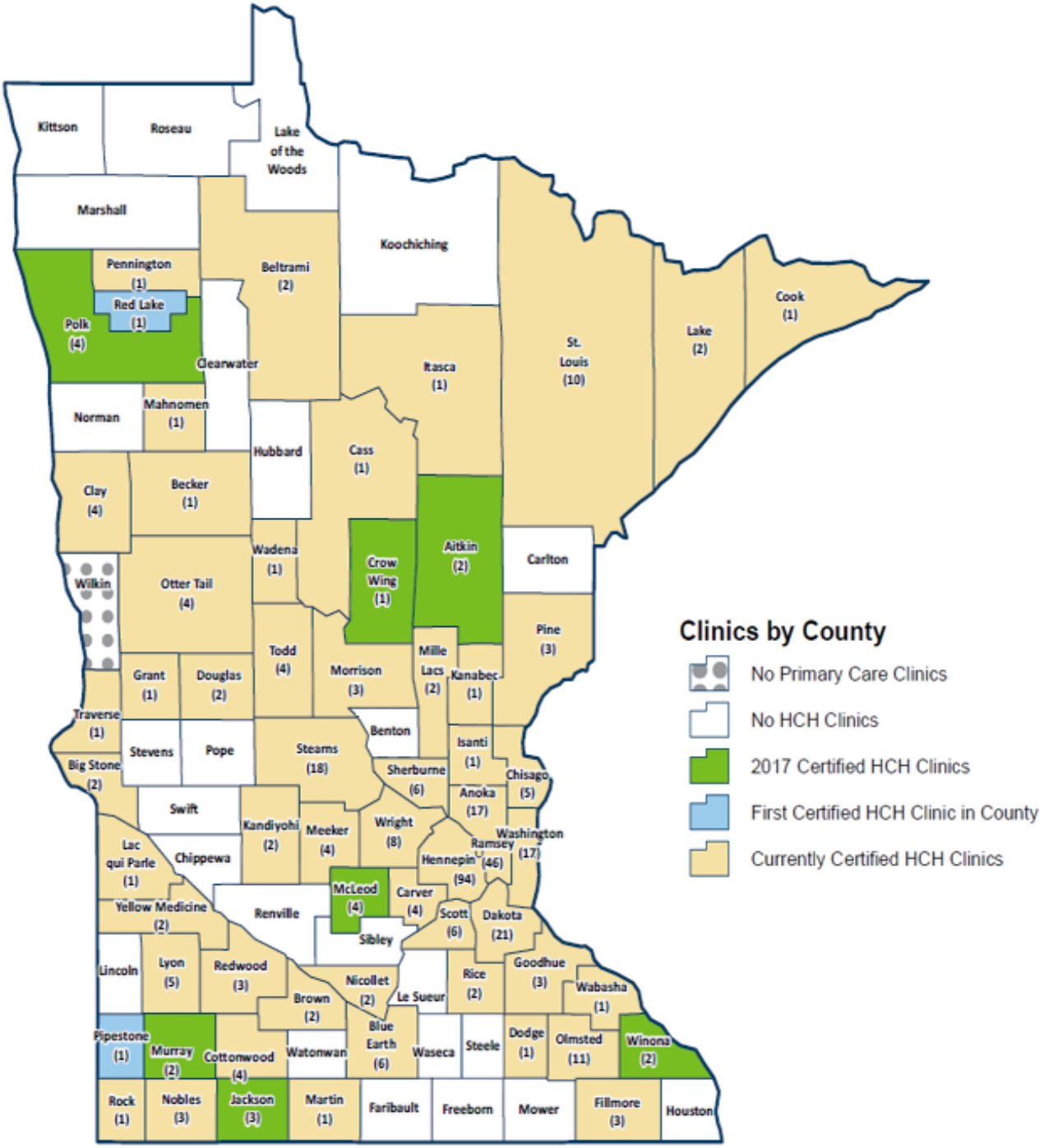
HCH program staff provide technical assistance and consultation to clinics working toward certification, and encourage innovation and implementation of practices that work best for the needs of the clinic and its patients.

Certification by the Numbers

The program certified an additional 14 Health Care Home clinics in fourteen counties across the state in 2017, for 368 certified clinics in Minnesota. The total number of certified clinics represents over half of the 692 primary care clinics in the state (see Figure 2). As of 2017, 61 of Minnesota's 87 counties have at least one certified HCH (70 percent). This geographic distribution of clinics throughout the state ensures access to patient centered, coordinated care for 3.9 million Minnesota

residents. Two of the newly certified clinics in 2017 are in rural counties that previously did not have a certified Health Care Home, Pipestone and Red Lake (highlighted in blue on Map 1). Also highlighted on the map in green are the seven counties with at least one additional clinic certified in 2017.

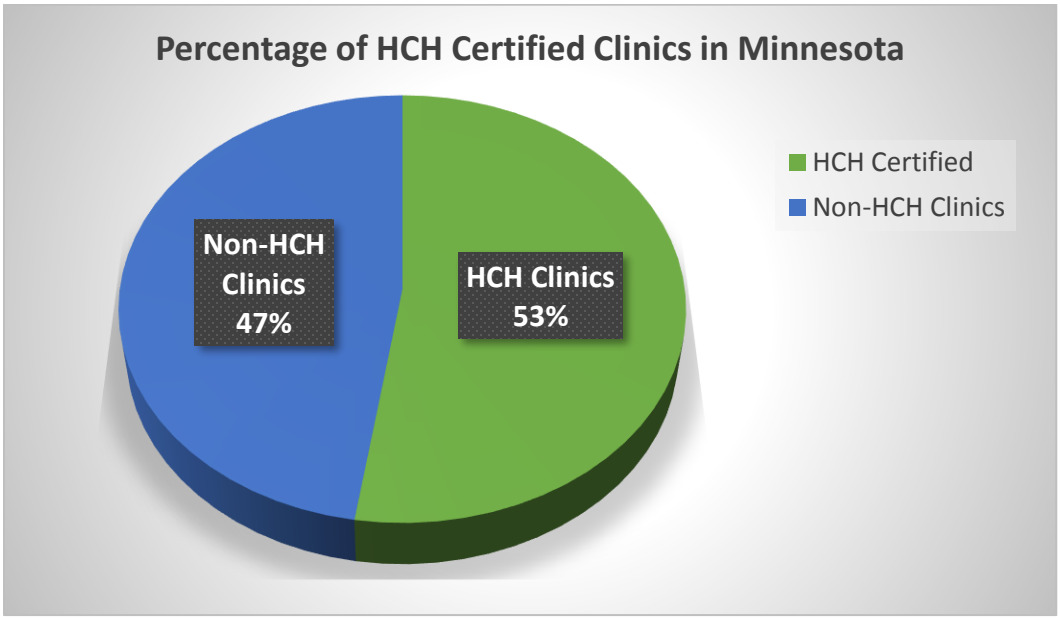
Map 1: HCH Clinic Locations by County in Minnesota



Map 1 also shows the one county in Minnesota (Wilkin) that does not have a primary care clinic within its borders. It is important to note, however, that people in these areas have access to primary care services in neighboring counties or a bordering state. An additional 20 clinics in border states of Iowa, North Dakota, and Wisconsin are certified as a HCH because they are part of a Minnesota healthcare system (see Appendix J). The Iowa Medical Assistance program requires primary care clinics to achieve patient centered medical home recognition and accepts Health Care Home certification in fulfillment of this requirement.

Overall, since 2010 when MDH certified the first clinics, 428 clinics have achieved certification as a HCH in Minnesota and bordering states. Forty clinics are no longer certified, due to clinic closures, organizational changes that disqualify the clinic from eligibility as a primary care provider, lack of resources for maintaining certification (time, money and staff), or changing recognition to a national organization due to having clinics located in multiple states.

Figure 2: Percentage of Primary Care Clinics Certified in Minnesota as of Dec. 2017



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

Capacity Building

The Health Care Homes program provides ongoing support to all primary care clinics in the state, certified and uncertified. Four registered nurse planners reach out to uncertified clinics to discuss the benefits of certification as a HCH and advise on strategies to increase capacity within the organization

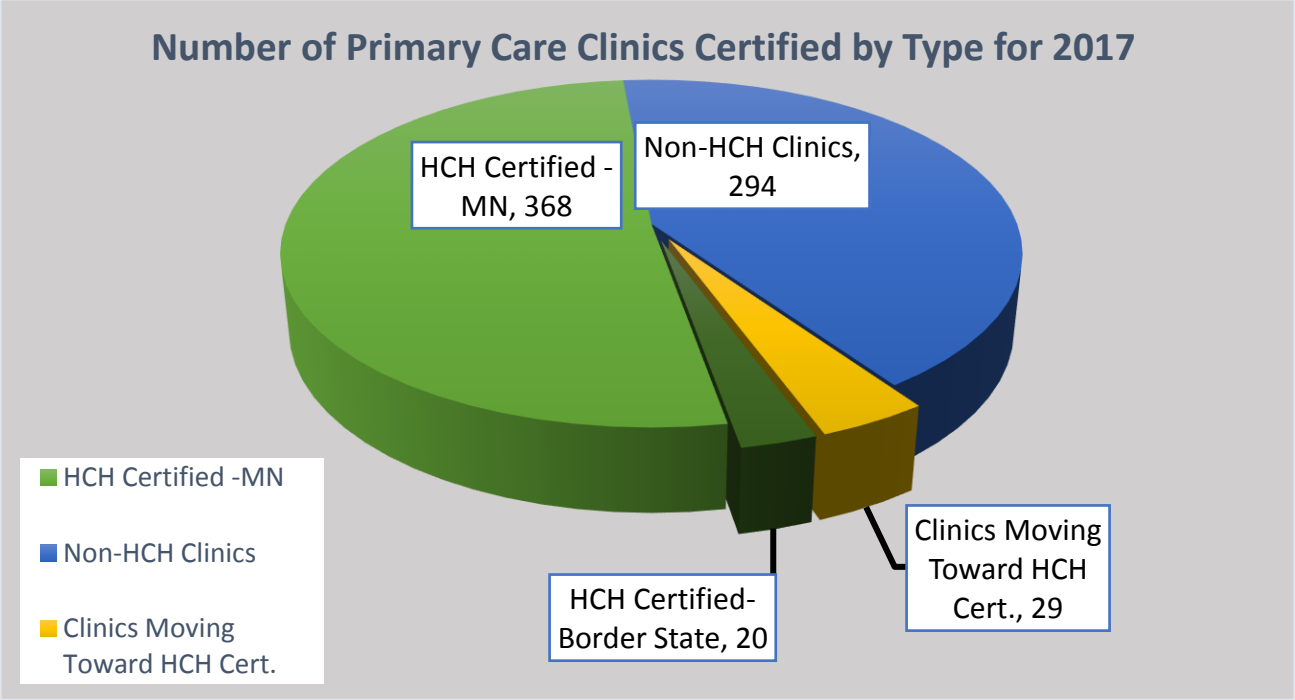
and prepare for certification. During 2017, nurse planners provided technical assistance via in-person meetings, phone calls, and emails to clinics and organizations on requirements and strategies for certification, and were successful in helping 14 clinics attain certification. An additional 29 clinics are moving towards certification.

Nurse planners also provide technical assistance to currently certified clinics as the clinic progresses toward recertification and transformation to improved care delivery. As part of the technical assistance process, nurse planners offer certified clinics or clinic systems an optional one-hour visit or phone call to answer questions and address clinic needs. Topics include orienting new staff to patient centered medical home concepts and reviewing steps for progression to recertification.

Other capacity building that nurse planners provide to help clinics achieve certification or expand certification to additional clinics within clinic systems includes technical assistance and support on:

- Care coordination models
- Strategies to ensure clinic health care professionals are working to the full potential of their license
- Patient risk stratification
- Quality improvement processes and goals
- Patient advisory committee development
- Billing and payment methodology for HCH care coordination services

Figure 3: Certification Status and Progress, 2017



Behavioral Health Home (BHH) Services

"I am really quite enthusiastic about broadening that kind of an approach, where care is coordinated across the whole person's health domain, not just mental health or chemical dependency but primary care. And then beyond that into areas like housing and all the other things that are important to a persons well being and quality of life. It's an opportunity to do things the right way. It's going to transform outcomes in the whole health care delivery system."

~ Northern Pines Mental Health Center, Todd County

Recognizing the successes and positive outcomes of HCH in Minnesota, the Minnesota Department of Human Services (DHS) identified a need for more intense, comprehensive services for those experiencing mental illness. In Minnesota, a 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.

Beginning July 1, 2016, behavioral health home (BHH) services are a Medical Assistance (MA) covered service in Minnesota, launched as a provision of the Affordable Care Act to serve the needs of complex populations covered by Medicaid. BHH services expand upon the concept of a HCH, building on its successes and expanding the concept to serve the whole person across primary care, mental health, substance use disorder treatment, long-term services and supports, and social service components (Table 1).

Table 1: HCH/BHH Comparison

HCH	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

There are currently 26 organizations certified to provide the service, geographically reaching most areas of the state. Implementation of BHH was in collaboration with HCH, with a mutual commitment towards behavioral health/primary care integration efforts. HCH nurse planners participate alongside BHH staff at site visits, bringing primary care expertise and community perspectives. Additional collaborative work includes:

- 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.
- Reducing duplication of effort for certified HCH clinics seeking BHH certification.
- Release of an RFP soliciting proposals for an Interagency Learning Liaison to work jointly with DHS and MDH to support providers in integration of primary and behavioral health and practice transformation.

Like HCH, capacity building, technical assistance, and a learning collaborative have been integral to implementing and sustaining BHH services. DHS collaborates with providers to inform ongoing delivery of services. DHS response to this feedback has informed policy changes, including those to the recertification process and the BHH certification standards. The BHH evaluation will be another important aspect of understanding the successes and challenges in implementing BHH services in MN.

Spotlight: Amherst H. Wilder Foundation Patient Story

A 32 year-old Hmong American diagnosed with Schizophrenia, currently living with his mother, and focused on maintaining a healthy lifestyle. Since he began receiving BHH services, he is no longer on any oral medication and is currently on IM injection every month, understands the importance of them. His insight into his illness has improved, and he continues working towards decreasing his overall anxiety and panic attacks. He is functioning well in the community with a part-time job and a lot of motivation to learn new things and takes online courses to help improve his working skills. He reports that he is grateful to see himself as a “normal” person like everyone else and be able to function independently. He’s very appreciative that the BHH navigator contacts him monthly to check in on him and provide services according to his needs/concerns.

Minnesota Accountable Health Model: Innovation in Care

> *"In the end, the ones who are going to benefit the most (from integrated care) are the consumers. And that is our goal – to provide the best care, with the best approach."*
>
> *~Hennepin County Medical Center (HCMC), Aqui Para Ti Program*

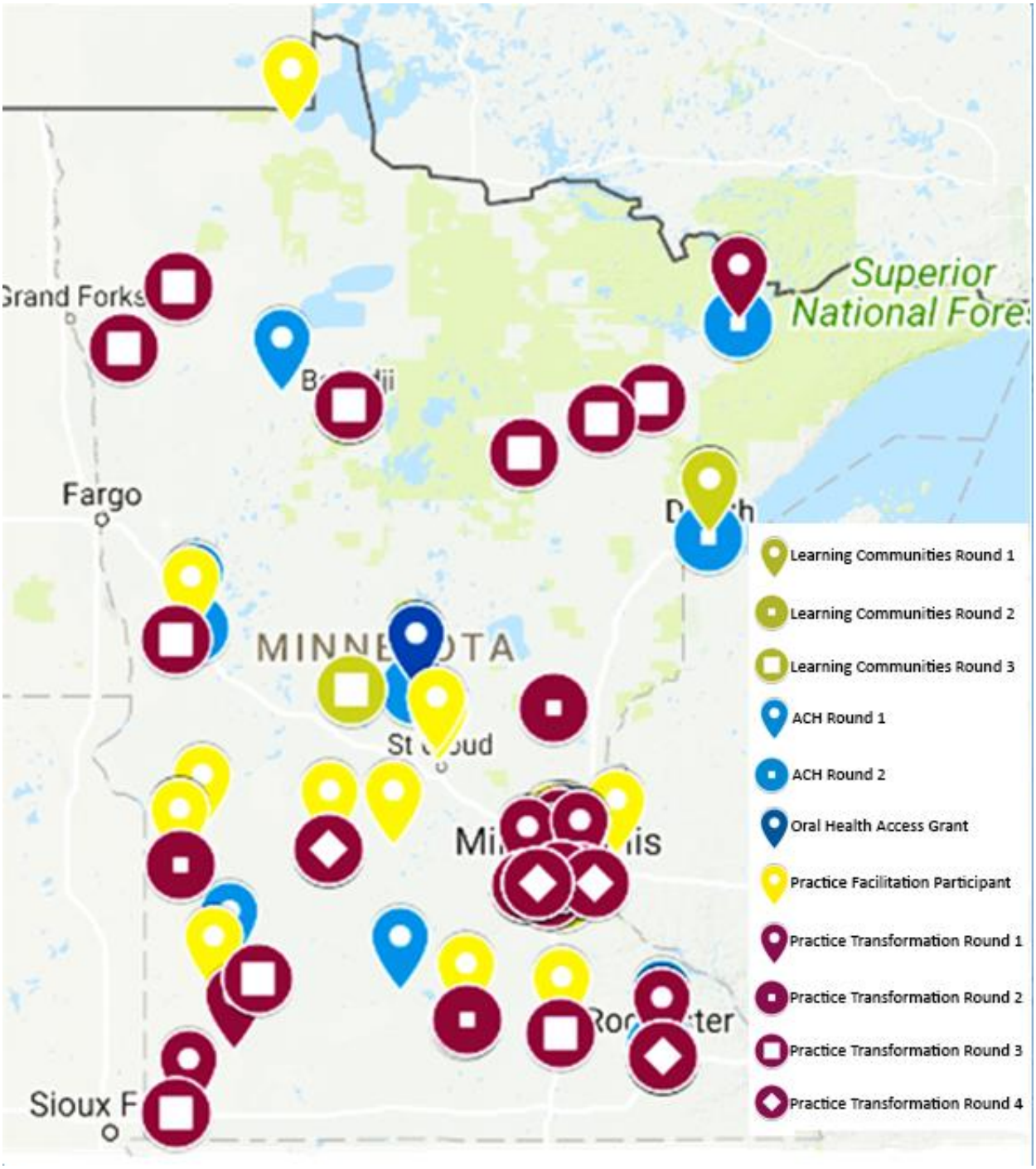
From 2013-2017, the Minnesota Departments of Health and Human Services were funded to implement the Minnesota Accountable Health Model through a $45 million testing grant from the Centers for Medicare and Medicaid Innovation (CMMI) as part of the State Innovation Model (SIM) initiative. The Minnesota Accountable Health Model framework is designed to improve health in communities, provide better care, and lower health care costs. It was built on the state's previously established service delivery and payment reform models in Minnesota, such as the Health Care Homes certification program, Medicaid ACO program, e-Health Initiative, Community Care Teams (CCTs), the Statewide Health Improvement Program (SHIP), Community Transformation Grants, and standardized quality measurement and reporting across payers.

Through the work of SIM, the HCH program was able to support the advancement of patient-centered, team-based care in Minnesota by supporting practice transformation efforts with funding through four rounds of Practice Transformation Grants, Practice Facilitation Grants, and three rounds of Learning Communities. This support was provided to primary care clinics, behavioral health organizations, social service providers, and community organizations across the state (See Map 2). In 2017, MDH was also able to award a grant to increase access to oral health and integration of care between a HCH and a dental provider, which has shown promise in the development of a successful approach.

The patient-centered, team-based care model was further supported through the development of the Minnesota Accountable Communities for Health (ACH) Model developed using the learnings from the Minnesota Community Care Team Pilot in 2011, which prioritized community-based care coordination and community collaboration.

For information on the grant programs and description of the programs, please see: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_Home

Map 2: Map of SIM Awards



Practice Facilitation Grants

The Practice Facilitation Grant Program funded two organizations in 2015, the National Council for Behavioral Health and the Institute for Clinical Systems Improvement, in partnership with Stratis Health (ICSI-Stratis Health), to provide practice facilitation services for primary care, behavioral health, and social service providers.

The original timeline for the grants was through 2016, however, with the approval of a no-cost extension from CMMI, the ICSI-Stratis Health grant continued through June 2017. ICSI-Stratis Health continued to work with five clinics who had received services in 2016 and three additional clinics in 2017. They continued to provide coaching, bi-monthly webinars, training sessions, and site visits to help agencies address their agreed upon goals. Practice facilitation contributed to improved care in these clinics as they formed change teams to integrate changed/improved workflows in their care delivery models.

ICSI-Stratis Health provided organizations with processes, education, tools, and resources to continue to build on the work completed in this project. A special project called “Prime the Pump” was developed by ICSI and offered in July through September 2017 to providers in the Baxter/Brainerd area, St. Louis Park, and the Redwood Falls area. The focus of the project presented quality improvement, and the unique role each staff person plays in the change process. The benefits of face-to-face teaching provided an opportunity to share across different clinics/organizations, and disciplines.

Some of the outcomes of practice facilitation included having staff work at the top of their license; reaching out to patients more effectively; increasing the comfort level of patients coming to the clinic; more follow-up with patients on referrals; and increasing the number of disciplines involved in a specific project.

Practice Transformation Grants

Practice transformation requires leadership commitment to support the involvement of staff time to focus on projects that will improve care delivery, improve access, and strengthen partnerships. Since 2014, MDH awarded 56 Practice Transformation grants, including 10 in 2017. Nine of the 10 grantees were behavioral health organizations working to improve access and/or integrate services, train staff, work towards behavioral health home certification, and strengthen their community partnerships. Outcomes from this grant cycle include:

- Improved staff capacity to address behavioral health concerns
- Development of direct secure messaging
- Stronger relationships with external stakeholders
- Behavioral health home certification
- Greater understanding of disability competent services.

Oral Health Access Grant

Unity Family Healthcare, affiliated with CHI St. Gabriel's Health, a certified health care home in Little Falls, was awarded an oral health access grant in 2017. The purpose of the grant was to integrate oral health preventive care within the primary care setting and improve access to oral health for underserved populations and those with chronic conditions in Morrison County. With grant funding, Apple Tree Dental (ATD) hired a care coordinator who worked with the Family Healthcare Center's health navigators and other members of the patient-centered medical home team to develop a bi-directional referral process for dental and medical information with the goal of electronic record exchange. This process will enable health care providers to better coordinate, exchange, and track oral and medical health information.

Spotlight: CHI St. Gabriel's Teams Up with Apple Tree Dental

The outcomes for this nine-month grant have been promising. Apple Tree Dental has moved into a permanent space on CHI St. Gabriel's Health campus, allowing for two days a week of oral health services, increasing from two days a month prior to the project. The increase in the number of days dental services are available allows for increased services for individuals with many barriers to care. Recently, a mother in Little Falls who is unable to drive due to vision problems was able to receive services for both herself and child. Previously it has been almost impossible to coordinate transportation with her child's programs. The mother was grateful that she did not need to find transportation and was able to stay in Little Falls and receive services.

Apple Tree Dental will continue providing dental services on the Unity Family Healthcare, St. Gabriel's campus in Little Falls, and is exploring availability of capital improvement funds. Unity Family Healthcare clinic, local public health and social services, Head Start and others continue to be committed to the integration of oral health with primary care delivery.

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. As part of its SIM work, MDH issued three rounds of Learning Community grant opportunities and awarded five grants. Topics included integration of behavioral health services for war-traumatized refugee populations, integration of pediatric primary care with behavioral health, integration of Community Health Workers (CHW) and Community Paramedics (CP) into Minnesota's health care delivery system, capacity building and quality improvement in rural practices, and the primary care public health partnership. The final Learning Community was awarded in 2017 and was supported by a state funded facilitator.

Morrison-Todd-Wadena County Community Health Board received the primary care public health partnership learning community grant for Todd County Health and Human Services to work with CentraCare Health at the Long Prairie Clinic. Staff from both agencies worked with a facilitator hired by MDH to work on strengthening their relationship through expanding understanding of each agency's role, capacity, and responsibilities, and developed an implementation plan with community partners. In developing this plan, they used community health needs assessment and primary care clinic data. This helped to identify the appropriate population and a greater understanding of available services offered by Todd County Health and Human Service agency and the Long Prairie Clinic. Efforts are underway to include the local chamber of commerce and other businesses to address the high incidence of tobacco use in the community.

Todd County Health and Human Services will continue this effort through a five-year Tobacco Free Communities grant, the only public health agency to receive this grant. There continues to be a strong commitment to continue to address the high tobacco use among youth and low-income community residents.

Accountable Communities for Health (ACH)

Fifteen Accountable Communities for Health (ACH) projects received approximately $5.5 million as part of the ongoing effort to ensure that every Minnesotan has the option to receive team-based, coordinated, patient-centered care that increases and facilitates access to primary care, behavioral health care, long-term and post- acute care and social services. The ACHs were funded to focus on the social needs of patients and to expand clinical care integration across a range of providers, guided by local leaders and community members with support of an accountable care organization. Certified Health Care Homes were an integral part of the ACH model, using the foundation of patient-centered, team-based care to strengthen the ACH model.

ACHs brought 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 and establish priorities for population health. An evaluation conducted by the University of Minnesota's State Health Access Data Assistance Center (SHADAC) identified the following benefits of working in ACHs: the development of valuable relationships; gaining new useful knowledge about services, programs, or people; and the development of new skills. Providers reiterated these benefits through an ACH Provider Survey when asked specifically about ACH care/service coordination.

Key outcomes for ACHs include increased coordinated and patient-centered care resulting in improved quality of care. Seventy-eight percent (78%) of ACH Provider Survey respondents stated that care/service quality was somewhat or much improved as a result of ACH care coordination services. Quality indicators mentioned most often by ACH interviewees included: care becoming more patient-centered, improved patient/client experiences and satisfaction, and improved

management of care transitions and chronic conditions. Among ACHs collecting data on utilization and cost there was a decrease in ED visits and costs.

In 2017, MDH awarded an additional $425,000 to six ACH projects, to allow them to expand their initial work through a nine-month expansion grant of $75,000 each. ACHs used these supplemental funds to build and strengthen their infrastructure, continue the development of services and supports that have a positive effect on health, and promote sustainability. Priority areas for the expansion grant funding included:

1. Involvement of an Accountable Care Organization (ACO) partner to collect, analyze, and report on utilization and quality data for attributed members of the ACH target population
2. Expansion of ACH services, supports, and partnerships
3. Increased capacity to exchange information between ACH partners
4. The use of data or screening tools to address social determinants of health.

Spotlight: Morrison County Takes on Opioid Addiction with Community Partners

The Morrison County Community Based Care Coordination initiative has created a care coordination model to facilitate excellence in controlled substance care. The partnership includes CHI St. Gabriel's Health (HCH certified and ACH lead agency), South Country Health Alliance (the insurance plan for Medicaid in Morrison County), and Morrison County Public Health and Social Services. The partnership formed to address the concern about narcotics use in the community, as evidenced by the number of Emergency Room (ER) visits for therapeutic drug monitoring and high numbers of Medicaid patients with eight or more narcotic prescriptions.

The partnership has evolved to include law enforcement, local pharmacies, the school district, and a substance use prevention coalition. A Prescription Drug Task Force of stakeholders meets monthly to facilitate further collaboration beyond the walls of health care. Early indications are showing positive outcomes, including reductions in Medicaid claims paid for narcotics.

ACH Next Steps

The individual ACHs have had varied success in the implementation of the ACH model, and the continuation of Accountable Communities for Health projects will vary. The most successful ACH projects were able to demonstrate reduction in the total cost of care for their target population that propelled their ongoing partnership beyond the Minnesota Accountable Health Model. Other ACHs were able to demonstrate that improved methods of care management lowered unnecessary use of high cost settings or services and/or increased the use of primary and behavioral health services.

While not all of the ACHs will be able to continue all aspects of their work post-SIM funding, a number of ACHs will continue to fund the coordinator position to maintain the partnership of the organizations. Some ACHs will continue to address their target population's needs by implementing service agreements and other informal or formal partnerships to exchange necessary information in

normal or emergency situations or to warmly hand off clients between partners or providers. The use of data to measure and guide staff time and resources is very important, and many of the ACHs implemented care delivery models that moved towards focusing on the Medicaid population because the Integrated Health Partnership program data can better show progress towards achieving the quadruple aim or the triple aim of health equity. Leveraging the data and systems of an ACO will be one important step in continuing the ACH efforts.

A total of 27 HCHs participated in ACHs, and it is clear that their participation contributed to the success of ACHs in a number of ways, by helping them to build the partnerships needed to better serve the whole person. The foundation of HCH certification, with its focus on patient and family engagement and the understanding that a clinic alone does not produce health, was a key factor in accelerating progress for ACHs that included one or more HCHs. As the ACH or similar models move forward, continuing to support a strong HCH foundation will be critical.

Cost of Care Coordination Study

As part of the state's SIM funding, in 2017 the Minnesota Departments of Human Services and Health contracted with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota to conduct a study of the costs for care coordination for HCH clinics. SHADAC used a case-study approach, and focused on six Minnesota HCH certified primary care clinics in both rural and urban areas. The estimated costs of care coordination were based on a list of activities developed in collaboration with certified HCH clinics, and included personnel and non-personnel costs related to fulfilling HCH care coordination requirements.

Key findings of the study included that care coordination costs varied significantly across study sites, with monthly costs from $1 to $12 per adult. The variance in costs is a result of the number and type of staff involved in care coordination activities and the difference in wages of staff performing care coordination. Patients with complex chronic conditions or those impacted by social determinants of health require a greater amount of time for care coordination, and care coordinators with higher education and credentials increase the cost.

The limitations of the study do not allow the information to be used as a basis for reimbursement, but the results do match anecdotal information from clinics to HCH staff and provide important insight into both the different ways that HCHs structure their care coordination teams and the individual and organizational factors that drive care coordination costs The study also reinforced the value that HCH clinic teams feel that HCH certification offers to patients and family members, as well as to clinic staff.

HCH Program Key Strategic Areas

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

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

Program Innovation

"(HCH) Need(s) to promote the implementation of expanded care teams that include the "full range" of providers. More emphasis on active partnerships between clinics and all relevant social service providers. Staff from social service agencies should be part of the care team."

~PI Work Group Member, 2017

Clinic and consumer engagement and involvement are integral to program operations and development as demonstrated by the committees, workgroups, site visit evaluators, and others who provide ongoing guidance to HCH. Far from being a static program, during the eight years of operation HCH has solicited input from a broad spectrum of stakeholders and consistently monitored and responded to national and state trends in health care delivery.

However, in Minnesota and nationally, the landscape for health care payment and delivery is changing very rapidly, and it is important that the HCH program keep pace with these changes in order to continue momentum in health reform and HCH primary care transformation. Payment models are becoming increasingly value based, and a foundational infrastructure that provides accessible, effective, team-based integrated care within a health care system is essential to successful participation in these models. The Joint Principles of ACOs[3] states that primary care should be the foundation of any ACO and the recognized patient and/or family-centered medical home or health

[3] American Academy of Physicians, American Adademy of Pediatrics, American College of Physicians, American Ostepoathic Association, 11/19/2010. https://www.acponline.org/acp_policy/policies/joint_principles_accountable_care_organizations_2010.pdf accessed 12/13/2017.

care home is the model that all ACOs should adopt for building their primary care base. The Vermont Blueprint for Health initiative has medical homes at the foundation of regional community health teams across the state as do many other state health care innovation models.

The HCH program is actively working with clinics and other organizations and stakeholders to recognize the innovation and high quality of care delivered around the state and to determine how best to demonstrate that value. With help from the HCH Advisory Committee and Program Innovation and Financial Sustainability Workgroup members, Department of Human Services, clinics, health systems, patients, family members, and other stakeholders, the program has been making important strides in 2017 towards its goals to:

1. Strengthen clinic-community linkages, population health, and health equity
2. Assist clinics in preparing for value-based care.
3. Support health information exchange (HIE) to improve secure data sharing to support coordinated care across the continuum.
4. Align with existing and emerging models of care delivery.

The Program Innovation workgroup includes rural and urban clinic/organization representation. Members reflect an array of clinic types and stakeholders - certified and uncertified, quality improvement, community entities, and Department of Human Services. The Program Innovation Workgroup met five times during 2017, providing valuable clinic, community, and stakeholder lenses to current and future care delivery models in Minnesota.

Outcomes

- Collaborated on opportunities to advance and strengthen HCH standards
- Reviewed and compared programs, research, best practice models, innovation, and experiential knowledge
- Provided input through roundtable-driven discussion
- Drafted concepts for potential enhancements to certification standards, including new levels of progression for HCH certification, to advance HCH program goals

Next Steps

- Recommendations for modifications to the HCH Administrative Rule to enhance HCH standards.
- Consideration and alignment with other state and national initiatives, and the Advisory Committee and work groups.
- Ongoing review and recommendations for quality improvement of HCH processes, website, and other program features.

Financial Sustainability

> *"Social determinates of health are a worthwhile investment of our dollars, it makes good business sense."*
>
> *~Mayo Clinic Community Health Staff, Olmsted County*

The purpose of the Financial Sustainability Work Group is to promote financial models that sustain primary care transformation, increase community partnership, improve population health, support provider resiliency and align with emerging state and federal models for value-based or alternative payment. The workgroup advises on:

- The development of initiatives to support financial sustainability
- Policies and procedures that influence financial sustainability.
- Encouraging alignment of payment models to minimize additional burden on primary care clinics.

Goals for the workgroup include:

- Building a coalition with payers and purchasers by January 2019 with the purpose of developing approaches to financially support Health Care Homes.
- Developing a population health payment model.
- Conducting an environmental scan of financial initiatives at the national, state and community levels.
- Ensuring that payers and stakeholders understand the benefits and costs of HCH certification.

One source of data on HCH financial sustainability is through periodic assessment of the volume of claims submitted to the Medicaid program for care coordination. Analysis of these data show that submission of HCH care coordination claims peaked in 2014.

While there was an increase in the number of HCH claims submitted throughout 2016 and into the first quarter of 2017 as compared to the downward trend seen in the second half of 2014 and into early 2016 (see Figure 4), these claims came from fewer billing entities (see Figure 5). In the first six months of 2017, 32,589 finalized claims for 8,456 Minnesota Health Care Program beneficiaries totaling $670,215 have been paid through HCH claims by DHS or the Medicaid Managed Care Organizations. DHS and the Medicaid Managed Care Organizations have paid $6,485,293 between January 2013, when HCH care coordination payments first became a billed service, and June 2017 for Minnesota Health Care Program

beneficiaries. 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.

Care Coordination Payments

Figure 4: Volume of HCH Claims from Public Health Care Program Members

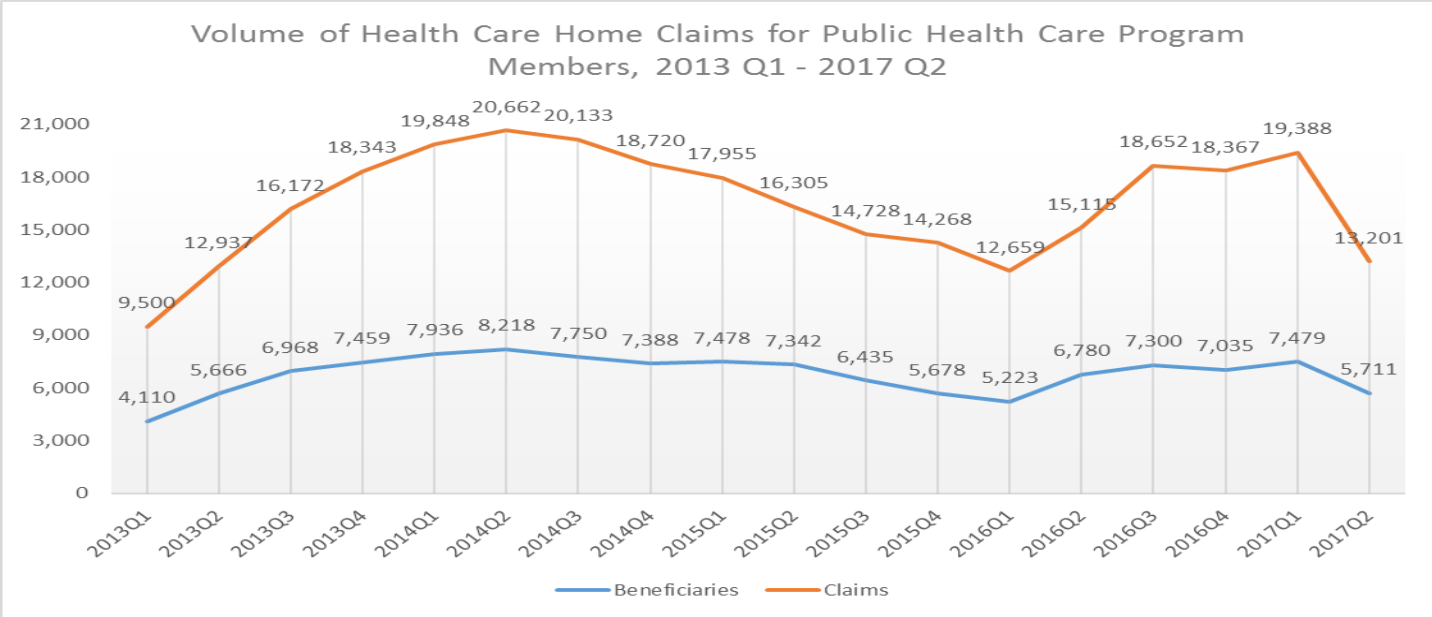
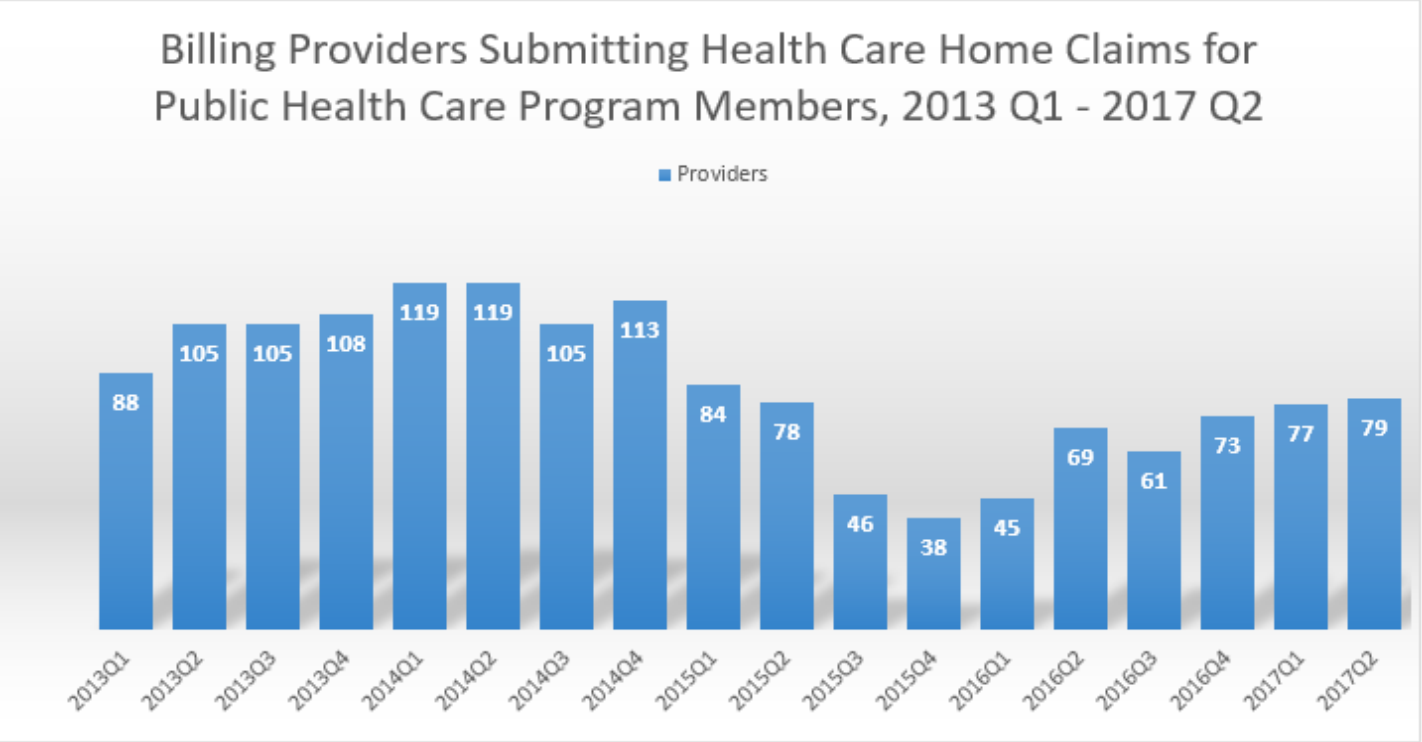


Figure 5: Providers Submitting HCH Claims for Public Health Care Program Members



Another way providers work to make their care coordination efforts financially sustainable is through participation in value-based arrangements such as the Integrated Health Partnership program. Although the number of HCHs participating in these arrangements across the market are not known, IHP participating providers included 163 HCHs in 2016 and 193 HCHs in 2017. Over the four years for which shared savings settlement information is available (2013-2016), $70,473,494 in shared savings payments have been made to participating providers.

Outcomes

The financial sustainability workgroup had a productive year, with efforts on many fronts to further strengthen the short and long-term financial sustainability of Health Care Homes. Among the workgroup's accomplishments:

- Strengthening the importance of the HCH care delivery model for employers and their self-insured population. The Minnesota Health Action Group (MNHAG) was invited to participate in the workgroup, as a representative of a group that convenes employers around health care related issues.
- Obtaining letters of support for changing and improving reimbursement for Health Care Homes services from the Commissioners of MDH and DHS.
- Strengthening links between Health Care Homes and the DHS ACO model, Integrated Health Partnerships (IHP). Financial Sustainability Workgroup members provided feedback to DHS

about joint communications involving HCH and IHP with the goal to make HCHs aware of IHP as an efficient option for obtaining Medicaid reimbursement for care coordination.

- Surveying and meeting with members of the Minnesota Council of Health Plans to discuss how they view the value of HCHs and how collaborative efforts could be used going forward to improve financial sustainability for certified clinics and provide patient centered care to improve quality, cost and patient experience.
- Exploring collaborative efforts around financial sustainability with multiple entities in order to identify and strengthen areas of cooperation, building business cases to support Health Care Homes.

Next Steps

The next steps for the Financial Sustainability Workgroup include:

- Working to better engage employers and their self-insured population.
- Ongoing development of business cases to demonstrate HCH value to different audiences.
- Ongoing development of strategies to improve reimbursement opportunities for HCH certified clinics

Learning

"I like the tools that were shared and I will be using them in the future."

~ 2017 Learning Days participant

A HCH statewide learning collaborative is required by Minnesota Statutes, Section 256B.0751. The learning collaborative was established in 2008 to provide resources for primary care clinics engaged in HCH certification and recertification. Through the learning collaborative, clinic staff and other professionals can participate in monthly webinars, learning communities, and annual in-person learning days conference. Learning collaborative activities focus on the opportunity for participants exchange information, enhance understanding of quality improvement and best practices for health system redesign, using face-to-face and virtual learning opportunities.

Learning Activities

In 2017, the HCH learning collaborative was supported by SIM funds and continued offering activities to facilitate primary care transformation for health providers and community partners. The annual statewide Learning Days conference, held in April in St. Cloud, Minnesota, provided an excellent forum for peer to peer learning, along with a series of webinars offered throughout the year. The results of these efforts are summarized under Outcomes in Table 2.

The HCH program also began developing a Learning Management System (LMS) to deliver learning resources in an accessible online environment that aligns with HCH program goals across a wide spectrum of HCH stakeholders.

This work was guided by the Learning and Technical Assistance Work Group, a team of community members with expertise in adult learning and learning management systems. This group studied data collected on HCH learning since the program began and applied expertise and best practice to assist the HCH staff with a learning strategy for the future in an LMS environment.

Outcomes

The work of the Learning and Technical Assistance work group is documented in a report and recommendations on the following deliverables:

- Evaluation of past learning events
- LMS infrastructure design
- E-Learning instructional design and evaluation
- Content curation for the LMS
- 2018 learning strategy and delivery system

Work group recommendations have been applied as the HCH staff began building the LMS and developing content in preparation for a 2018 launch. The plan and recommendations will guide ongoing learning collaborative activities.

Additional detail about HCH learning activities offered in 2017 is in Table 2 below.

Table 2: Learning Collaborative Activities 2017

Topic	Activity	Month	Registered
Our Health Care Home Journey	Webinar	January	106
Engaging Community Paramedics and Pharmacists in Self-Measured Blood Pressure Monitoring Loaner Programs – Challenges and Successes	Webinar	March	100
2017 HCH/SIM Learning Days Conference: Our Journey Toward Accountable Health	Statewide Conference	April	362
Using Prediabetes and Hypertension Change Toolkits in the Context of Improving Quality of Care	Webinar	May	40
Check Up from the Neck Up: Assessing Cognition in Older Adults	Webinar	June	200
Using Appointment Reminders to Reduce Clinic No Shows	Webinar	September	24
Partnering with Public Schools to Keep Kids Healthy and Support Learning	Webinar	October	72
Using Community Health Workers to Address Social Determinants of Health in Public Housing	Webinar	October	90
Developing a Community Based Tobacco Cessation Program: Lessons Learned from the Primary Care-Public Health Learning Community	Webinar	October	59
Integrating Diabetes Prevention into Everyday Practice	Webinar	November	84
Integrating Oral Health and Primary Care	Webinar	Novenber	100
Improving Asthma Management in Robbinsdale	Webinar	December	103

Next Steps

In 2018, MDH will implement an accessible and robust online learning system to strategically meet the needs of HCH stakeholders at all levels of learning through a variety of learning modalities based on best practice for adult learners. The new system will build on past successes and add new components to increase opportunities for peer-based and applied learning.

The Learning and Technical Assistance workgroup will continue its work, shifting its focus from planning to implementation by testing rollout of the new learning system, providing support as new processes are developed for content development and curation, identifying opportunities for improvement, and monitoring feedback to ensure that the HCH program continues to provide value to its stakeholders.

Partnerships and Communication

"I am thankful that my daughter and family have someone we can rely on for care coordination services. My questions are always answered and when my daughter has urgent needs, the first thing that comes to my mind is to come to the clinic to help problem solve."

~Parent with Special Needs Child, Community University Health Care Center (CUHCC), Twin Cities

The goals of the HCH program cannot be realized without the participation and understanding of various stakeholder groups such as MDH partners, professional organizations, advocacy groups, patients and their families, and social service and other community organizations. After eight years, there continues to be a need to educate the general public and other partners about the HCH initiative to enhance understanding on how they can become partners in care, learn ways to better manage and improve health, and access care in the right place at the right time.

Communication goals for the HCH program include:

- Evaluate the effectiveness of the communication plan.
- Track and measure partnerships and the effect on clinic partners.
- Assess the effectiveness of education with patient and community partners.

Outcomes

The HCH Partnerships and Communication workgroup is comprised of communication experts, MDH staff, clinic representatives, and external stakeholders. The actions the work group has taken this year involve the finalization of an overall communication plan that is being used as the basis for developing media campaigns. Most 2017 communications activities were targeted at health care providers, community partner organizations, patients and policy makers; 2018 communications activities will include an increased focus on communications aimed at or developed for patients and certified and non-certified providers.

Media Engagement:

- Expanded social media outreach highlighting the certification of clinics, clinic success stories, and connections between the HCH program and other health-related topics using Facebook and a Twitter (#MNHealthCareHomes).
- Created a "Spotlight" page on the HCH website that represents the wide array of clinic types, geographic areas, innovative tools, creative strategies, and community partnerships that have improved the health and well-being of the population served.
- Posted 10 YouTube videos through the MDH channel that showcase HCH clinic providers and staff discussing the important elements of the program related to care coordination, community partnerships and individual successes.
- Started a quarterly HCH online newsletter.

Next Steps

The communication efforts will continue to focus on expanding and improving the outcomes from the previous year. Social media, provider and patient outreach will continue to highlight the importance of the HCH model and how it relates to other health-related areas throughout the state. In 2018, the workgroup's activities will include:

- Developing a patient empowerment campaign that informs patients of what HCH clinics provide in terms of care coordination, care planning and access.
- Creation of a story template and process for collecting stories from HCH clinics that can be published in smaller newspapers and radio outlets to counties, in primarily rural areas, that do not have a certified HCH clinic.
- Measuring the impact of media outreach by recording the number of readers/listeners that each publication reaches. MDH will track this strategy geographically to determine that media outreach is going to counties where there are no HCH clinics and throughout all regions of Minnesota.

Spotlight Story: Southside Community Health Services

To align with their vision to be an exceptional community health care model that sets the standards for wellness, Southside Community Health Services recently implemented a new "Garden Produce Share Program." This program provides fresh produce and targeted health education through the clinic to help patients/families improve overall health and decrease the effects of diabetes, obesity and hypertension. Participants receive a weekly box of fresh produce and track their health progress through the growing season. At the end of the season, they will measure health results of those enrolled in the program through clinical health screenings and survey data, and measure costs to establish a future business case.

Measurement and Evaluation

"It is all transparent, we see one another's measure results, there is healthy competition, but more than that, we are able to replicate what is working well."

~ Chief Medical Officer, Riverwood Clinics- Aitkin, Garrison and McGregor

The HCH program requires program evaluation and certified clinic benchmarks to ensure HCH clinics and the program are making progress towards their intended purpose of creating community linkages that impact the social determinants of health, improving health disparities, and impacting health outcomes.

The measurement environment is changing in Minnesota and nationally. Various initiatives require different measures and these requirements cause burden at the clinic level. There is a need for alignment and evaluation of the current HCH measure requirements to ensure measures are meaningful and represent the goals of the program, particularly as it continues to evolve.

Meaningful goals related to HCH program measurement:

- Benchmarking measures align with other initiatives.
- Clinic partners' feedback on the usefulness of benchmarking measures.
- Creating mechanisms to evaluate the program's impact on population health, equity, and triple aim.

Spotlight: Pine and Kanabec County FirstLight Health System transform care delivery

FirstLight Health Systems serves as a powerful success story of care delivery transformation advanced through the State Innovation Model (SIM) grant and guided by strong internal leadership. The grant goals aligned with those of FirstLight culminating in the achievement of MDH Health Care Homes Certification in June of 2016, which addressed the grant's goal to provide integrated, accountable care using an innovative model, responsive to local health needs. The grant's project team met consistently with their leadership team and their committed and engaged patient advisory council. This work is supported by registries that proactively track and manage care. At the MDH Certification site visit the CEO shared, "HCH formalizes the work and brings about system integration. We lived out the integration process and overcame perceived barriers of this transformation through continual conversations." The grant and HCH certification fostered alignment of competing quality metrics. This work helped the clinics and organization to realize a measurable impact through rapid cycle process improvement. FirstLight clinics credit the SIM Practice Transformation Grant with quality improvements specific to patient experience in their care transitions.

Outcomes

Over the course of 2017, MDH has taken a number of important steps to address strategic goals related to measurement and evaluation. MDH established a workgroup that includes stakeholders from a variety of research and clinic backgrounds. This workgroup is working to understand how HCH measures align with state and national PCMH measures.

A major focus has been to address the quadruple aim of healthcare reform, which includes how providers and clinic staff are satisfied in a HCH setting along with goals related to cost, quality and patient experience of care. For the first time in 2017, MDH staff developed survey questions based on this focus and built them into the recertification process to reduce measurement burden for clinics.

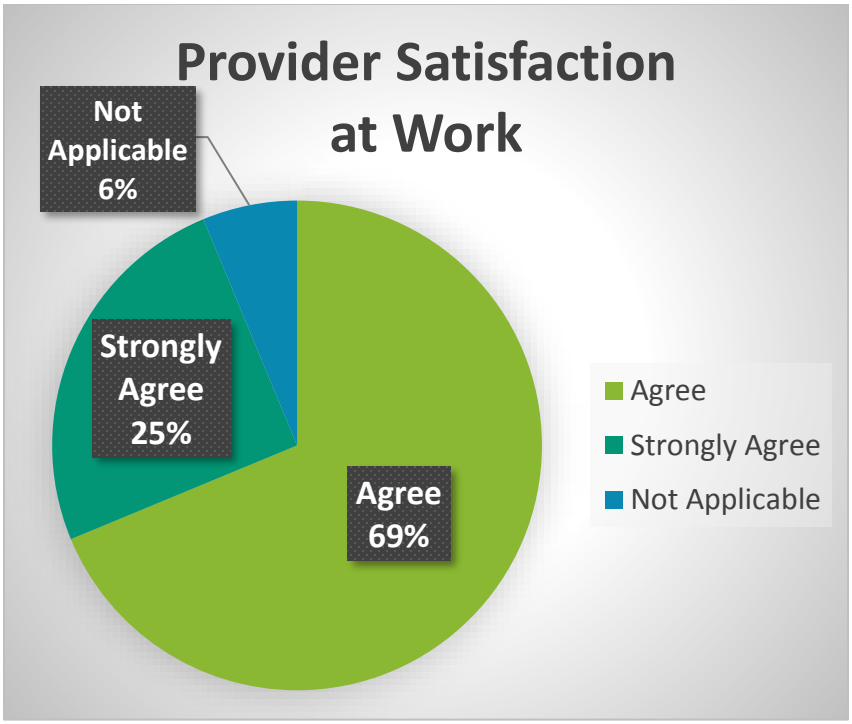
To date, MDH has received responses representing 104 clinics with 1,202 clinicians. This sample includes large and small clinics, and clinics that are part of larger healthcare systems as well as independent and solo practitioners from throughout the state. Respondents overwhelmingly agreed that the HCH program increased provider and care team satisfaction in their clinical work.

These questions asked in the survey related to satisfaction were:

1. Since adopting the HCH model of care delivery, the *other members of the care team* have communicated **greater** satisfaction in their work and practice.
2. Since adopting the HCH model of care delivery, the *clinic providers* at my organization have communicated **greater** satisfaction.

Table 3: Health Care Homes Improves Care Team Satisfaction

Table 4: Health Care Homes Improves Provider Satisfaction



Additional measurement strategies include:

- A survey to determine the value of clinic check-ins that occur between recertification cycles. The survey focuses on the format and frequency, value and improvements to the process.
- The workgroup focusing on the term “burden” for clinics by developing survey questions that address issues related to measurement, care coordination, tiering and submitting claims.
- Aligning with other state programs to ensure measurement is consistent across agencies.

Next Steps

In 2018, the Measurement and Evaluation workgroup will continue to focus on strategic plan efforts related to:

- Reducing clinic burden while maintaining accountability to improving quality, cost and patient experience
- Alignment of quality measures based on state and national PCMH initiatives
- Supporting a long-term strategy to evaluate the HCH program in a way that builds on the previous five-year evaluation.

Conclusion

"From a provider's perspective, our clinic has really improved our care of our pediatric patients with ADD and mental health issues by using a team approach. A care coordinator RN is able to interface with school staff, counselors, county social workers before and between visits to get information about school performance, gather Vanderbuilt rating scales, and other information. Behavioral Health Consultants meet with families at office visits and when needed, between visits, to address behavioral ways to help manage symptoms. There is more communication and coordination between the full team caring for these patients and parents know they can call their care coordinator if there are issues. It is still a work in progress but our efforts to date have really made my interactions with these families more robust as I have some much more information about how the patient is functioning in all settings and more resources to offer them. The school year is short and kids grow fast so the more we can offer in these years to families is invaluable. "

~Physician, Sawtooth Mountain Clinic, Grand Marais, MN.

For most Americans, primary care serves as the entry point into the health care system, delivering and coordinating care for patients and families, with an emphasis on promoting access and population health and managing chronic illness (PCPCC).[4] But even when they have consistent access to preventive and primary care through a local primary care provider, many people still feel lost in the system, especially if they have complex care needs.

A Health Care Home is an innovative approach a clinic uses to deliver advanced primary care to patients. The primary care practice changes their traditional approach to organizing and delivering care and puts into place procedures for achieving a patient centered, high-quality, accessible, and efficient care delivery system. The HCH transitions the culture of a clinic from a purely medical model with a focus on treating illness to an enhanced focus on primary care with wellness, prevention, self-management and linkages with community services. It provides care that is respectful of and responsive to individual patient preferences, needs, and values ensuring that patient values guide all clinical decisions.

The Health Care Homes model emphasizes teamwork between the care team and patients, care coordination, communication and continuous quality improvement. It is a place where patients and

[4] https://www.pcpcc.org/sites/default/files/resources/The%20Patient-Centered%20Medical%20Home%27s%20Impact%20on%20Cost%20and%20Quality%2C%20Annual%20Review%20of%20Evidence%2C%202014-2015.pdf

their health care needs are the focus. The Health Care Home clinic team listens to patient's questions and help them make the right choices. Clinic care team members help coordinate needed care and support patients in navigating a complex health care system. The primary care team includes a patient, a doctor, a nurse practitioner or physician assistant and their team members, but also extends to others involved in the patient's health, such as family, friends, and community organizations.

Since 2010, the Minnesota Health Care Home program has grown to include 3,871 dedicated certified HCH primary care clinicians, their teams and their community partners in 368 clinics around the state, serving an estimated 3.9 million people. These champions of advanced primary care are delivering patient-centered, team-based, coordinated care that has resulted in improvement in health quality outcomes and significant cost savings. We know that the HCH model of care delivery forms a strong foundation for improving access and quality of patient outcomes, positions clinics for value based payment and for success in advancing health equity. It has proven to be a model for achieving primary care excellence so that care is received in the right place, at the right time, and in the manner that best suits a patient's needs.

But we also know that, in Minnesota and nationally, the landscape for health care payment and delivery is changing very rapidly, and it is important that the HCH program keep pace with these changes. Payment models are becoming increasingly value based, and a foundational infrastructure that provides accessible, effective, team-based integrated care within a health care system is essential to successful participation in these models.

With input from a wide range of stakeholders, the HCH program is moving forward in 2018 with strategies that will:

- Prepare Minnesota providers for entering into and succeeding in value-based payment arrangements.
- Increase care coordination and collaboration between primary care clinicians and care team members, specialty care, and community services and organizations to address whole person integrated care and health equity and improve population health.
- Examine certification and recertification processes and ensure a balance between an appropriate level of accountability for HCH recognition and administrative burden.
- Support secure exchange of clinical information to improve the safety and efficacy of care and reduce fragmentation of services.

Working to implement these strategies in 2018 will ensure that the program continues to evolve and innovate, and offers value to providers, patients and communities into the future.

Appendices

Appendix A: HCH Advisory Committee

QUALITY IMPROVEMENT ORGANIZATION REPRESENTATIVE

Cally Vinz, Chair of HCH Advisory Committee
Institute for Clinical Systems Improvement (ICSI)

ACADEMIC RESEARCHER IN MINNESOTA

Rhonda Cady
Gillette Children's Specialty Healthcare

CERTIFIED HEALTH CARE HOME REPRESENTATIVE

Dale Dobrin
South Lake Pediatric Clinic
Emily Goetzke
Mankato Clinic, Ltd.
Kahlea Zobel
University of MN Physicians
Tracy Tealander
HealthEast

CONSUMER OR PATIENT

Elizabeth Goldstein
Melissa Winger
Ashlea McLeod
Pa Vang

HEALTH CARE PROFESSIONAL

Dana Brandenburg
U of MN Department of Family Medicine and Community Health
Coral Garner
City of Minneapolis, Department of Health and Family Support
David Thorson
Primary Care Provider

HEALTH PLAN IN MINNESOTA REPRESENTATIVE

Mika Baer
Ucare

Appendix B: List of Partnership & Communication Workgroup

MEMBERS	MEMBERS CONTINUED
RN, MSN Casey Langworthy Zumbro Valley Mental Health	**COMMUNICATIONS MANAGER** Michelle Gerard Wilder Research Foundation
SPECIALTY CARE FOR GILLETTE CHILDREN'S HOSPITAL Mary Kautto Gillette Children's Hospital	**PUBLIC INFORMATION OFFICER COMMUNICATION** Scott Smith Minnesota Department of Health

Appendix C: List of Financial Sustainability Workgroup Members

MEMBERS	MEMBERS CONTINUED
FINANCE Aaron Bloomquist North Memorial	**EMPLOYER** Deb Krause MN Health Action Group
HEALTH PLAN REPRESENTATIVE Charles Abrahamson Health Partners	**QUALITY IMPROVEMENT ORGANIZATION** Jan Schuerman Institute for Clinical Systems Improvement (ICSI)
STATEWIDE REPRESENTATIVE HCH CLINIC Dale Dobrin South Lake Pediatric Clinic	**DEPARTMENT OF HUMAN SERVICES** Jeff Schiff Medical Director
HCH PROVIDER David Thorson Entira Clinics	**RECERTIFIED CLINIC** Jill Swenson Sanford Health

Appendix D: List of Learning and Technical Assistance Workgroup Members

MEMBERS

INSTITUTE FOR CLINICAL SYSTEMS IMPROVEMENT (ICSI)
Cally Vinz
Vice President
Chair, Health Care Homes Advisory Committee

MINNESOTA DEPARTMENT OF CORRECTIONS
Jeremy Hermann
Instructional Designer

SANFORD HEALTH
Jill Swenson
Medical Home Program Coordinator

THE BARCLAY GROUP, LLC
Michelle Barclay
President and Co-Founder

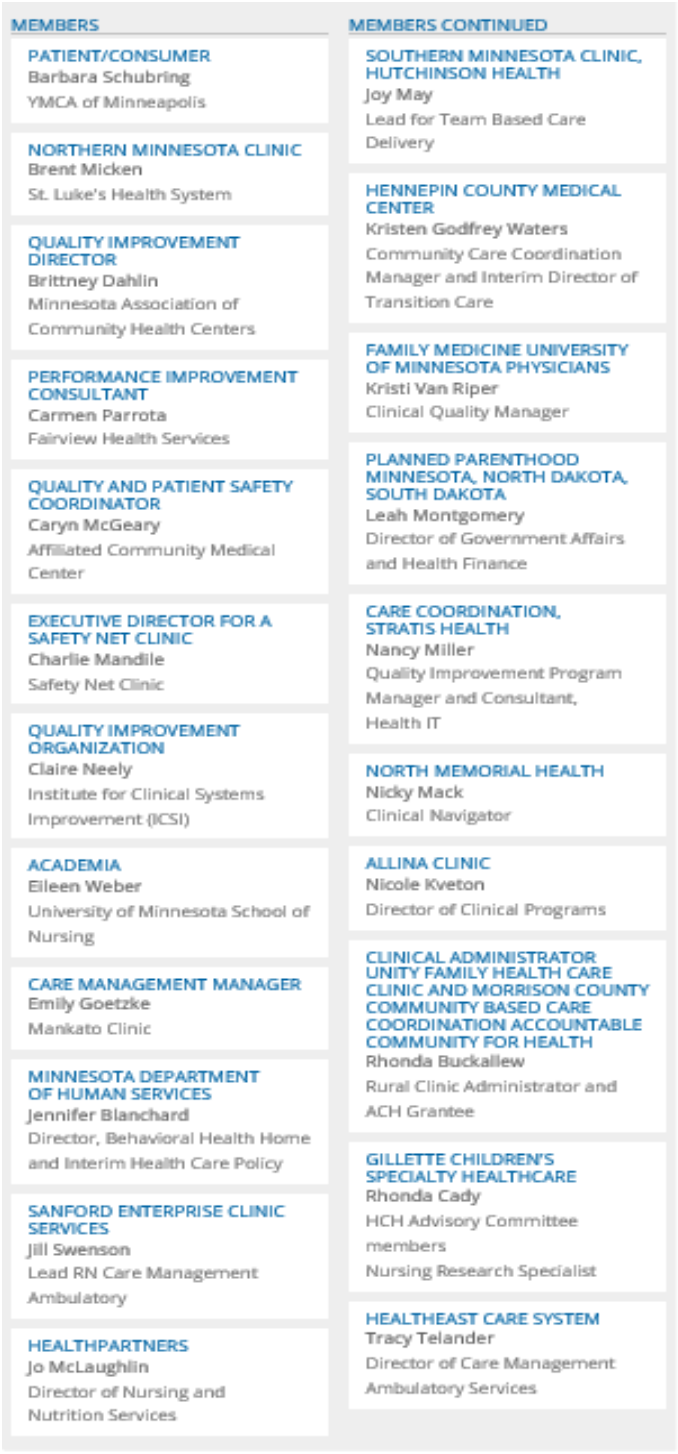
MEMBERS CONTINUED

NORTH MEMORIAL HEALTH CARE
Peter Carlson
Community Paramedic Manager

NORMANDALE COMMUNITY COLLEGE
Sunny Ainley
Associate Dean

MINNESOTA DEPARTMENT OF HUMAN SERVICES
Traci Warnberg-Lemm
Learning Collaborative Coordinator

Appendix E: List of Program Innovation Workgroup Members



MEMBERS

PATIENT/CONSUMER
Barbara Schubring
YMCA of Minneapolis

NORTHERN MINNESOTA CLINIC
Brent Micken
St. Luke's Health System

QUALITY IMPROVEMENT DIRECTOR
Brittney Dahlin
Minnesota Association of Community Health Centers

PERFORMANCE IMPROVEMENT CONSULTANT
Carmen Parrota
Fairview Health Services

QUALITY AND PATIENT SAFETY COORDINATOR
Caryn McGeary
Affiliated Community Medical Center

EXECUTIVE DIRECTOR FOR A SAFETY NET CLINIC
Charlie Mandile
Safety Net Clinic

QUALITY IMPROVEMENT ORGANIZATION
Claire Neely
Institute for Clinical Systems Improvement (ICSI)

ACADEMIA
Eileen Weber
University of Minnesota School of Nursing

CARE MANAGEMENT MANAGER
Emily Goetzke
Mankato Clinic

MINNESOTA DEPARTMENT OF HUMAN SERVICES
Jennifer Blanchard
Director, Behavioral Health Home and Interim Health Care Policy

SANFORD ENTERPRISE CLINIC SERVICES
Jill Swenson
Lead RN Care Management Ambulatory

HEALTHPARTNERS
Jo McLaughlin
Director of Nursing and Nutrition Services

MEMBERS CONTINUED

SOUTHERN MINNESOTA CLINIC, HUTCHINSON HEALTH
Joy May
Lead for Team Based Care Delivery

HENNEPIN COUNTY MEDICAL CENTER
Kristen Godfrey Waters
Community Care Coordination Manager and Interim Director of Transition Care

FAMILY MEDICINE UNIVERSITY OF MINNESOTA PHYSICIANS
Kristi Van Riper
Clinical Quality Manager

PLANNED PARENTHOOD MINNESOTA, NORTH DAKOTA, SOUTH DAKOTA
Leah Montgomery
Director of Government Affairs and Health Finance

CARE COORDINATION, STRATIS HEALTH
Nancy Miller
Quality Improvement Program Manager and Consultant, Health IT

NORTH MEMORIAL HEALTH
Nicky Mack
Clinical Navigator

ALLINA CLINIC
Nicole Kveton
Director of Clinical Programs

CLINICAL ADMINISTRATOR UNITY FAMILY HEALTH CARE CLINIC AND MORRISON COUNTY COMMUNITY BASED CARE COORDINATION ACCOUNTABLE COMMUNITY FOR HEALTH
Rhonda Buckallew
Rural Clinic Administrator and ACH Grantee

GILLETTE CHILDREN'S SPECIALTY HEALTHCARE
Rhonda Cady
HCH Advisory Committee members
Nursing Research Specialist

HEALTHEAST CARE SYSTEM
Tracy Telander
Director of Care Management Ambulatory Services

Appendix F: List of Measurement and Evaluation Workgroup Members

MEMBERS

ADMINISTRATOR
Corinne L Abdou
Wayzata Children's Clinic, P.A.

QUALITY REFORM IMPLEMENTATION UNIT
Denise McCabe
Statewide Quality Reporting Measurement System
Minnesota Department of Health

RN CLINIC MANAGER
Erica Schuler
Ridgeview Medical

SENIOR DIRECTOR CARE MANAGEMENT
Gena Graves
HealthPartners/ Park Nicollet

HEALTHCARE POLICY AND QUALITY ANALYST
Karolina Craft
Care Delivery & Payment Reform, Department of Human Services

HEALTHCARE INITIATIVE COORDINATOR
Kristin Erickson
PartnerSHIP 4 Health - Public Health/SIM Grantee (1)

MEMBERS CONTINUED

DEPUTY EXECUTIVE VICE PRESIDENT
Lyn Balfour
Minnesota Academy of Family Physicians

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Maria McGannon
South Lake Pediatrics

CLINIC OPERATIONS MANAGER
Michele Gustafsson
South Lake Pediatrics

DIRECTOR OF POPULATION HEALTH
Nate Hunkins
Bluestone Physician Services

ASSISTANT PROFESSOR HEALTH POLICY & MANAGEMENT, RESEARCH
Nathan Shippe
U of MN: Public Health

ASSISTANT PROFESSOR FAMILY MEDICINE AND COMMUNITY HEALTH
Peter Harper
U of MN: Family Medicine

Appendix G: Health Care Homes Certification Committee

John Halfen, MD
Medical Director
Lakewood Health Systems

Jen Hartmann
Social Worker
Morrison County Social Services

Lisa Hoffman-Wojcik
Patient and Family Advocate
Open Door Health Center

Ellen K. Ryan, RN, MSN
Chief Quality Officer
First Light Health System

Cally Vinz, RN
Vice President
Institute for Clinical Systems Improvement (ICSI)

Becky Walsh, CPC
Provider Relations & Contracting Manager
PrimeWest Health

Melissa Winger

Patient and Family Advocate

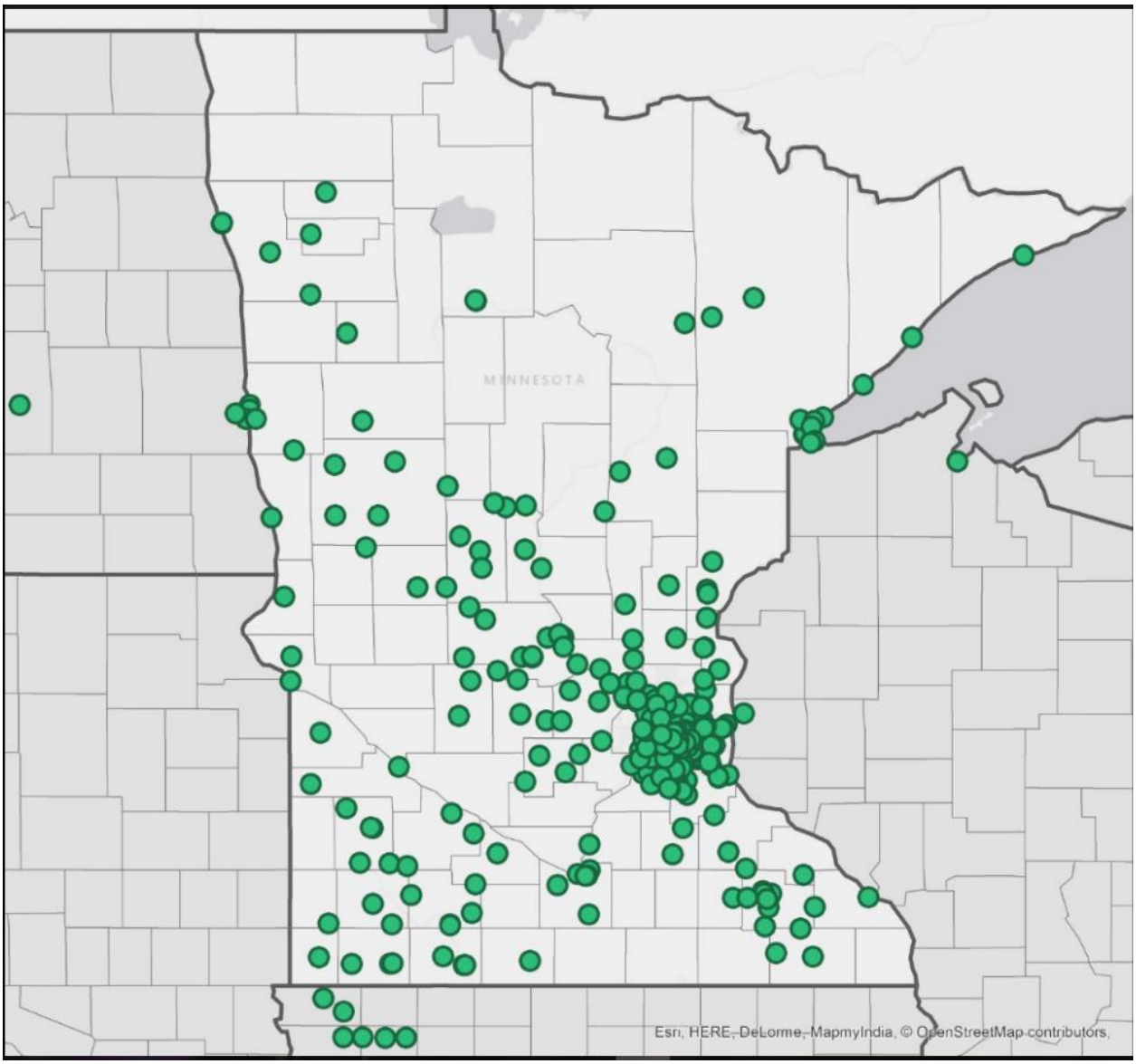
Appendix H: Counties based on number of Health Care Homes

County	2010 Population	% of Population	Region	Total # of Clinics	# MN Current HCH	% of Clinics Certified	County has at least One HCH	County with at least one clinic
Aitkin	16,202	0.3%	Northeast	3	2	67%	1	1
Anoka	330,844	6.2%	Metropolitan	19	17	89%	1	1
Becker	32,504	0.6%	Northwest	7	1	14%	1	1
Beltrami	44,442	0.8%	Northwest	3	2	67%	1	1
Benton	38,451	0.7%	Central	1	0	0%	0	1
Big Stone	5,269	0.1%	Southwest	3	2	67%	1	1
Blue Earth	64,013	1.2%	South Central	11	6	55%	1	1
Brown	25,893	0.5%	South Central	5	2	40%	1	1
Carlton	35,386	0.7%	Northeast	4	0	0%	0	1
Carver	91,042	1.7%	Metropolitan	14	4	29%	1	1
Cass	28,567	0.5%	Central	9	1	11%	1	1
Chippewa	12,441	0.2%	Southwest	3	0	0%	0	1
Chisago	53,887	1.0%	Central	5	5	100%	1	1
Clay	58,999	1.1%	West Central	7	4	57%	1	1
Clearwater	8,695	0.2%	Northwest	2	0	0%	0	1
Cook	5,176	0.1%	Northeast	1	1	100%	1	1
Cottonwood	11,687	0.2%	Southwest	6	4	67%	1	1
Crow Wing	62,500	1.2%	Central	8	1	13%	1	1
Dakota	398,552	7.5%	Metropolitan	37	21	57%	1	1
Dodge	20,087	0.4%	Southeast	1	1	100%	1	1
Douglas	36,009	0.7%	West Central	4	2	50%	1	1
Faribault	14,553	0.3%	South Central	5	0	0%	0	1
Fillmore	20,866	0.4%	Southeast	6	3	50%	1	1
Freeborn	31,255	0.6%	Southeast	2	0	0%	0	1
Goodhue	46,183	0.9%	Southeast	7	3	43%	1	1
Grant	6,018	0.1%	West Central	4	1	25%	1	1
Hennepin	1,152,425	21.7%	Metropolitan	142	94	66%	1	1
Houston	19,027	0.4%	Southeast	4	0	0%	0	1
Hubbard	20,428	0.4%	Northwest	2	0	0%	0	1
Isanti	37,816	0.7%	Central	1	1	100%	1	1
Itasca	45,058	0.8%	Northeast	8	1	13%	1	1

County	2010 Population	% of Population	Region	Total # of Clinics	# MN Current HCH	% of Clinics Certified	County has at least One HCH	County with at least one clinic
Jackson	10,266	0.2%	Southwest	4	3	75%	1	1
Kanabec	16,239	0.3%	Central	1	1	100%	1	1
Kandiyohi	42,239	0.8%	Southwest	4	2	50%	1	1
Kittson	4,552	0.1%	Northwest	2	0	0%	0	1
Koochiching	13,311	0.3%	Northeast	6	0	0%	0	1
Lac qui Parle	7,259	0.1%	Southwest	3	1	33%	1	1
Lake	10,866	0.2%	Northeast	2	2	100%	1	1
Lake of the Woods	4,045	0.1%	Northwest	1	0	0%	0	1
Le Sueur	27,703	0.5%	South Central	5	0	0%	0	1
Lincoln	5,896	0.1%	Southwest	5	0	0%	0	1
Lyon	25,857	0.5%	Southwest	5	5	100%	1	1
McLeod	36,651	0.7%	South Central	5	4	80%	1	1
Mahnomen	5,413	0.1%	Northwest	3	1	33%	1	1
Marshall	9,439	0.2%	Northwest	1	0	0%	0	1
Martin	20,840	0.4%	South Central	6	1	17%	1	1
Meeker	23,300	0.4%	South Central	5	4	80%	1	1
Mille Lacs	26,097	0.5%	Central	2	2	100%	1	1
Morrison	33,198	0.6%	Central	6	3	50%	1	1
Mower	39,163	0.7%	Southeast	4	0	0%	0	1
Murray	8,725	0.2%	Southwest	3	2	67%	1	1
Nicollet	32,727	0.6%	South Central	3	2	67%	1	1
Nobles	21,378	0.4%	Southwest	3	3	100%	1	1
Norman	6,852	0.1%	Northwest	3	0	0%	0	1
Olmsted	144,248	2.7%	Southeast	12	11	92%	1	1
Otter Tail	57,303	1.1%	West Central	7	4	57%	1	1
Pennington	13,930	0.3%	Northwest	1	1	100%	1	1
Pine	29,750	0.6%	Central	6	3	50%	1	1
Pipestone	9,596	0.2%	Southwest	4	1	25%	1	1
Polk	31,600	0.6%	Northwest	10	4	40%	1	1
Pope	10,995	0.2%	West Central	2	0	0%	0	1
Ramsey	508,640	9.6%	Metropolitan	68	46	68%	1	1
Red Lake	4,089	0.1%	Northwest	3	1	33%	1	1

County	2010 Population	% of Population	Region	Total # of Clinics	# MN Current HCH	% of Clinics Certified	County has at least One HCH	County with at least one clinic
Redwood	16,059	0.3%	Southwest	4	3	75%	1	1
Renville	15,730	0.3%	Southwest	4	0	0%	0	1
Rice	64,142	1.2%	Southeast	8	2	25%	1	1
Rock	9,687	0.2%	Southwest	1	1	100%	1	1
Roseau	15,629	0.3%	Northwest	3	0	0%	0	1
St. Louis	200,226	3.8%	Northeast	34	10	29%	1	1
Scott	129,928	2.4%	Metropolitan	10	6	60%	1	1
Sherburne	88,499	1.7%	Central	6	6	100%	1	1
Sibley	15,226	0.3%	South Central	5	0	0%	0	1
Stearns	150,642	2.8%	Central	21	18	86%	1	1
Steele	36,576	0.7%	Southeast	2	0	0%	0	1
Stevens	9,726	0.2%	West Central	4	0	0%	0	1
Swift	9,783	0.2%	Southwest	2	0	0%	0	1
Todd	24,895	0.5%	Central	6	4	67%	1	1
Traverse	3,558	0.1%	West Central	1	1	100%	1	1
Wabasha	21,676	0.4%	Southeast	5	1	20%	1	1
Wadena	13,843	0.3%	Central	3	1	33%	1	1
Waseca	19,136	0.4%	South Central	3	0	0%	0	1
Washington	238,136	4.5%	Metropolitan	22	17	77%	1	1
Watonwan	11,211	0.2%	South Central	2	0	0%	0	1
Wilkin	6,576	0.1%	West Central	0	0	0%	0	0
Winona	51,461	1.0%	Southeast	2	2	100%	1	1
Wright	124,700	2.4%	Central	12	8	67%	1	1
Yellow Medicine	10,438	0.2%	Southwest	3	2	67%	1	1
State of Minnesota	5,303,925			692	368	53%	61	86

Appendix I: Dot Map of HCH Clinic Locations



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