Health Care Homes (HCH) Strategic Planning Analysis of Round 1 Input

CURRENT TO MARCH 27, 2025

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Introduction

Process

Health Care Homes (HCH) has had multiple strategic plans over the years. It's been some time since we last looked deeply at this program, and there have been substantial changes to the program and its purpose. As we move forward in planning for the future, we are working closely with our key stakeholders to help us understand how to best meet program and stakeholder needs and sustain this critical work well into the future.

As shown on the graphic, we began our strategic planning process by gathering input from internal and external key stakeholders to shape our draft vision, mission, goals, and strategies. That ran from mid-January to mid-March 2025, and many are also contributing to our comprehensive SWOT analysis. In late spring 2025 we'll ask for feedback on those drafts, and use that to finalize them and then develop detailed actions to collectively advance our critical priorities.

Key stakeholder groups included staff, rural and urban clinics and clinicians, collaborators, partners, and patient advisory groups.

Staff, clinics and clinicians, clinics and clinicians, collaborators, and partners responded to the following questions:

1. **Continuous improvement:** Thinking about ways HCH effectively supports advanced primary care for better patient outcomes… What could we do even better?
2. **Changes:** Thinking about what HCH is doing that is not as effective or valuable in supporting advanced primary care…What are your suggestions for key changes or improvements?
3. **Health equity:** In what ways does HCH help ensure that health equity is successfully embedded in primary care?
4. **Health equity, continued:** What could we do better or differently?
5. **Moving forward, staying relevant:** In the years since the Minnesota Legislature established HCH in 2010, the whole-person, patient-centered primary care model has shifted from new and novel to the standard of care. Thinking ahead 5-10 years, what opportunities and innovations could we work on together to measurably improve health outcomes for Minnesotans?

Background summary: A health care home (https://www.health.state.mn.us/facilities/hchomes) is an approach to primary care in which primary care providers, families, and patients partner to improve health outcomes and quality of life for individuals with chronic or complex health conditions, specifically to: Improve the individual experience of care, improve the health of the population, and improve affordability by containing the per capita cost of providing care. HCH supports advanced primary care through certification and level progression, support from program staff, learning opportunities, and patient resources.

Because HCH doesn't work directly with patients, patient advisory groups were asked for advice on the information that HCH includes on its website, through the following questions:

1. What new or different information on the Health Care Homes website would be more helpful to patients and the general public?
2. Understanding that Health Care Homes staff has no direct access to patients, what are some additional ways to help patients and the public learn this information?
3. How might advisory groups such as yours help ensure that information for patients about health care homes remains valuable over time, and that patients can access it?
4. Feel free to use the space below to offer any additional thoughts below.

Staff and patient advisory groups were engaged in person. Other stakeholders were engaged virtually, by phone, or via an online survey.

Participation and Demographics

Number of stakeholder ideas

There were 641 ideas from all stakeholder groups. Of these, 566 were from staff, rural clinics and clinicians, urban clinics and clinicians, FQHCs, collaborators, and partners; and 75 were from members of patient advisory groups.

Certification level

Clinics and clinicians who are certified were asked to provide their certification level. The table below shows the results from participants who provided this information.

	Foundational			Level 2			Level 3		
Participant Group	**0-3 yrs**	**4-6 yrs**	**7+ yrs**	**0-3 yrs**	**4-6 yrs**	**7+ yrs**	**0-3 yrs**	**4-6 yrs**	**7+ yrs**
Rural clinics, clinicians	**3**	**4**	**3**	**1**	*0*	*0*	**3**	*0*	**3**
Urban clinics, clinicians	**1**	**2**	**2**	*0*	*0*	*0*	**2**	*0*	**2**
FQHCs	**2**	*0*	*0*	**1**	*0*	**1**	**1**	*0*	*0*
Totals	*4*	*2*	*2*	*2*	*0*	*1*	*3*	*0*	*2*

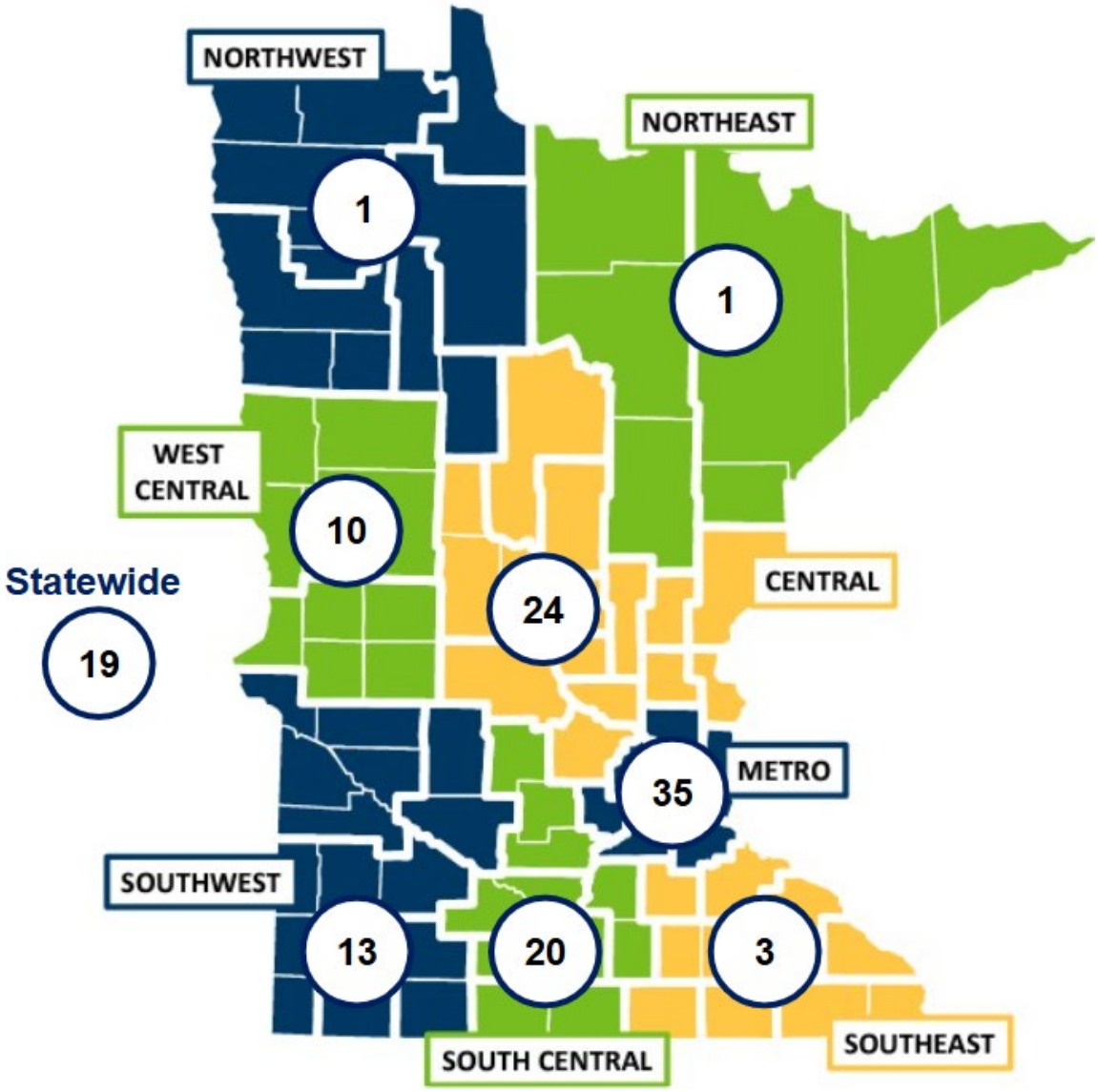
Number of clinics in systems

Clinics and clinicians were asked how many clinics they have in their systems. The table below shows the results from participants who provided this information.

Participant Group	1-9	10-20	21+
Rural clinics, clinicians	9		1
Urban clinics, clinicians	5	2	1
FQHCs	8		

Location

The map below shows the location of the 127 participants who provided this information. Note that a few clinics serve multiple regions, all of which were included.



Methodology and Navigation

The analysis below is split into the two sets of stakeholders described above, and then by question. Similarly, the appendix contains a compilation of all results, presented as written or documented by the interviewer or facilitator, with corrections to spelling and grammar as necessary for clarity.

To navigate, the table of contents is hyperlinked. There is also a link back to the table of contents after each question in both the analysis and appendix with the compilation.

Analysis

Staff, clinics, partners, collaborators

1, Continuous Improvement: Thinking about ways HCH effectively supports advanced primary care for better patient outcomes… What could we do even better?

2, Changes: Thinking about what HCH is doing that is not as effective or valuable in supporting advanced primary care…What are your suggestions for key changes or improvements?

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Note: The responses to questions 1 and 2 overlapped significantly, so the analysis below combines the two.

"Advance or reform billing and reimbursement for financing community integrated and culturally responsive care"

Keeping in mind that these suggestions are for ways to make good work better, participants are interested in improved evaluation and accountability, better patient-focused information and support, more and better learning opportunities including increased collaboration and knowledge sharing, funding of various kinds, and a clearer, more appealing, and efficient certification process.

"Continue to focus on strategies for advancing health equity, reducing health disparities, and cultural and community focused care even in uncertain times"

"More research into patient outcomes after intervention from Health Care homes"

Improved outcomes through evaluation, accountability, performance measures, standards, and data: Not surprisingly, these stakeholders -- all of whom are committed to better outcomes for across all patient groups -- want more, better, and well-aligned ways to determine what is and isn't working, for whom, and how to use those results to make improvements to internal processes and patient outcomes. A number urged HCH to maintain the focus on equitable outcomes for patients served, SDOH, and locally and culturally responsive care. Other priorities include using additional data sources (partners, patients, communities), more focus on increasing the connection to evidence-based care guidelines, stronger internal program measurements, and sharing results more widely.

"Partner across various sectors to make HCH model THE standard/ expectation"

"Use policy levers within other agencies + programs to elevate HCH as the primary care delivery model in MN."

Information and communications: The comments were primarily about helping staff and community members understand the meaning, value, benefits, successes, and efficiencies of health care homes, coordinated and integrated care, and certification levels. Some need clarity, details, examples, process information, and sample text for themselves and their colleagues, while others need the same to share with patients and the general public. Some also noted the importance of making HCH and certification meaningful and relevant to patients, and others recommended showcasing the efficacy and improved outcomes from certified clinics.

Learning opportunities: People want more and better ways to learn from peers, along with models, best practices, subject matter experts, and examples of both successes and struggles. There is interest in specific or more tailored offerings, such as SDOH, chronic disease management, a clinic's specialty or unique needs, in-depth technical issues, geographic-specific topics (e.g., rural), certification level, or internal issues such as staffing, quality measures, or billing and reimbursement systems. Others highlighted the advantages of volunteer pairing or mentoring, and some want more in-person learnings.

Collaborations: There is interest in collaborating with and supporting two-way learning from other nonprofit, community, public education, and public healthcare organizations. Another idea was to encourage collaboration across HCHs to get patients connected with the best medical and social supports, such as community resources, specialty care referrals for conditions, chronic disease management, and similar. Another key idea was to support more connections with community resources to address SDOH. Others suggested creating or strengthening collaborations with nursing associations, NCQA, and across MDH.

"Partner with community leaders in underrepresented groups to identify new ways to reach their community"

"Align patient outcomes to national standards for care coordination for children and youth with special healthcare needs"

Financial support and systems: There is consistent interest in more funding and grants for various purposes, such as to support initial or further certification; for reimbursements; or for specific uses or purposes related to HCH or equity such as rural areas, underfunded clinics, to pay for staff related to this work, certain populations, etc. Some participants also need faster and more efficient systems for reimbursements, billing, and collecting course registration fees, along with more training and support. A related idea is to integrate the HCH program with state reimbursement systems as is done in some other states. Others asked for support to advocate for better funding, and help to develop better partnerships with payers and work more effectively with insurance companies.

"HCH has led the way in clinic best practice across the state, leading to a real change in how healthcare is delivered. So, difficult to quantify and compare between certified HCHs/ non-certified HCHs."

"Condense the application process for certification to get more clinics on board."

"We could make being certified 'cool' so everyone would want to be certified"

"Certified clinics could see noticeable perks ($, education, pts#'s, services report)"

Certification: Participants are concerned that financial barriers and current funding threats may make certification a lower priority or impossible. They pressed for HCH to ensure people understand the *tangible* appeal, value, and benefits of certification, develop new strategies to engage uncertified clinics, and provide a streamlined and easier application process along with better training, support, and communications.

3, Health equity: In what ways does HCH help ensure that health equity is successfully embedded in primary care?

4, Health equity, continued: What could we do better or differently?

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Note: The responses to questions 3 and 4 overlapped significantly, so the analysis below combines the two.

What's working well

Participants appreciate that HCH:

- Supports the foundational commitment to measuring health equity, and identifying gaps and barriers, and making specific improvements to improve outcomes
- Focuses on person-centered care, and facilitates and supports inclusion, coordination, and community support, which yield more equitable outcomes
- Embeds health equity and SDOH in the certification standards and requirements
- Increases awareness around health equity and SDOH
- Embeds equity into learning opportunities, online information, and written materials
- Includes analyses and reporting that support a focus on equitable outcomes

Suggested improvements

These are summarized below, some of which overlap with the responses to questions 1 and 2 on page 4:

Collaboration and partnerships:

- Create/support more opportunities for sharing and collaboration among clinics; examples include case studies, successes, learnings from challenges, deeper or more extensive qualitative and quantitative analyses, building shared goals to decrease inequities among HCHs
- Support clinics to identify, create, or strengthen connections with community organizations, community health workers, and other groups and individuals who can help clinics understand and better address culturally specific needs.
- Work with providers, payers, insurers, and others to increase support for health equity work; this also relates to a suggestion to reduce unique data/reporting requirements by aligning HCH metrics with those of payers

"Highlight clinic and payer partnerships who are working together to address HE"

Patient resources:

- Offer more patient-oriented resources, connections, or networks that HCHs can share with patients
- Provide information in multiple languages

Awareness, understanding:

- Provide more education about SDOH to deepen knowledge and awareness of non-clinical factors
- Help clinics see the benefits of addressing health equity issues

"more equity voices on staff, advisory groups, and other ways of incorporating representatives of health equity and disparities"

Education, training, and information to support equitable health outcomes:

- Provide more education and training to help clinics/clinicians better collect and analyze data and use results to improve outcomes (In addition to the certification process).
- Specific examples include identifying and addressing inequities, finding opportunities for improvement, understanding patient/population characteristics and needs including those that are culturally specific,

incorporating health equity into all the clinic's work, identifying better measures for health equity, and similar.
- Support clinics to include a diverse range of patients on committees, in surveys, and other participatory methods to identify issues, needs, opportunities, and solutions; include that participatory expectation in the certification requirements
- Collect and share data on SDOH, health equity, disparities, and similar

Certification: Offer more specific direction and guidance for recertification and advanced certification, with a number specifically calling out the health equity requirements

Funding, advocacy: These address needed efforts primarily within MDH, other state agencies, and the state legislature.

- Advocate for MA patients to have access to expanded services such as dental care
- Support culturally specific services such as BIPOC screenings
- Advocate for funding and resources to serve undocumented immigrants
- Advocate for reimbursement for work done by community health workers
- Help generate support by highlighting and promoting the positive health equity work that HCH clinics do

"Some of the rural sites just don't have the resources and staff to apply for or do the work for HCH or to go for certification. Although they would benefit the most"

Staff:

- Hire more diverse HCH staff
- Better support HCH managers and staff doing this difficult work; help reduce burnout

5: Thinking ahead 5-10 years, what opportunities and innovations could we collaborate on to measurably improve health outcomes for Minnesotans?

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Responses to this ranged widely and are broadly grouped below.

Collaboration, integration, innovation:

- HCH alignment with other model efforts, initiatives, and advances that have emerged since HCH began (e.g., IHP, ACOs, community care hubs)
- Fully integrated medical, dental, and behavioral health care; integrated general and specialty care
- Statewide care coordination, across multiple providers
- Partnerships with community organizations to co-create a new model of primary care
- Statewide peer-to-peer networks Collaboration with health plans to build value-based models of care that address social determinants of health
- Better connections between systems and shared records; shared dashboard for patient outcomes across systems; stronger Health Information Exchange; better documentation of patient-centered care
- Data warehouse across different sectors including; payers, government, clinics, etc.
- Better collaboration and alignment within MDH to support HCH efforts -- including working with the Office of Rural Health and Primary Care to enhance mutual understanding of available data and how to effectively apply it

"Better coordination with value-based care and figuring out how we can better support success in participation in such models."

"elevate innovative practices, large and small - study their impact"

Rigorous evaluation and evidence-based efforts:

- Evidence-based practices embedded in HCHs and routinely updated
- Interdisciplinary, team-based care models
- Statewide standard outcomes and measures
- Tight connections between health disparity data and evidence-based interventions; broad support for value-based care

"...more efficient incorporation of evidence- based practices into HCHs, noting they continuously evolve with research…"

"...roadmap for the more efficient incorporation of evidence-based practices into HCHs, noting they continuously evolve with research"

Health equity and SDOH:

- Improved equity measures, data collection, analysis, medical and community responses, and resulting health outcomes
- Statewide hub for SDOH resources
- Healthcare redefined to include social determinants of health

Prevention:

- Stronger focus on prevention and population/condition-specific screenings
- Wellness incentives and supports for patients; focus on healthy lifestyles
- Prevention education for children and youth through schools
- Patients are actively involved with clinics in measuring results, providing feedback, and helping improve outcomes
- Patients are included on HCH committees and task forces, and reached out to/engaged in ongoing efforts to ensure patient perspectives help shape the work

"... shared decision making between patients and their care team"

"Increasing abilities for remote visits...no one should have to travel if they are unable and still be able to get the healthcare they need"

"Health care is very expensive. We need to knock down barriers for our patients AND providers AND care teams."

Patient access, healthcare information and literacy:

- Better access to care that meets people's needs; "healthcare for all"; insurance coverage for everyone
- Improved integration of and access to specialty care
- More information, understanding, and access to insurance
- Improved healthcare literacy so patients can find and access the care they need, and navigate electronic systems so they can access good care plans, be more informed, and better able to manage their own healthcare
- Widespread and consistent access to remote care *and* remote patient monitoring
- Patient access to information they need to make informed choices: insurance comparisons, healthcare quality, healthcare costs

Funding:

- Sustainable funding model that works for payers, providers, and individuals, with aligned incentives
- Payers understand the HCH-demonstrated link between coverage/costs and outcomes
- More funding to support staff and services that meet everyone's healthcare needs; fully-funded community health workers
- Value-based HCH reimbursement mechanism that includes prospective payments; easier claims process; efficient processing of reimbursements and other financial supports; increase reimbursement for primary care
- Financial incentives for certified clinics
- Funding for consistent evaluation of results for certified clinics/clinicians
- Working with the payers on coverages/cost/etc. Use our data to show them that cost is a barrier to their improved outcomes. Connecting those dots.

"Find a way to designate payers as 'HCH friendly' "

Education, training:

- Standard curriculum for the patient-centered medical home (PCMH) model to be used in all healthcare training

Patient Advisory Groups

Introduction

These questions focused on ways to improve patient access and understanding about health care homes, and the role that patient advisory groups (PAG) might play in supporting such efforts. Note that as there were a limited number of responses to these questions from the three participating patient advisory groups, process and content improvements are likely best done in further collaboration with such groups.

PAG 1: What new or different information on the Health Care Homes Patient Information (https://www.health.state.mn.us/facilities/hchomes/patient.html) webpage would be more helpful to patients and the general public?

PAG 2: Understanding that Health Care Homes staff has no direct access to patients, what are some additional ways to help patients and the public learn this information?

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Note: The responses to PAG questions 1 and 2 overlapped significantly, so the analysis below combines the two.

Website improvements

Clear explanations: Simplify and clarify what a health care home is, focusing on the fact that these are clinics; write it more clearly for *patients* to read

Quotes, examples:

- Add details and examples to explain why an HCH is relevant, valuable, and beneficial to patients
- Add more stories and experiences; focus on improved outcomes

Comparisons and clinic information:

- Provide comparative information about HCH vs. non-HCH clinics, highlighting what's most relevant to patients
- Make it easy for patients to find HCH-certified clinics

Costs:

- When there is an HCH charge on patient bills, provide explanatory information and explain the benefits
- Explain/reconcile the apparent conflict between the website statement that there is no extra cost for choosing an HCH clinic, with HCH charges on patient bills

Specific website recommendations:

- Under What is a HCH, Level 2: Add examples of how connecting to community resources could be or is done within clinics
- Under What is a HCH, Level 3, "The emphasis is on participating and sharing responsibility in community-based health improvement efforts." Add examples of how this is achieved

> *"Explain what happens in the background if a patient is receiving care in a HCH. Tout the extra things a HCH does for patients that others may not. All the things that you mentioned in the HCH standards."*

Marketing recommendations

These focused on better promoting patient awareness of and access to HCH information on the website and via other sources as summarized below.

- Have clinics include the link to the HCH website from their clinic websites
- Encourage clinics to explicitly reference their being a "health care home" for patients in their own marketing information, along with the many benefits to patients

- Provide content and/or a media kit for clinics to write articles in their own regular communications (newsletters, etc.); provide for local TV, newspapers, and other mainstream media sources that reach the general public; post on clinic and community partner websites and social media outlets
- Provide clinics with content for a handy card, posters, or brochures with HCH information (perhaps including quotes) that they can produce locally and post or hand out to patients
- Share HCH info via an HCH Facebook page
- Ensure clinic medical staff, support staff, community partners, and county public health and social service staff fully understand what an HCH is and how it benefits patients, so they can explain that to current and make informed referrals

PAG 3: How might advisory groups such as yours help ensure that information for patients about health care homes remains valuable over time, and that patients can access it?

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Two key suggestions emerged here:

- HCH could work with patient advisory groups to add HCH to future agendas for members to learn more, offer other ideas to improve awareness and understanding, etc.
- Some advisory groups are willing to help spread the word about their clinic's HCH status, and perhaps support outreach to other clinics, community organizations, and other groups

"I like that you came here in person to get our opinion, that is important to me. It also makes me think that this program is important. You should go to other places to talk about HCH, such as our clinics/organizational meetings, to other clinics, boards, and community meetings and all over the state"

PAG 4: Feel free to use the space below to offer any additional thoughts below.

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These varied too widely to analyze, so content that has not been addressed elsewhere is summarized below.

- Connect with home health care programs; they are key in transitions and in coordination
- Provide information on the HCH cost efficiencies and how that benefits patients, payers, and clinics
- Include information about HCH clinics along with insurance information, so patients can use that information when selecting a clinic
- From the facilitator: On the hospital side, when I'm in a patient's chart, if they have a plan of care with a health coach it pops up right away, and their patient dashboard provides all the key details along with their norm. If they present to the ER as a diabetic or something, you can see that they've been talked to about this and other things by their health coach.

Appendix: Compilation of Round 1 Input

Results: Staff, clinics, partners, collaborators

1, Continuous Improvement: Thinking about ways HCH effectively supports advanced primary care for better patient outcomes… What could we do even better?

There were 146 responses to this question. *(Navigation: Return to Table of Contents)*

- A stronger focus on equity outcomes (BIPOC breast cancer screening, etc.)
- Add more performance measures to access standards
- Advance or reform billing and reimbursement for financing community integrated and culturally responsive care
- allow patients to contact MDH with concerns on their HCH
- As a consumer site visit evaluator, I am interested in patient perspectives and advocacy to do my job better.
- As always, get the word out on the benefits of the HCH model and certification
- Better education to providers and teams for more engagement of services.
- Better understand the metrics used to assess clinic performance. What is HCH doing with this data?
- Bring model - program - success - before legislative
- Build out learning opportunities based on need + feedback. Opportunities to share best practices, promote a community of Primary providers
- Can HCH do better when it comes to measurement and support for patient care?
- Can HCH expand to a use of data sources above and beyond traditional medical quality data? Community health needs assessments, for example. Other MDH data. Data from community partners.
- can info be tailored to our specialty or area of the state
- Care Coordination
- Certified clinics could see noticeable perks ($, education, pts#'s, services report)
- Check-ins and Reminders
- clarity in the guidelines/ requirements (aka, dumb them down) :)
- Clinical Quality accountability
- Clinical sharing between sites for success
- Clinicians can't do everything. Expand emphasis on team and away from clinicians.
- collaboration with other health care resources IE. American Lung Association
- Collect course registration fees with a better system
- Communicating the nature and value of HCH
- Condense the application process for certification to get more clinics on board.
- Connect certified clinics to reimbursement
- Connect clinics with subject matter experts
- Connecting clinics to help each other with best practices
- Consider simplifying the names for level of certification to align with existing standards.
- continue to focus on strategies for advancing health equity, reducing health disparities, and cultural and community focused care even in uncertain times
- Continue to have training and learning opportunities related to progression levels of certification - particularly advancing to community integration
- Continue to review and improve application portal for efficiencies & advanced technology
- Database of action plans for specific disease processes that we could utilize for our patients.
- Develop consistent approach/strategy to engage uncertified clinics with model
- ditto to reimbursement
- do not waver from focus on inequities
- Easy Certification
- education for patients
- education opportunities
- Efforts seem to focus on Care Coordination and coordinators; expand to include org leaders, finance, providers, and payers.
- elevate standards on the use of patient data to improve care
- encourage measurement of HRQoL
- Engage staff in different roles in the clinic with learning specific to them (beyond care coordination)
- Engaged support; realistic expectations
- Enhanced access to technical expertise
- Excellent learning opportunities
- Excellent support
- Financial benefit of being HCH certified - could be many different ways

- Find ways to better publicize program successes.
- Find ways to make data more accessible to a general population.
- flexibility and understanding of local context
- free CEU education opportunities on a regular basis for RN Care Managers
- Gather data from patients and communities.
- Grant funding or supports for HCH organizations/clinics to progress to levels of integration
- Great understanding of how even the smaller clinics work
- Greater incentives for HCH participation (level progression)
- Have a central location where HCH team members can bounce ideas off of one another for difficult cases.
- Have more in-person (with remote possibility) learning opportunities
- Having a consistent contact at HCH when certifying and recertifying. We do that really well I believe
- HCH does a great deal to support advanced primary care, in particular through a commitment to support use of data to drive decision making.
- HCH does a lot of work with clinics – how is this leveraged among the peer collaborative and outside the program more broadly. Especially to share novel/promising practices.
- HCH has led the way in clinic best practice across the state, leading to a real change in how healthcare is delivered. So, difficult to quantify and compare between certified HCHs/non-certified HCHs.
- Healthcare has changed and I don't think elderly populations are aware
- Help to advocate for more vaccines for children
- Help to provide more funding that would help us to employ a CHW
- Help us to better understand the value or resources available under HealthCare Homes
- Highlight successes - feature (award) organizations who are top performers-share actions
- I do not feel that we have had any benefit from being a HCH for many years. Frequently, we forget that we are part of one. This is my answer for most of these first questions.
- I think everything is good at this time
- Identify population specific patient outcomes - based on diagnosis or age
- If you have little to no control over payments, highlight what HCH provides apart from finance. That said, without financial changes it may not matter.
- improve collaborations with other clinics
- Improve education on patient choice in specialty care (connect to outcomes performance, cost, etc.)
- Improve value of HCH certification for organizations (could be multiple strategies, covers multiple topics)
- Improved billing for care coordination
- Improved Reimbursement
- Improving care plans to make them meaningful to patients
- In-person training that is well attended (other than learning days)
- Increase awareness beyond the certified clinics
- Increase consumer education on what a healthcare home is
- Increase focus on building patient cohorts to align with the appropriate clinical experts
- Increase funding for care coordination services based on patient/needs and complexity
- increase patient partner/advisor engagement
- Increase public/patient awareness of model + its success
- Increased reimbursement opportunities from health plans.
- Involvement for patients in their health to help HCH succeed as goals
- Learning Days
- Learning Opportunities
- Legislative help with prior authorization reform
- Make HCH recertification or initial certification exciting and easy (or easier)
- Make understanding the benefits of a HCH more understandable to the general public
- Making use of data we collect to drive programmatic improvement
- More continuing education opportunities for Rural Leaders.
- More educational opportunities
- More educational opportunities for our teams.
- More focus on clinical quality improvement data.
- More targeted resources for rural locations.
- NCQA=HCH
- Need to better communicate aspects of the program that support health equity.
- Networking great performers with other clinics who need support
- Offers continuing educational opportunities

- Opportunities, incentives for (increasing/ developing) care coordination workforce
- Overall, you need to stay relevant. A strong communication plan and presence in MN healthcare is essential.
- Partner across various sectors to make HCH model THE standard/expectation
- Partner to set up (align) measures of patient outcomes on which all agree
- Pediatric to adult transitions
- peer to peer sharing
- periodically have another program come to HCH team meeting to share work with primary care clinics ORHPC, HEPD, HEP, etc.)
- Proactively communicate value in messaging to various audiences
- Process development when first becoming a HCH and developing policies etc.
- Promote elearning by featuring subjects or groups of topics in an ongoing basis
- Provide (better) reimbursement for certification
- Provide clinic resources i.e. ($, grants) to improve level 2 & 3 certification ability
- provide connections to common community resources impacting SDOH
- Provide more focused technical assistance. I.e. specific to a clinic
- Provide specific examples of level 2 and 3 community supports for individuals.
- Provide understanding and education to patients
- Provide ways to increase collaboration with community resources - two way communication, etc.
- Providing technical assistance specific to level 2 and level 3
- Reimbursement and incentives are lacking. Whatever is within your sphere of influence-influence.
- reimbursement pathways
- Remove any patient co-pay for HCH participation
- resources for all to use for patients and staff
- Responses to learning requests are addressed individually
- Roadmap to possible operational changes for successful outcomes
- Sharing of lessons learned
- Sharing tips and tricks to create community based programs
- Sharing with organizations how other organizations are able to meet certain requirements for the certification - workflow ideas/sharing.
- show how this benefits everyone
- Still need better coordination outside of our four walls. It is hard getting non medical collaboration and identifying partners
- strengthen relationships with our MDH contacts
- Support clinics in addressing social determinants of health and improving health equity
- Support for measurement and evaluation
- Support in billing/reimbursement for the additional services provided.
- supportive networking among clinics
- surveys to patients about care coordination services/supports in their clinics
- TA on specific quality measures, staffing challenges
- Target learning to clinics based on certification level or want to expand their level
- Technical Support
- The practice improvement specialists are amazing!!
- Vaccines for un- and underinsured adults such that when patients come in asking... we can provide for them.
- We appreciate the check-in emails/updates
- We are able to care for patients of all ages and payer types for Care Coordination needs.
- We are unsure as we are new to the process
- We could make being certified “cool” so everyone would want to be certified
- We could make HCH certification even more enticing/exciting for uncertified clinics
- yes funding to make progress - or some other ways to support teams of relatively low-resources

2, Changes: Thinking about what HCH is doing that is not as effective or valuable in supporting advanced primary care…What are your suggestions for key changes or improvements?

There were 112 responses to this question. *(Navigation: Return to Table of Contents)*

- A clear roadmap to billing practices; 1:1 support with billing team
- Additional support for billing issues
- Adjust patient outcomes to better support chronic disease management, specialty populations, and pediatrics
- Align patient outcomes to national standards for care coordination for children and youth with special healthcare needs
- Alignment of measures to reduce duplicity and burden on clinics
- alignment with MIPS and other quality measures (if not already doing this)
- And market all elements of the program- as HCH applies to all people who receive care
- assistance with contracting -proof of our enhanced patient care to insurance companies
- Assisting with connections between clinics that are doing well and clinics that need support
- better reimbursement/ making it easier to get
- Billing opportunities for the program implementation
- Build evidence base through research, program evaluation etc. measurement
- Building the case for why organizations should obtain and maintain HCH certification
- Care Plan improvements to make them meaningful to patients
- Change the name of the program to clarify what we do
- Commissioner Cunningham engaged with program
- Communication with HCH clinics leveraging technology ↑ accessibility make it easy as possible
- concise recertification instructions, or sharing others recertification presentation to determine what other clinics are focused on
- Conduct stronger P.R. with providers, patients, payers, etc.
- consider developing a one pager that describes the benefits of certifying health home
- Continue to provide ongoing training to ensure sustainability for clinics with turnover in staff
- Could HCH nurse planners connect with SHIP grantees who've selected community-clinic linkage projects?
- Data analysis, internal program measurement + Q1 processes
- Develop stronger partnerships with payers
- Difficulty in billing eliminated + make billing worthwhile
- Direct payment for care coordination
- Do more in-person training in different parts of the state
- easy reimbursement
- easy to access data to share with VP/admin teams on statewide successes and future goals of HCH
- education on recruiting and collaborating with patient advisors
- Encourage collaboration across HCHs to get patients connected with the best medical and social supports (ex: community resources, specialty care referrals for conditions/chronic disease management)
- Engage clinicians and other clinic staff with whom HCH does not "normally" connect
- Engage with partners that then request their servicing clinics be certified
- Ensure HCH is connecting with the right leaders/stakeholders at the clinics
- Establish adequate reimbursement mechanism that supports implementation of the HCH model
- Evaluate HCH program on a semi-regular basis
- Expand beyond physicians in primary care. Inclusion of non-clinical care in primary care.
- Expand the model application beyond primary care.
- Expanding awareness of MN work nationally elevating HCH's work
- Financing and reimbursement to support staffing and implementation of HCH certification guidelines
- Focus equally on rural, lots of discussions apply to metro area more
- Funding availability and mechanisms are not well aligned to the program's ambitions
- Have certified clinics mentor non certified ones to guide + coach them to certification
- Have HCH program integrated with state reimbursement like other states who have similar programs like HCH
- HCH data reports electronically (easy entry - great graphs)
- HCH involvement across MDH - collaboration with every division or bureau
- Help or improve billing

- Help us advocate for additional funds -- grants, in-kind, etc.
- help with costs associated with unreimbursable care coordination
- I agree with the incentives and partnering with our payors.
- I still feel that many providers are not on board with patient centered care
- I still think there's a lack of understanding of what Health Care Home is. Within healthcare and within the general public.
- Identify barriers within clinics on why they wouldn't become HCH certified. Ex. Cost, support, etc.
- Improve partner engagement - consider required sharing/peer-to-peer engagement
- Improve reimbursement or grant opportunities for HCH certified locations.
- Improve the “value” or importance of HCH certification by exclusivity and “reward based” incentives
- Improved financial incentives - partner with DHS IHP
- Improved messaging to community what it means to be HCH - tagline (we’re doing it)
- improved technology for outreach and identifying collaborators
- Incentives for certification
- Increase contact with uncertified organizations
- increase engagement with patient partners
- Learning Days Cost - Many healthcare orgs are on tight budgets right now. Scholarships/Discounts/etc.
- Learning opportunities bigger budget for enhanced presentations
- Mandate payers provide a generous payment to certified HCH + publish it
- Market your program, as mentioned in our Sustainability meeting- to providers, the public, other healthcare organizations.
- marketing of program to recruit staff
- More education for clinicians and support staff
- More focus on increasing the connection to evidence based care guidelines
- more frequent structured touch points with clinics to stay on task. could include future goal planning, strategy and quality discussions
- More networking with other clinics outside of learning days
- More opportunity to integrate public health into recertification and the HCH model.
- More research into patient outcomes after intervention from Health Care homes
- More rural resources
- More structure for what needs to be completed for Certification. Maybe not so vague
- None
- not necessarily an HCH issue per-se but we see a lot of uninsured patients - is there a way to quantify value of this care in that group (maybe cost and financial drivers might be unique/different)
- Obtain & showcase data (publicize) that shows improved outcomes of certified clinics
- Our local teams do not get enough recognition for their efforts.
- Partner with community leaders in under-represented groups to identify new ways to reach their community
- Partner with NC QA to achieve same or similar criteria = >value
- Partner with nurse assoc. Or other professional orgs to offer C.E. for HCH learning
- Payers request the clinics become HCH certified + reward it
- Proactively collaborate and partner with schools and community resource groups
- Provide clinics with data & financial incentive on benefits of becoming HCH
- Provide financial resources to support adoption of changes necessary for level 2 +3 certification
- Provide public with data surrounding efficacy of the health care homes model
- Public service +announcement +commercials +social media campaign for the HCH program
- Recognition + payment for level 2 + level 3
- Recognition of certified clinics
- Reduce administrative burden in recertification (although it's come a long ways!)
- Reimbursement ↑rate ↑prospective $
- reimbursement/ financial assistance
- Resources for small rural sites to be part of HCH
- Rural physician recruitment help
- SDOH is so important and our community health workers are overwhelmed with the need for social worker access
- Sharing ideas from others as to what is and isn't working
- State mandate that all clinics providing primary care become HCH certified within first few years of operation
- State mandate that all primary care clinics register with state so we know who they are + give contact person

- Support -public acknowledgement- of program from key leaders
- Support with insurance companies
- Target learning to clinics based on certification level or want to
- Technical assistance on some of the program components
- There could be more emphasis on aligning patient cohorts with the provider's best positioned to support them
- Tiering tool to capture the patients' conditions more accurately
- Training in Billing for Care Coordination services.
- Understanding the role of CHWs in Health care homes
- Use policy levers within other agencies + programs to elevate HCH as the primary care delivery model in MN. Esp. Medicaid. Other payers
- value-based care education
- We are unsure about how we can leverage the value of healthcare homes while meeting the needs of patient
- We need more connections to resources in the community to address SDOH
- We really do not understand what the value proposition is, and are unable to explain to others why we are in Healthcare Home

3, Health equity: In what ways does HCH help ensure that health equity is successfully embedded in primary care?

There were 58 responses to this question. *(Navigation: Return to Table of Contents)*

- Adding this piece to Level 3 holds clinics accountable
- Advanced certification levels (i.e. Level 2 and Level 3)
- agree with standardization
- Ask our speakers to make sure HE is incorporated into teaching
- assessments and screening tools
- By having an advanced level of certification that speaks to social determinants of health.
- By requiring this work for higher levels of HCH Certification
- Certification has many areas where you need to show how your community health improvement teams will help address equity.
- Certification standards & requirements
- certification standards based on levels
- Concentration on certain disease processes
- educational resources
- Emphasis on SDOH questions to achieve LVL 3 status
- Engagement with the work of the Equitable Health Care Taskforce
- HCH supports the foundational effort of measuring health equity and the identification of gaps
- HE is embedded throughout the certification program - level 2 & 3 puts a greater focus on HE
- Healthcare Homes helps us to raise some awareness as to the need and the imperatives of social justice.
- I think the new levels address this
- I would love some type of HCH dashboard for managers to utilize. Something that we can see more data points from and have access to reporting capabilities.
- Includes patients in things.
- Inclusion of focus on assessing and addressing barriers to care
- Incorporation of level 2-3 - ensures PC addresses SDOH & population health
- keeping it as a core/foundational principle
- Learning activities often emphasize equity
- Learning objectives specific to health equity in HCH learning opportunities
- Level 2 and 3 certification
- Level 2+3 recert, cert requirements
- level 3 focus on SDOH
- Making sure equity is incorporated into our learning opportunities
- Ongoing support for clinic-community partnerships
- Online and printed materials include equity related examples (es. compass)
- Organizations sorting data to identify opportunities
- part of certification and moving up to levels 2. 3
- Patient and community advisory committees and engagement in HCH models
- Pr. adv. Council
- Program requirements verified through cert/recert
- Promoting advanced levels of certification, integration with community, addressing health related social needs, diverse workforce, culturally appropriate care and access
- Promoting HCH workforce focused on health equity, such as CHWs
- Provide trainings to support clinic health equity efforts
- provides a standard/model - these are important
- Provision or social health-related data as part of recertification
- Quality reporting that shows we are making an impact with improvement across cultures, race, etc.
- Seeking those populations that are very complex and are maybe burned out with all the selfcare. HCH facilitates RN coordination along with other disciplines to assist in coordinating care that is successful for our patients. The outcome is almost always positive
- Sharing best practices among clinics creating platforms for clinics to share their work - successes and challenges
- standards requirements
- Standards that require patient involvement participation
- stratification of patients by risk, not other demographics
- Target patient providers (direct & indirect) for HE training
- The certification ensures screening questions are being done and the follow-up with how they are being addressed.
- The emphasis on person-centered care and community support addresses where a person is at and what their individual needs are.
- The HCH administrator came to our clinic to help us with the enrollment process. Joan was

supportive from the beginning to the end.
- The Higher Level of Certification helps to ensure this.
- The Patient Centered approach
- The rule and certification process
- The values around patient, family, and community
- Tiering model such as levels 2 and 3
- Training on HE (webinars, e-learning at learning days
- Cultural, linguistic, social concerns are the main focus of HCH equity.

4, Health equity, continued: What could we do better or differently?

There were 102 responses to this question. *(Navigation: Return to Table of Contents)*

- acknowledge and educate teams that patient outcomes are mostly determined by non-clinical factors
- acknowledge "years of involvement" with clinics -i.e. digital certificate annually - recognition for continued involvement etc.
- addressing different cultures and needs
- Align metrics with payors. We already have SO many measures we are held accountable to.
- Are there questions or components of certification that report on progress towards health equity specifically?
- As a FQHC we continue to identify Patients with multiple SDOH needs but due to external restraints (immigration status) we are unable to access care options. We can identify so much need but trying to fill the gaps is so very complex
- Ask clinics/staff how we can help them address + learn HE
- Assess the impact of Level 2 and 3 certification.
- Award clinics for advances in their HE clinics
- Because reimbursement is limited, the scope as to which we can have team members doing this work is limited. We need improved reimbursement opportunities so that we do not feel like we are limited in how many HCH enrolled patients we can have due to lack of staff resources.
- Buy in from providers for HE activities
- Case studies or success stories on how specific HCH clinics are advancing health equity
- clear requirements
- collect and share data on disparities
- Community education on Health Equity
- Connect clinics that might be working on similar equity issues
- Consider Community Health Workers (CHWs) in communities to bridge gaps in care
- continue to clarify how primary care practice addresses health equity. Who is included?
- Continue to work on standardizing our analysis of clinic /community. SDOH & HE that is shared with others
- Create stronger partnerships with individuals in underserved communities who have real knowledge of those communities and their needs.
- Educate how to use data and the HCH approach to identify and address inequities, become MNs subject matter experts in this area
- elevating the stories
- emphasize patient improvement on SDOH scores/results
- engage patient partners on projects in equity
- Engage with community leaders (non-medical) in under-represented groups to identify improved ways to reach their community
- ensure the certification process identifies specifics on how the organization is hearing the health equity voices and addressing equity in their practice
- Equity data collection and reporting
- Feature success stories more + details
- Financial incentives to ensure sustainability of assessing and addressing barriers to care
- Give examples from clinics similar to mine.
- give us funding to build programs to give things to patients who need them
- handouts or patient-facing info in other languages
- Have a health equity toolkit for all types of clinics.
- have a learning session on what HCH offers in regards to health equity not really sure on that
- Have clinics share how they addressed HE and what works + what does not + how they partner to do so
- Have payer reward clinics for addressing health equity in their population
- Healthcare homes could become a stronger advocate within the political environment, and especially at the Minnesota Department Of Health, to raise awareness of the work that Clinics, such as ours are already doing.
- Help clinics better understand diversity in the patient population and communities
- Help rural clinics better meet needs, outreach etc. when they have very limited resources and staffing
- help standardize language around health disparities and inequities
- Help the Clinics to secure reimbursement for community health, workers, and the work that they do within the community advancing the imperatives of Healthcare home... In other words advocate with the department of health, Numan

services that a community health worker's time or encounter is billable.
- Highlight clinic and Payor partnerships who are working together to address HE
- Highlight organizations who are doing this well.
- highlight successes w stories, and qual/quant evidence (I know we do this, maybe do it more?)
- Highlight those doing well AND share what they are doing
- Highlight those who are doing it well
- How about asking somebody in leadership at the Minnesota Department Of Health to actually visit the clinics to see first-hand the work that is being done.
- I don't have an answer, but we have low childhood immunization rates in our MA patient population
- Identify "top 3" patient outcomes with the greatest inequity and create common goals to decrease the gap across HCHs
- Identify health equity issues and create goals such as improving BIPOC breast cancer screenings
- Improve or create an importance on HCH training. Provide HE training opportunities annually + participation options
- Improve sharing of community based resources, and increase their availability
- Include diverse patients & partners on committees & surveys
- increase access to dental services for patients with medical assistance
- Increase education on how to recruit patient partners that represent the cultural makeup of the clinic.
- increased transportation resources
- intermittent check ins with sites to provide support
- Interview diverse staff when HCH openings exist
- It is a problem when one of our major insurers UCare is not in with our safety net hospital - Regions
- It's part of recertification, beyond this, I think there is a lot of room for improved assistance for local teams with this requirement.
- Make HE activities more specific
- Make it easier for clinics to recognize HE initiatives that may work for them
- more equity voices on staff, advisory groups, and other ways of incorporating representatives of health equity and disparities
- More resources for SDOH, who is available to us in our area
- More targeted HE initiatives in learning - always address HE when we have the opportunity
- Much more education on involving patient participation in all levels of QI DEI
- Offer certified locations funding to hire dedicated nurses to focus solely on HCH and health equity
- Offer resources/ connections/ networks for patients. Educating HCH Clinics on these resources so we know where to go with these patients.
- Once the Equitable Health Care Taskforce recommendations have been finalized, bring them to the HCH Advisory Committee for review and discussion. Maybe these recommendations could help inform the HCH strategic planning process?
- Partner with other government programs to better support equity in primary care
- Promote + build evidence - base to articulate how HCH impacts equity
- Provide education that takes clinics step-by-step through data stratification + identifying opportunities
- Provide education to clinics on how to find or identify health inequities.
- Provide more guidance/learning on how clinics can incorporate HE into their facility
- Provide more training to staff
- Providing access to help/support for those patients that we have screened for SDOH.
- Publish/promote to others ways that various clinics have successfully addressed health equity
- Raise awareness of what other clinics are working on
- resources for certified diabetic educators
- Shared resources to help with documentation and meeting goals for rural sites to be apart
- Sharing best practice and tangible (successful) workflows for improving health equity
- show alignment and how focus on equity helps everyone/entire system
- So much of social justice and our ability to serve the community well, that is as a healthcare home, requires better resources. In our case, Healthcare Homes could help us by providing the critical resources to better serve the community.
- Some of the rural sites just don't have the resources and staff to apply for or do the work for HCH or to go for certification. Although they would benefit the most

- Spotlighting successful clinics and partnerships is a great idea
- Start public transportation in rural areas
- statewide resources to give to patients
- stay nimble with the current national administration on how to continue promoting health equity
- Strengthen the HE criteria in certification
- Stronger measures that show health equity
- support better public transportation in rural areas
- Support clinics in identifying disparities or highlighting inequities. - sharing actionable data -financial support - system transformation
- The HCH program can also partner to highlight success work, and market how HCH led to the improvement.
- training and hands on support regarding process and workflow changes for frontline staff
- Transportation for rural areas
- Use measurement and data to support work on health equity
- We need more support for our HCH team members. The work they do is very draining and the burnout is significant. Managers for these teams need help with supporting them.
- We really need to get to the point where healthcare is considered a right, health care for all,
- Work collaboratively with other stakeholders to better support the use of closed-loop referrals between clinics and community-based organizations.
- How can local public health work more with clinics to promote equity?
- Health literacy really needs to be strengthened. We need to measure it.
- Should lift up the work of Hennepin Healthcare to strengthen their staff's capacity to support health equity; they've done an impressive job.

5: Thinking ahead 5-10 years, what opportunities and innovations could we collaborate on to measurably improve health outcomes for Minnesotans?

There were 155 responses to this question. *(Navigation: Return to Table of Contents)*

- Advancing community based care models such as community care hubs
- Agree on 2-3 Clinical Quality Measures that we work towards improving
- Axis is willing to host continuing education and seminars, can healthcare homes support us in an initiative to improve the overall health literacy of the Staff?
- be an organizing force or model for collaboration
- Better coordination with value-based care and figuring out how we can better support success in participation in such models.
- Better integration of Dental, Behavioral and Medical care
- better preventative screenings, access to obtain
- better reimbursement, to spend the time needed to with our patients
- Better ways to address SDOH in a quick manner.
- Breaking down barriers in the county based processes such as long wait times for processing waivers, MA applications, can't get through to case managers on the phone
- Broad education on health insurance (options, what are the benefits, what plan should I choose)
- Build curriculums that should be used in any healthcare training facility regarding the patient-centered medical home (PCMH) model
- Build partnerships with specialty areas that allow easier transitions to specialty care.
- Build strong support among public and private employers for HCH
- Can healthcare homes loan us a nurse?
- Care coordination is a major feature of HCH. CHWs, care coordination, is this really happening? Seems like still a battle to get these services, especially for the elderly. More demand than there is supply. Opportunity to try and solve this problem.
- Care integration- how many times we sit at tables and talk about how to integrate primary care with oral health and behavioral health? Need to move forward with integrated care that is financially supported. HCH has done a lot to move the needle on this issue, but there is more work to be done. What can be done that is meaningful above and beyond just referrals. Are there gaps and opportunities in our standards? Stretch possibilities?
- clinical teams partnering together to meet whole person needs
- Collaborate on efforts to expand health literacy patients in the some 20% of Minnesotans who have real problems navigating the healthcare system.
- Collaborate with employee groups for promotion
- Collaborate with other parts of MDH (ORHPC, HPCD etc.) more broadly to help expand HCH reach, recognition & effectiveness
- collaboration with other healthcare entities
- collect patient-reported measures on health (as a health outcome itself)
- Connect what is done for HCH certification with better outcomes
- consider the patient experience (via satisfaction surveys) in integration
- Continue and maybe increase collaboration with other entities that work toward improved health both within MDH and outside the agency
- Continue documenting the evidence and impact of HCH in MN through studies like MNCARES
- coordination of "care coordinators" across clinics, payors, LPH, etc.
- Could HCH play a role in finding ways to pay for and incentivize efforts to promote health equity?
- Create a statewide "hub" for SDOH resources
- Create a sustainable funding model that works for payers, providers, and individuals with incentives aligned appropriately
- Creating a roadmap for the more efficient incorporation of evidence based practices into HCHs, noting they continuously evolve with research
- Demographically, what are the MN population health care needs and how can Primary Care deliver on them?
- Develop a grant for Community Health Workers to become contracted within an organization
- Disaster planning for short term and long term events. No one expected Covid.

- EB reimbursement for SDOH work done in the clinic from federal + state & private payers
- Education to patients and communities with language and access to care barriers
- Education to patients early to prevent future decline in health
- elevate innovative practices, large and small - study their impact
- Emphasis on remote patient monitoring
- Enhance HCH capacity to provide useful social and health data to stakeholders
- Enhanced shared decision making between patients and their care team
- Establish standard outcomes and measures, within the state, that provide benchmarking
- Establishment of a value-based HCH reimbursement mechanism that includes prospective payment
- Expand our definition of integration (i.e., more than just behavioral health/medical)
- Expand program to specialty clinics
- Expand standards that address access to care
- Expand the knowledge in public + gov of value of HCH model of care to increase funding for clinics
- Figure out how to uplift clinicians and leaders to be advocates of the HCH model.
- Financial incentives for certified clinics
- Find a way to designate payers as "HCH friendly"
- Focus on children, education to schools etc on diet, focus on prevention of illness , outreach
- Fund consistent evaluation of the program
- Funding availability for HCH certificated clinics based on levels
- Gathering data + sharing what works within clinic to improve outcomes - evidence based
- Greater emphasis in connection between health disparity data and evidence based interventions QI initiatives
- Greater emphasis on physiology vs pharmacology. General well being weight loss, active lifestyle. etc.
- Greatly increase clinic capacity to address health disparities and health-related social needs to change through learning, TA, and peer-to-peer engagement
- Have goals to make sure that primary providers understand what is important to the individual needs of the patients. Make sure that everyone is treated as an individual, and they are fulfilling their goals for the visits.
- HCH can work with stakeholders to promote greater investment in primary care.
- HCH cert required for IHP participation + full Medicaid/Medicare payment
- Health care for all, Statewide formulary which would remove barriers for prescriptions,
- Health care is very expensive. We need to knock down barriers for our patients AND providers AND care teams.
- Health insurance for everyone in MN
- Health plans/insurers are part of the conversation when it comes to preventative care. They have access to the kind of financial resources that can effect change. Need to bring them into closer alignment, especially when we think about long-term impact on social determinants of health. Work with health plans to build value-based models of care that would address social determinants.
- How can AI help?
- How can we encourage patient centered communication for those that do not want to use a portal?
- How is care coordination measured, evaluated, advocated for? This would be a meaningful quality measure from a patient perspective.
- How will medical services delivery systems continue to evolve vis-a-vis payment and other broad issues?
- I would push back- is it recognized as a standard of care? I think you need to work to make sure it becomes that. The converse is that it could become obsolete.
- Identify possible levers that could be used to enhance cooperation between clinics and community providers.
- Improve data infrastructure - shared dashboard for patient outcomes across systems
- Improve patient awareness in the HCH designation & what that means for their care
- Improved access to care for all MNs.
- Improved competence for patients' ability to navigate MyChart and other electronic platforms
- Improved Health Information Exchange
- improving geriatric care
- Incentives for demonstrated improved outcomes (financial or other)
- Increase access to BH resources - consider virtual accesses.
- Increase diversified care in all clinics

- Increase feedback from patients
- Increase peer to peer clinic connections through the creations of a statewide networking model
- Increase reimbursement for primary care
- Increasing abilities for remote visits...no one should have to travel if they are unable and still be able to get the healthcare they need
- Interdisciplinary, team-based care models
- It's passé, but looking ahead to an even older population and needs.
- leading to expand the definition of health care to match determinants of health
- Let's stay engaged and continue to work together.
- Let's really achieve the Holy Grail of interoperability in EHRs
- linking healthcare and technology
- Make it easier for clinics to make claims. W/all payers collaborate
- Mapping and alignment of HCH with other efforts, initiatives and advances in models of care since HCH began. e.g. IHP, ACOs, Community Care Hubs
- Maybe different regions could have a regional approach each year? Something specific to target work on that is impactful for that dedicated region of HCH clinics.
- Maybe HCH regions could have patient representatives at meetings more frequently. We need to be getting their perspective more often.
- MDH HCH home team to be accessible to the patients to ask questions or report concerns
- meaningful care plans that are used by the patient to navigate through the systems of care
- methods/workflows proven successful for broader integration
- More transparency for patients on cost and quality of care
- Moving the dollars to health care providers/organizations so we/they have the resources to impact outcomes.
- Need for stronger community and public health partnerships.
- Need to keep our hospitals for the critically ill, we need to measure how we can help prevent hospitalization by what the work is doing
- Nursing leadership opportunities to attend HCH educational events
- opportunities for more connectedness between systems and shared records
- Overall, you need to stay relevant. A strong communication plan and presence in MN healthcare is essential.
- Partner w/ DHS to support HCH as "the" certification
- partner with Dept of Human Services on the SDOH needs
- partner with Electronic Health Record vendors to improve documentation of patient centered care
- patient partners will be engaged at all levels of clinic
- Patients' understanding that they can actually improve their health. Discussions and education from the onset of a dx.
- Payer prouder program. Alignment of medical + social outcomes
- People are rewarded for taking care of their own health (incentives for wellness)
- policy, systems and financing changes to support HCH as a standard of care
- prevent a staffing crisis (go to schools and share info to market healthcare careers)
- public facing education on HCH
- Push for funding for care coordination services in some way from all payers.
- Real need for a "redesign" of the healthcare system to better meet the needs of those populations not being well served under the current model.
- reducing disparities
- regional QI or Performance Improvement Project projects to work on together with HCH team and consumer site evaluator
- reimbursement for HCH to see patients, no matter what insurance they have.
- Rural area community resources to meet SDOH needs
- shaping incentives for specialty providers to engage with primary care providers on improving value and quality of care
- Shaping the future with health informatics
- shift 80% of HCH services and effort (from MDH) to connecting clinics/health systems to community resources.
- Staff/Provide a Community Health Worker that HCH clinics could refer patients out to for help with SDOH resources.
- still lot of gap in preventive screening in different populations , collaboration around education
- Strengthen + Leverage community + network of HCH's and their primary care teams (to be a powerful voice)
- Stronger alignment between HCH and ACOs/value-based payment models. Better communicate how HCH works together with such models to support better health for patients.

- Supporting advocacy efforts to sustain patient care when under-resourced
- sustainable partnerships with community organizations
- Technology linking hospitals to help with discharge planning and getting patients scheduled for visits before ER/UC/ER discharges to minimize readmissions
- Telehealth options to work with HCH at the clinics
- The HCH program needs to partner with other organizations, similar to the expectations of the new levels, to leverage the program in new ways, increase awareness, and ensure the application of the program is as broad and relevant as possible.
- The need comes down to critical funding. We are willing to do the work of serving the community, we need critical funding.
- Training to nursing and physicians on value-based care
- Transportation options in rural areas
- true data exchange with community organizations/partners and clinics or health systems
- Universal directory of community resources to help address HRSN
- Universal health care or Medicare for all - primary care is free to patients
- We can align on specific outcome measures and prioritize appropriately
- We HAVE to have better partnership with our MNCM leaders to help align measures across the board. What measures are truly impactful.
- We need more community paramedics.
- We need sustainable services to provide for ALL our patients. Oftentimes, there just aren't enough resources out there.
- We need to be able to get into pay for performance. We need to improve quality. And it would be helpful to create actual workflows and solutions to these needs.
- We screen for SDOH but we need resources to support patients' needs
- With all the new clinics popping up in our area, it would be nice to know who is providing primary care in our area and how/who they serve.
- Work to build a data warehouse across different sectors, including; payers, government, clinics, etc.
- Work together to create a strong data sharing model. All efforts in healthcare are going to continue to be thwarted until there is meaningful data exchange and a data warehouse. All Payer Claims Database (APCD) is great, are there ways to leverage more? How can clinical data be added?
- Work with clinics and MDH partners such as CHIPT in order to expand data sharing. State (HIOs) and national (TEFCA) models exist.
- Work with DHS to highlight HCH cert to promote primary care
- Work with Leg rulemaking to promote better reimbursement for primary care
- Working together with community partners to co-create a new model of primary care.
- Working together with the Office of Rural Health and Primary Care to enhance mutual understanding of available data and how to effectively apply it.
- working towards streamlining access between primary care and community organizations - we put the burden on our patients today
- Working with the payers on coverages/cost/etc. Use our data to show them that cost is a barrier to their improved outcomes. Connecting those dots.
- Yes! How do we build our future healthcare staff? Constant shortage is exhausting

Results: Patient Advisory Groups

PAG 1: What new or different information on the Health Care Homes Patient Information (https://www.health.state.mn.us/facilities/hchomes/patient.html) webpage would be more helpful to patients and the general public?

There were 24 responses to this question. *(Navigation: Return to Table of Contents)*

- A bit difficult to understand. Simplify even more.
- Add new tagline on webpage
- Agree, how do people get to the public facing site?
- Discuss that insurance companies encourage patients to go to HCH clinics.
- Explain what happens in the background if a patient is receiving care in a HCH. Tout the extra things a HCH does for patients that others may not. All the things that you mentioned in the HCH standards.
- Have a plan to get people to this site (marketing)
- Have this link on our clinic's website if patients have questions on HCH. Do clinics know about this area of the HCH website?
- I like how it explains what it is and then it tells you the terms that puts you in there that explains each one of those.
- I like the links within the webpage
- I think so far you got it right on the website, but I would have to spend more time reviewing.
- I, like most patients I believe, do not know what a HCH is and why it is important, even though I receive care in an HCH. I would not go to the HCH website and find the patient's webpage unless it was linked in some information I received from my clinic. Like in the portal, on their website, in their Facebook page, something like that.
- If not, the link or direction to the 'public' page needs to be seen within the first view- no scrolling necessary (currently too low, and people will miss it)
- Is there a way for people to arrive at the public website without going through HCH?
- More data for home page of website could draw in more attention.
- Most people in our area choose a clinic by distance from their home or family history with that clinic, I am not sure if they care if it is a HCH or not.
- On webpage, under what is a HCH - Level 2 bullet, add examples of how connecting to community resources could be or is done within clinics.
- On webpage, under what is a HCH - Level 3 bullet, add examples of how improvement is gained. The emphasis is on participating and sharing responsibility in community-based health improvement efforts. How is this done?
- Provide a comparison of quality between HCH certified clinics vs non HCH on website.
- Share personal success stories on the website (MDH's)
- Simplify #1 – what is a HCH – I did not realize it was talking about my clinic (a Certified HCH) at the beginning. Start with describing that a HCH is a clinic, the way they provide care. I did not know this.
- Video Testimonial: show me
- What is the cost to me, the patient? That's what everybody wants to know. I am glad that is noted on the website.
- What's in it for me- show outcomes
- Why does this matter to me as a patient? Why do you want me, a patient, to know anything about a health care home? Should I care? I trust my clinic is providing the best care.

PAG 2: Understanding that Health Care Homes staff has no direct access to patients, what are some additional ways to help patients and the public learn this information?

There were 29 responses to this question. *(Navigation: Return to Table of Contents)*

- Advertisements explaining the HCH on social media.
- Attend Church and Community Meetings
- Create a Facebook page. Advertise in the newspapers, on local TV, and other media.
- Email Marketing
- Have a "media kit" for clinics and others to use. Things for TV, newspapers, websites, and other things that you do not need an account to access (unlike Facebook and Twitter). This would especially reach the older population.
- Have a simple card explaining what a HCH is and does for patients and why they should seek care in a certified HCH. Provide these to all certified clinics and general public during events.
- Have articles on HCH and how it benefits patients in the Thrive magazine (Mankato Clinic's own health and wellness publication) just to get the word out and familiarize others with HCH.
- Have clinics put their clinic name "Ortonville AHS, your home for healthcare", on their website and on the very top of HCH pamphlets. Then explain what a HCH is and why being cared for within a HCH is important/valuable to a patient.
- Having educated Drs, nurses, NP, PA, staff and community partners to help identify patients and families that would benefit from a program like this.
- Help clinics with marketing by providing fliers, letters, media, storytelling to get it mainstreamed.
- I get a HCH charge on my bill, I have a chronic condition and have care management. Is there a way to send information regarding this HCH program with the bills? Explain what the charge is (if there is a HCH/care management charge on bill) and the benefits we receive from being in a HCH and in care management.
- In our county, Big Stone, Family Services is pretty much the resource for 75% of our population here in some facet, whether it's for their children or themselves or transportation, financial, healthcare like we are intermingled with the county. That would be a big place that you could make HCH known. Especially that care coordination/health coaching would be an option for some of their patients. I feel like the majority of the patients that they take care of probably could benefit from care in a healthcare home, especially the health coach portion of it.
- Make sure the information is condensed and concise.
- Periodic press release that HCH certified clinics can customize and pass onto their local papers and social media. Maybe highlight a positive of HCH, what they do, or patient experience in each article.
- Physicians and Nurses Associations
- Posters/brochures available in clinic patient areas like lobby or patient rooms to educate patients on HCH (OAHS said they would gladly put them in patient areas if provided by HCH). Better yet, could add clinic specific info into them or their own patient quote. Make sure they are simple and clear. (Like the current HCH brochure)
- Posters/flyers
- Press Release
- Provide clinics with something educational/informative about HCH that they can post on their websites, Facebook page, other social media.
- Provide pamphlets or something so that our county public health and social services would know that clinics in their area are HCH, what a HCH is and that they can refer patients for care coordination or other HCH services. There needs to be an explanation out there for them.
- Put information on patient boards in each exam room and in the lobby waiting area.
- Put out information that clinics can easily post on their social media (e.g., Facebook page) about HCH.
- Put posters in exam rooms explaining the HCH program, maybe have a QR code that links to the MDH HCH website.
- Recommend a marketing plan: how would someone new to MN, searching for primary care, find information about HCH? That is how you need to think about reaching patients/families.
- Run a feature: newspapers, patient education channels (played in waiting rooms), or other health materials (magazines)
- Social Media
- Social media reaches the younger people and could draw more attention and get people to understand

HCH. This might encourage some to seek care in a HCH.

- Video
- You must not rely on a website, as rural and older individuals do not always have access

PAG 3: How might advisory groups such as yours help ensure that information for patients about health care homes remains valuable over time, and that patients can access it?

There were 12 responses to this question. *(Navigation: Return to Table of Contents)*

- Add HC info onto focus groups in the community – clinic and community related.
- Checking in and advocating
- Conduct periodic focus groups on this with patient advisory councils.
- Educate clinic staff and providers to talk more about this great feature of Mankato Clinic.
- HCH is one of those things that is like the other thing we talked about, you don't know about it until you need to utilize it or you don't look into it until you need to utilize it. If it doesn't pertain to you right now, you probably do not care.
- I like that HCH staff (MDH) came to visit with us about HCH. We have never talked about it before this, or at least I do not remember it being discussed.
- I like that you came here in person to get our opinion, that is important to me. It also makes me think that this program is important. You should go to other places to talk about HCH, such as our clinics/organizational meetings, to other clinics, boards, and community meetings and all over the state
- I was not aware of what a HCH is until now.
- Is it important that patients know the HCH name, or should they just know that their clinic has a program / certification to provide them a high standard of care?
- Our PFAC could spread the word and promote our clinic's HCH care. Maybe more education for PFACs about HCH?
- Return to clinics/advisory meetings every so often to get new ideas and educate.
- We can spread the word verbally to our PCP and internal med Dr.

PAG 4: Feel free to use the space below to offer any additional thoughts below.

There were 10 responses to this question. *(Navigation: Return to Table of Contents)*

- Connect with Home Health. They are key in transitions and in coordination
- Could you publish a study of the cost efficiency HCH brings to all (patient, payers, clinics)? This would make an impact on how important a HCH is.
- From the facilitator: On the hospital side, when I'm in a patient's chart, if they have a plan of care with a health coach, it's like one of the first things that pops up in their chart for me. When I pull up their patient dashboard, that gives me all their information and then I can see all the results and then it has their plan of care with the healthcare coach. So we can see what their norm is, too. If they would present to the ER as a diabetic or something, you can see that they've been talked to about this and other things by their health coach.
- Have data comparing HCH to non-HCH – link to other websites that might show this.
- I work for the state of MN and get my insurance through SEGIP. I never saw anything about which clinic is a HCH. We look through the list every year and I know it was not there. Make sure there is a larger Notation for certified HCH clinics on their website. I totally missed it if it was even there this past year.
- Our quality is very good here at OAHS, much better than our other area clinics. We need to promote that more, so could HCH provide us with ideas on how to do this?
- Provide examples and/or gather stories from patients who received care in a non-certified HCH clinic and now are receiving care in a certified HCH – what is the difference? Compare the two for patients to realize the importance in receiving care in a HCH.
- Public Web page is buried in the HCH site.
- Storytelling around value-based care – what is the value of care coordination? How is it paid for?
- We have two RN health coaches that do the majority of this stuff. They cover the caseload and work with the provider of the patient to establish a plan.