

Health Care Homes: Annual Report on Implementation

Report to the Minnesota Legislature 2010

Minnesota Department of Health
Minnesota Department of Human Services

December 2010



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Executive Summary

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

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

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

Activities and accomplishments

In 2010, the Minnesota Department of Health (MDH) and the Department of Human Services (DHS) have made significant progress toward the statewide transformation of primary care through health care homes. 2010 accomplishments included:

1. Certification of the first health care homes in Minnesota
2. Enrollment of state health program participants in health care homes
3. Continuation of collaborative learning/capacity building activities
4. Implementation of the payment methodology
5. Development of evaluation plans and outcomes measures
6. Creation of tools to engage consumers about health care homes
7. Selection as Medicare demonstration project site

1. Certification of first health care homes

MDH has developed an efficient process for certification with consumers on the certification teams and interviews of consumers/patients from the clinic. Through that process, MDH is able to see if clinics/clinicians meet the rigorous standards for certification. MDH certified the first set of health care homes in August 2010. As of December 2010, 47 health care homes have been certified. These include both urban and rural clinics, range from single-physician to large systems clinics and stretch across several regions of the state.

2. Enrollment of state health program participants in health care homes

Based on past claims data, DHS estimates that roughly 80,000 Minnesota Health Care Program (MHCP) enrollees are being served by one of the state’s 47 certified health care homes. This figure represents 10.5 percent of total MHCP enrollees who use primary care. The number of MHCP enrollees served by a HCH will increase in proportion to the number of certified clinics, increasing over time.

3. Continuation of capacity building/collaborative learning activities

MDH and DHS, in collaboration with a consortium of primary care providers, have provided capacity-building opportunities for clinics and clinicians across the state. These activities included webinars, conference calls, regional workshops as learning collaboratives, mini-grants and the evolution of shared decision making concepts. MDH also realigned regionally based nursing staff to help build capacity for

HCHs across the state. MDH is developing the curriculum and structure for the statewide learning collaborative, which the agency expects to kick off in 2011 and include 1,300 participants.

4. Implementation of the payment methodology

Minnesota's HCH initiative includes a multi-payer payment methodology that reimburses certified practices for care coordination. DHS and MDH created an innovative payment methodology and tools that stratify reimbursement based on patient complexity. As required by law, the payment methodology was implemented on July 1, 2010.

5. Development of evaluation plans and outcomes measures

The MDH-sponsored Outcomes Measurement Work Group (comprised of a number of community stakeholders including representatives from the provider community, health plans and government) has selected initial measures for evaluation that focus on the areas of the Triple Aim, including patient health, patient experience of care and cost-effectiveness for the total patient population.

6. Creation of tools to engage consumers

MDH is developing tools to expand consumer understanding and engagement about health care homes. These tools include a consumer-oriented brochure and a certification seal for certified HCHs. MDH is working with partners to survey consumers and providers and use the information gathered to develop targeted messages for consumers and an overall communications plan for health care homes.

7. Selection as Medicare demonstration project site

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

Challenges

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

- **Implementation of payment methodology.** Despite the successful and timely launch of the HCH payment methodology, challenges remain to achieving the multi-payer "critical mass" necessary to support practice transformation. Developing the appropriate spectrum of payment models with new innovations such as "accountable care" models will be important so that primary care is enhanced, but there is not duplication of payment for coordination.
- **Linkages to community resources.** Creating needed connections between HCHs and community resources and preventive services continues to be a challenge.
- **Clinic transformation and readiness.** The transformation to a certified HCH requires whole-practice redesign in order to have a proactive, population-based approach to care. While many clinics and clinicians around the state are embracing these changes, the transformation takes time.
- **Focus on patient-centered care.** While many providers are moving toward this focus, care can still be in "silos" according to conditions, rather than focusing on a holistic, patient-centered approach that includes a whole-person orientation encompassing acute, chronic, preventive and end-of-life care.
- **Consumer engagement.** Patients who are engaged as active partners in their HCH are vital to achieving the Triple Aim outcomes. Many patients move through the health care system as passive recipients of care, rather than as central members of the health care team.

Introduction

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

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

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

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

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

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

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

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

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

The Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS) collaborate in the development and implementation of Minnesota's HCH initiative, with the input of a broad range of public and private stakeholders. As required by statute, this report is an annual report from the commissioners on the implementation and administration of the health care home model, especially for state health care program enrollees in the fee-for-service, managed care and county-based purchasing sectors.

Program Development Updates

Certification

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

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

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

In addition to developing the standards for certification, MDH has also created an efficient process to certify providers as health care homes. This process includes a letter of intent, an application, an assessment and a site visit.

In August 2010 MDH certified the first 11 health care homes in Minnesota. They represented a broad range, both geographically and in clinic size and scope: They were in several regions of the state, included both urban and rural clinics and ranged from single-physician to large systems clinics.

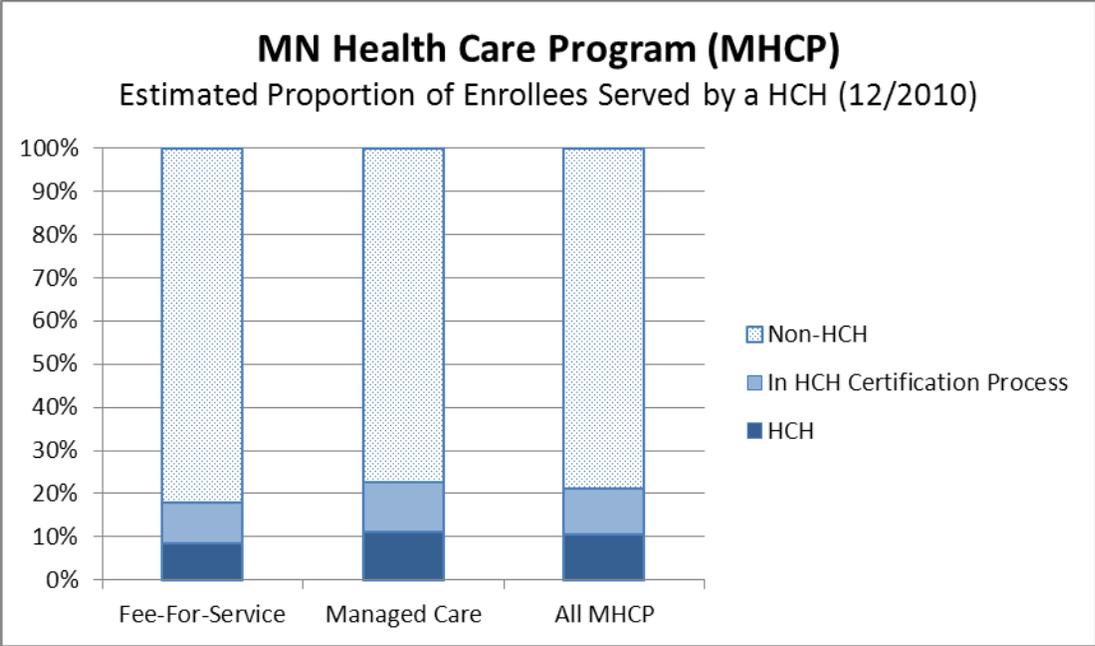
To date a total of 47 HCHs have been certified, representing 428 clinicians. An additional 105 clinics, representing about 1,270 clinicians, are working toward certification. MDH continues to offer a variety of opportunities for collaborative learning and training to support clinics that are in the process of certification (see "Learning collaborative activities" section).

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

It is worth noting that MDH has taken extra steps to maintain a focus on the consumer throughout the certification process. MDH developed an innovative approach to site visits, for example: Not only are consumer representatives included on the site visit teams, but consumers are also interviewed as part of the site visit evaluations.

Current state health care program enrollees

As of December 2010, there are 47 certified health care homes. Based on past claims data, DHS estimates that roughly 80,000 Minnesota Health Care Program (MHCP) enrollees are currently being served by a health care home. This figure represents 10.5 percent of total MHCP enrollees who use primary care. The table below shows the distribution of HCH participation for MHCP enrollees in fee-for-service and managed care coverage.



The number of MHCP enrollees served by a HCH will increase in proportion to the number of certified clinics, increasing over time.

Learning collaborative/capacity building activities

To support clinics that are in the process of certification as a HCH, MDH has offered a variety of opportunities for collaborative learning/capacity building. A consortium of primary care provider associations, including the Minnesota Chapter of the American Academy of Pediatrics, the Minnesota Academy of Family Physicians and the American College of Physicians-Minnesota Chapter, has also assisted with capacity-building work. Activities have included:

Webinars and conference calls

Throughout 2010 MDH has hosted monthly informational conference calls and webinars. These sessions have included a presentation on a particular aspect of the certification process, and applicants and potential applicants have been able to ask questions about certification. Themes have included submitting variances, registries, site visits and care planning.

Additional educational webinars and conference calls in 2010 have covered creating effective practice teams, getting started with limited funds, free and low-cost registry options, the payment methodology for HCHs and contracting with health plans.

Regional workshops

Between April and June 2010 MDH held six regional workshops on certification throughout Minnesota. These day-long events covered the certification rules around access, registries, care planning, care coordination, payment for care coordination and quality measurement. About 300 people attended the six workshops. Another set of workshops is planned for early 2011.

Mini-grants

MDH awarded two rounds of mini-grants in 2010 to help clinics prepare to become HCHs:

- 1) In February 2010, 21 clinics received funding to improve their readiness to provide patient-centered care and to implement HCH standards.
- 2) In June 2010, 16 clinics received funding to help them move forward with HCH certification.

Regionally based district consultant nurses

MDH has aligned the work of the Minnesota Children and Youth with Special Health Needs program with the HCH initiative, in order to better utilize existing resources as HCHs expand across the state. The program's district nurses were reassigned to the HCH section to provide needed regional expertise and support in expanding HCHs throughout the state. This move is in line with their historical focus on building more effective health systems that can better serve children with special health needs and their families. The move also leverages existing federal resources, such as Title V funds, to help scale up health care homes across the state. The district nurses will work actively to support capacity building for new HCHs by providing technical support and project management consulting; they will facilitate and expand relationships in the community with groups such as local public health, social services, mental health and others to further solidify how HCHs integrate with the community around the comprehensive care of patients.

Statewide HCH learning collaborative

Although the state has been providing collaborative learning opportunities for clinics as they have been preparing for health care homes, one of the requirements of certification is that HCHs participate in a statewide learning collaborative that MDH anticipates will kick off in 2011. Plans for the learning collaborative project include:

- **HCHs learning collaborative leadership committee.** This committee will provide oversight for the project, establish criteria required for certified clinics/clinicians to participate in the collaborative and review the overall comprehensive evaluation plan. The committee will include members from the public and private sectors, such as representatives from state health and medical professional organizations, clinics, consumer groups, local public health and MDH. Also included will be education specialists and other knowledgeable individuals with experience in quality improvement learning collaboratives, medical home/HCH models, and patient- and family-centered care delivery and payment systems.
- **HCHs learning collaborative curriculum.** A curriculum appropriate for both pediatric and adult medicine will be developed using best practices of existing national and state medical home curricula for providers, clinics, care coordinators, clinical administrative leaders, patient partners and families and community resources including public health.
- **Implementation of three phases of the statewide HCHs learning collaborative.** The goal is to recruit approximately 1,300 learning collaborative participants.

- **Phase I - Preparation (pre-certification).** Voluntary for groups that have submitted a letter of intent to become certified as a HCH or are considering certification.
 - **Phase II - Certification and implementation.** Required for all HCH certified clinics/clinicians.
 - **Phase III - Ongoing improvement and maintenance.** Required for all health home certified clinics/clinicians after they complete Phase II.
- **Evaluation plan for the learning collaborative.** An evaluation plan will be developed that includes the learning collaborative and participants' evaluation of each learning session.

Development of payment methodology

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

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

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

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

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

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

Stakeholders continue to evaluate this first iteration of the payment methodology and identify opportunities for improvement. A steering committee of nominated representatives from health care and consumer organizations provides oversight, and a contracted formal evaluation of the billing process is under way to ensure administrative simplicity. A multi-payer implementation work group is collaborating to address early administrative issues, and DHS and the University of Minnesota are analyzing the adoption of the payment methodology.

MDH is also working with the Institute for Clinical Systems Improvement (ICSI) to develop tools aimed at helping clinics implement the tiering system and bill for care coordination payments. For example, ICSI created a visual work flow for the billing process from the clinical perspective, which outlines the operational steps a certified HCH should take in order to bill for care coordination payments. ICSI also developed a “train-the-trainer” module to facilitate clinic understanding of the tiering and billing processes.

ICSI will also evaluate the effectiveness of risk tier tools for clinics that are certified and using the tools by March 30, 2011. This will include an evaluation of the effectiveness of both the use of risk tier tools and the internal billing mechanism in the clinic. ICSI will provide evaluation data and recommendations to MDH and DHS and report to the payment methodology steering committee. This evaluation will include a qualitative assessment of the challenges and opportunities related to the payment methodology as a way to understand how the design is working in the real world and to continue to refine the tools.

Evaluation

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

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

The legislative report must include:

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

Outcome measure collection will be phased in over the next two years, with legislative reports evaluating the statewide program’s effectiveness due three and five years after the initial certification of health care homes.

Outcomes measures

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

The work group has selected the following initial measures for HCH evaluation:

1. Clinical quality:
 - a. Optimal asthma care (well controlled, no increased risk of exacerbations and a written asthma action/management plan in the medical record); and
 - b. Optimal vascular care (LDL cholesterol = <100 mg/dl, blood pressure <130/80, daily aspirin use as appropriate and documented tobacco free).
2. Access and patient experience of care from CG-CAHPS surveys, including additional questions about shared decision making developed by the Minnesota Shared Decision Making Collaborative in conjunction with National Committee for Quality Assurance (NCQA) and the Agency for Healthcare Research and Quality (AHRQ).
3. Cost-effectiveness from DHS claims data on:
 - a. Risk-adjusted utilization rates (e.g., emergency room visits and avoidable hospitalizations); and
 - b. Risk-adjusted total annual cost of care for patients attributable to individual clinics.

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

In addition, through its collaboration with Minnesota Community Measurement (MNCM), a well-established statewide performance measurement and public reporting entity sponsored by Minnesota's non-profit health plans, the state will also be developing a functional status measure over the course of the next two years for use by HCHs.

Additional evaluation efforts

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

This AHRQ-funded evaluation will address the following questions:

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

Consumer awareness and engagement

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

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

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

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

CMS Advanced Primary Care Practice Demonstration

Minnesota has been selected by the Centers for Medicare and Medicaid Services (CMS) to become one of eight states participating in the Medicare Multi-payer Advanced Primary Care Practice (MAPCP) demonstration project. This demonstration will add Medicare to Minnesota's existing multi-payer HCH initiative as a payer for certified HCHs.

MDH and DHS jointly applied for the demonstration project. To develop the strongest possible application, MDH and DHS HCH staff convened an advisory group of stakeholders with Medicare expertise to provide guidance on key strategic issues. The group included more than 25 stakeholders, representing professional associations, consumer organizations, health care providers, health plans, local public health, community service organizations and higher education. This group will also continue to play an important role as the state implements the demonstration project. The University of Minnesota School of Public Health also contracted with the state to develop a detailed analysis showing that the state's participation in the demonstration project would be budget neutral.

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

The demonstration also requires that Minnesota participate as a collaborative partner with CMS in a comprehensive evaluation process that will focus on primary care results in improved clinical quality, better patient experience and improved affordability of health care delivery for Minnesotans.

The application also served as the impetus for Minnesota to join Vermont, New Hampshire, Maine, Rhode Island, Massachusetts, Pennsylvania and Colorado to initiate a framework for a multi-state learning health system with common metrics, shared learning and rapid cycle data-guided improvement of their respective medical home models. These states plan to use common measures and comparative effectiveness to guide their delivery system reforms, providing the best opportunity to evolve models that are clinically and financially effective for a successful CMS demonstration.

Challenges and Next Steps

In the past year, much progress has been made in implementing HCHs in Minnesota. However, MDH and DHS have seen important challenges to consider moving forward.

Implementation of payment methodology

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

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

Linkages to community resources

A HCH serves as the central point for coordinating care around the patient’s needs and preferences. It also coordinates care between all of the various health care team members. This coordination should include the patient, family members, other caregivers, specialists, other health care services (public and private) and nonclinical services as needed and desired by the patient. Creating needed connections between HCHs and community resources and preventive services continues to be a challenge.

Next steps: MDH is working to align its current resources (i.e., district public health nurses) to assist clinics to develop enhanced partnerships with local public health and with other community partners.

MDH is also working to raise awareness about alternative staffing models to connect patients and the community (i.e., community health workers, health educators, social workers).

Clinic transformation and readiness

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

Next steps: Building on the collaborative learning options from the last few years, the expansion of knowledge transfer with the statewide learning collaborative in 2011 will provide important opportunities for clinics and clinicians to share best practices and continue the redesign process.

Focus on patient-centered care

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

Next steps: MDH is working to facilitate the alignment of population health management into the current disease management framework through the learning collaborative activities. The agency plans to recommend additional outcomes to measure for recertification for whole-person orientation metrics.

Consumer engagement

Patients who are engaged as active partners in their HCH are vital to achieving the Triple Aim outcomes. The HCH certification standards support consumer engagement by encouraging clinics to have patients as members of their HCH quality improvement team; mandating the use of care plans; and utilizing a patient experience survey for measurement. Still, too many patients move through the health care system as passive recipients of care, rather than as central members of the health care team.

Next steps: MDH and DHS are working to develop public awareness messaging about HCH that can inform consumers about patient-centered care. The agencies are also working to incorporate even more information for clinics on patient activation and shared decision making through educational options in the future, e.g., the statewide learning collaborative.

Plans for 2011

- Focus capacity building for small and medium-sized clinics in both urban and rural settings.
- Achieve the goal of 150 certified clinics by June 30, 2011. Continue to add 25 certified clinics quarterly throughout the year with the goal of 200 certified clinics by the end of 2011.
- Implement the annual recertification process with outcomes benchmarks.
- Begin collecting outcomes measures through the statewide quality reporting system for use with recertification and evaluation; explore how to use provider peer grouping as outcome measures.
- Look for opportunities to align and build shared accountability in the community for the outcome measures being developed for health care homes.
- Implement a strategy to facilitate focused communication with community members such as home health, local public health, social services, mental health, physician specialists, pharmacy

and others to build stronger community connections to support implementation of certified health care homes.

- Begin conducting the first evaluation report for the Legislature on the implementation of health care homes due three and five years from implementation, which formally began in July 2010. Provide annual reports to the Legislature on program progress.
- Implement consumer messaging plan.
- Launch the next phase of the statewide learning collaborative with a focus on establishing opportunities for clinics, clinicians, the state and others to share information in face-to-face and electronic methods.
- Implement the MAPCP demonstration project and participate with CMS in evaluation activities.
- Complete the first stage of the payment methodology evaluation and continue to work with private payers to increase critical mass.
- Collaborate with other community stakeholders on exploration of the spectrum of accountability for redesign of care and redesign of payment models that will be needed for the continued transformation of care.
- Develop ACO models built upon HCH.
- Continue engagement with CMS to ensure that the unique contributions of the Minnesota model factor prominently in the primary care redesign being promoted by the new Center for Medicare & Medicaid Innovation.

