MINNESOTA
HEALTH CARE HOMES

Health Care Homes: Celebrating 10 years of Redefining Health, Redesigning Care

2019 YEAR END REPORT

12/31/2019

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Executive Summary

"One of the most cost effective and efficient strategies in today's primary care setting is to establish a patient care team conducive to all members working to the top of their license or scope of practice. In a world of provider and nurse shortages, coupled with delivering more complex care at a lower cost, it is crucial that offices develop strategies to make patient flow as efficient as possible."

CMO, Open Door Health Center, Blue Earth County

Benefits of a Health Care Home

Health Care Homes (HCH) are well-positioned to lead and drive change across Minnesota. Evidence demonstrates that increased investment in primary care improves health outcomes, helps to reduce disparities, and can lower overall health care spending. But while U.S. health care spending levels are high and unsustainably growing, the proportion spent on primary care is less than ten percent, far less than that spent in other countries. Identifying payment, network, workforce, technology and practice levers to support greater access to comprehensive, coordinated primary care, such as that provided in Health Care Homes, is imperative to achieving a stronger, higher-performing health care system that meets the needs of all patients. This report provides an update on the important role that Minnesota's HCH program plays in moving us towards that goal, and where additional investments may be needed.

The majority of Minnesota primary care clinics are certified as a HCH. Minnesota HCH primary care clinics have leveraged HCH certification to drive health care transformation by organizing and delivering care that is coordinated, patient-centered, and team based. The HCH, known nationally as a patient-centered medical home (PCMH), model of care delivery is an approach to primary care that is:

- **Patient-centered:** A partnership among practitioners, patients, and their families ensures that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care.
- **Comprehensive:** A team of care providers is wholly accountable for a patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care.
- **Coordinated:** Care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, community services and supports.
- **Accessible:** Patients are able to access services with shorter waiting times, "after hours" care, 24/7 electronic or telephone access, and strong communication through health Information technology innovations.
- **Committed to quality and safety:** Clinicians and staff enhance quality improvement to ensure that patients and families make informed decisions about their health.

Making a Difference: 2019 HCH Program Outcomes

The HCH Program continued to take important steps to advance the program in 2019 by:

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- Certifying 19 clinics, ending the year with a total of 378 Minnesota clinics certified as HCHs
- Increasing the number of Minnesota counties with HCH clinics to 64 (74%) by adding three new counties: Le Sueur, Lincoln, and Sibley
- Offering capacity building support towards HCH certification to all uncertified Minnesota primary care clinics; HCH practice improvement and integration specialists are actively working with 15 health systems with a total of 54 clinics to achieve certification
- Working with the Minnesota Department of Human Services (DHS) to certify 11 additional Behavioral Health Homes (BHH) bringing the total of certified provider locations to 37
- Seeking input through 7 community engagement sessions for enhancing the HCH program's focus to increase community linkages, advance health equity, increase ability to impact social determinants of health, and identify barriers and needed resources. Work includes strengthening the HCH administrative rule with input from a 29 member advisory committee
- Completing three Learning Community grants to expand partnership between HCH clinics, public health and behavioral health
- Providing support to primary care clinics and behavioral health providers through in-person technical assistance, on-line educational courses, 1 webinar, 2 regional trainings and a two-day conference for 335 participants to support re-design of health care delivery
- Collaborating internally with the Minnesota Department of Health (MDH) programs such as the Center for Health Information Policy and Transformation, Children and Youth with Special Health Needs, the Statewide Health Improvement Partnership program, and Public Health Practice
- Collaborating externally with the Institute for Clinical Systems Improvement and Stratis Health in developing learning opportunities for clinic staff
- Assessment of HCH program and process to optimize certified HCH customer experience, attract eligible uncertified providers, and streamline HCH operational processes through interviews, focus group and survey findings.

Introduction

"Our journey is a transformation. Development and progression of the model is circular, it will never be done, but continuously change and improve as we learn."

Clinic administrator, CHI St. Gabriel's Health, Morrison County

Celebrating 10 years of Redefining Health, Redesigning Care

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

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they strive for better care and better health in the midst of an ever-changing landscape of health care payment and delivery reform.

Minnesota's HCH model of advanced primary care delivery, known nationally as a patient-centered medical home (PCMH), is redefining health and redesigning primary care across the state. Minnesota HCH activities include targeting disease prevention, managing chronic conditions, population health improvement, and care coordination as important levers for controlling costs and improving health outcomes. Consensus exists around the basic components of a HCH, but not all models look alike or use the same strategies to improve health care quality and control costs.[1]

Minnesota's HCH model of care is based on five standards:

- **Access & Communication**: care when the patient needs it; ongoing communication with the patient and family
- **Registry & Tracking**: electronic, searchable registry to assess needs of the population
- **Care Coordination**: coordinated care focused on patient and family needs
- **Care Planning**: a patient-centered care plan for patients with chronic or complex conditions
- **Performance Reporting & Quality Improvement**: continuous improvement processes that focus on patient experience and health, and cost-effectiveness of services

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 with community resources. The standards for certification as a health care home allow flexibility among providers and give them an opportunity to achieve needed outcomes without being overly prescriptive. The goal in developing the original standards was to enhance primary care without burdening providers with daunting expectations.

Over half of Minnesota certified HCH clinics have embraced advanced primary care as a way of delivering care to improve the cost, quality and experience of care. This report provides an overview of the Health Care Homes program's work in 2019, including program progression, key strategic areas to advance the primary care model to transform clinician practices and the importance of investing in primary care to improve quality, cost and experience of care.

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[1] NCQA (2019). Patient-Centered Medical Home: Developing the business case from a practice perspective. Milliman White Paper

Health Care Homes Model Progression

The health care context has changed since the program began, and HCH (in consultation with an established advisory committee and other stakeholders) is engaged in rulemaking to update the rules and improve the program. MDH initiated the rulemaking process for HCH rules in 2018 with approval from the Governor's office and publication of the Request for Comments in the State Register.

Current State to Future State

Main components of proposed rule amendments:

- **Model progression.** Proposed rule amendments include new language for a modified framework for the HCH program with addition of two optional levels of recognition beyond current requirements. The purpose of the new framework is to recognize clinics that are advancing their models beyond the existing standards to further reduce health disparities, improve the value of health care investments, and address population health.
- **Rule updates.** Rule language for the foundational care plan standard would be updated to align with changes in care planning strategies and reduce prescriptiveness of the requirements.
- **Statutory compliance.** Proposed revisions align with statutory change in the frequency of required recertification from annually to every three years.

Rulemaking Process

The HCH program continued to solicit input from the HCH Advisory Committee and work groups on proposed rule revisions and development of the progression model.

MDH sent an initial draft of proposed rule revisions to the Office of the Revisor of Statutes in October 2019. HCH staff are preparing the statement of need and reasonableness (SONAR) that will accompany the rule amendments document when MDH receives approval to publish from the Office of Administrative Hearings.

As part of the rulemaking process, the HCH program has taken steps to obtain stakeholder feedback through two contracts with Management Analysis and Development (MAD). The first MAD contract organized community engagement events to gather input on proposed changes to the rules. The *Summary of Findings: Community Engagement Sessions, January – May 2019* documents this input. The second MAD contract focused on how the HCH program could be improved. MAD and MDH designed the process improvement assessment based on the following research questions.

- What are the main reasons certified Health Care Homes (CHCH) decide to pursue (re)certification?
- What are the main barriers to (re)certification, according to CHCH?
- How can MDH improve the experience of its customers (i.e., CHCH)?
- How can MDH better attract noncertified, eligible providers to pursue and complete HCH certification?

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- What are the main barriers to certification, according to these providers?

Care Delivery Innovation

"The philosophy [of HCH] helped bring everything together for us as a large community care team. It gave us the 'language' to be able to educate everyone throughout the entire organization."

MAD focus group participant, certified health care home

The HCH program is pursuing the following process improvement initiatives that align with key recommendations in the MAD report, *Health Care Homes Program & Process Assessment*, June 25, 2019, and with other stakeholder feedback.

Review of assessment and application materials. Stakeholder feedback emphasized the need to use plain language in guidance and other documents describing standards and certification requirements. Although the program routinely updates documents, the website, and other communication tools, HCH staff have begun a thorough analysis of how it communicates instructions and requirements with the goal of identifying and eliminating redundancies, inconsistencies, and ambiguous and convoluted 'legislative' language.

Streamline aspects of certification and recertification. Feedback on aspects of the certification process that present challenges or barriers included time and effort to complete the assessment and documentation, requirements to submit repetitive information, and the application process itself. The HCH program is analyzing each step of the certification and recertification process for potential improvements and action. Other processes under review are documentation requirements, assessment forms, report writing, and data collection including using and entering information in the web portal.

Staff are preparing standard operating procedures to document updated processes and ensure consistency, and using quality improvement methods to evaluate changes.

Certification Activity

Health Care Homes

During calendar year 2019, 19 clinics achieved certification for the first time and 227 clinics were recertified (see Appendix K), for a total of 378 certified clinics in Minnesota. The number of currently certified clinics represents 55 percent, or over half of the 683 primary care clinics in the State. Since 2010 when MDH certified the first clinics, 459 clinics have achieved certification as a HCH in Minnesota and bordering states.

61 clinics are no longer certified due to clinic closures, organizational changes that disqualify the clinic from eligibility as a primary care provider, lack of resources for maintaining certification (time, money and staff), or participating in a national patient-centered medical home program because the organization has clinics in multiple states. Overall, clinic participation in HCH is stable and a small portion of clinics and organizations have

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surrendered their certification or opted to not recertify every three years. According to the 2019 MAD survey, certified clinics are generally satisfied with being in the program. Ninety-one (91) percent of surveyed respondents indicated that their organization plans to apply for recertification at the end of the current three-year period, and none of the survey respondents indicated their organization would not pursue recertification.

64 of Minnesota's 87 counties (73 percent) have at least one certified HCH clinic (see Map 1 below). Counties with at least one additional clinic certified in 2019 are highlighted in green. Map 1 also shows the one county in Minnesota (Wilkin) that does not have a primary care clinic within its borders. However, Wilkin County residents have access to primary care services in neighboring counties and a border state. An additional 20 clinics in the border states of Iowa, North Dakota, and Wisconsin are certified as part of a Minnesota healthcare system (see Appendix J).

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Map 1: HCH Clinic Locations by County in Minnesota
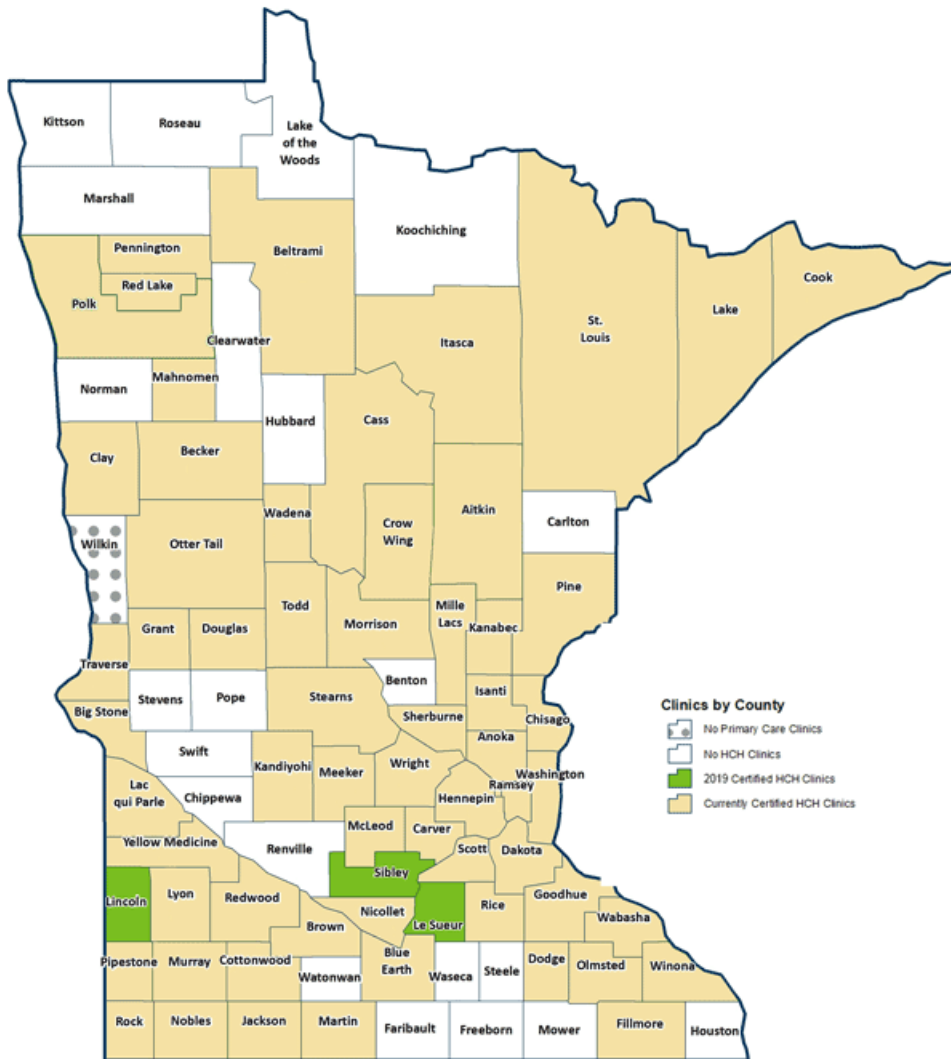
Appendix H provides a breakdown by county in Minnesota of the total number of HCH-eligible primary care clinics and certified clinics.

Behavioral Health Homes (BHH) Services

DHS implemented BHH services as a Medicaid covered service July 1, 2016 for eligible individuals with Serious Mental Illness, Serious and Persistent Mental Illness, Emotional Disturbance, or Severe Emotional Disturbance. Individuals with these diagnoses are among a subpopulation known to be at higher risk for poorer health outcomes and fragmented care.

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BHH services build upon the successes of HCH and create a comprehensive care coordination service that integrates physical health, mental health, the health concerns of substance use, long-term services and supports, and social services for individuals. There are currently 37 provider locations certified by DHS to provide BHH services. According to claims data, approximately 3,776 individuals have engaged in BHH services, a number that has steadily risen each month and indicating that more individuals are continuing to access the service. One of the challenges in bringing up BHH services is that BHH services are not well-known, that it can be difficult to help others understand what BHH services are, and that overall, BHH services referrals from community partners have been slow to receive. DHS makes available written materials that providers can use when educating partners about BHH services and when appropriate, DHS has provided direct outreach to outside service partners and communities.

Of the 37 BHH services providers, 11 are certified HCHs. HCHs create a platform to integrated and value-based care, and for some HCHs, BHH services have been a way to successfully engage and better serve a subset of their population.

In September 2017, Minnesota contracted with Wilder Research to evaluate the implementation of BHH services. Wilder Research evaluated program implementation by assessing how sites were using the BHH services model and documenting the successes, challenges and preliminary outcomes associated with it. Through individual interviews conducted in partnership with the National Alliance on Mental Illness Minnesota, Wilder Research was also able to obtain information about how participating in BHH services may have changed a person's beliefs and behaviors. Wilder completed the evaluation in September 2019. Highlights include:

- Nearly all individuals receiving BHH services feel there is a supportive approach to creating and fulfilling health goals and plans; most reported that participating in BHH services has improved quality of life and wellness; and about 2/3 said that BHH services staff helped them learn about their health condition.
- BHH services staff make thousands of referrals to community organizations to meet the needs of people they serve, and individuals mostly follow up on referrals they receive. (Data shows BHH services sites made nearly 4,000 referrals during the 9-month data collection period and individuals followed up on 62% of those referrals.)
- BHH services help the individuals they serve access more mental, physical, and chemical health care.
- Organizations with a history of integrated care are well-positioned to implement BHH services.

The implementation evaluation conducted by Wilder Research will inform a later outcome evaluation and also serve to identify challenges and areas where BHH services providers may need additional support from DHS.

Through HCH and BHH services, MDH and DHS share a commitment towards supporting coordinated, whole person care, particularly through the integration of primary care and behavioral health, with close referral relationships across social services and community based partners to address the social and environmental factors affecting a person's health. An interagency agreement between DHS and MDH formalizes this commitment and outlines the following cooperative work:

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- Participation by the Integration Specialist nurse planner in the DHS Community and Care Integration Reform division, including BHH services certification processes, provider trainings, and support for the ongoing implementation and evaluation of BHH services.

- Planning and implementation of learning opportunities that meet the needs of HCH and BHH services providers, including the coordination of these activities across the HCH Learning Collaborative and DHS practice transformation work.

- Designing and developing a practice transformation learning framework that will assist in supporting Minnesota health care providers in the integration of primary and behavioral health care, including the development of a six month learning experience for 2020 called, "Building Systems of Culturally Responsive Integrated Care". This initiative will support HCHs, BHH services providers, and Certified Community Behavioral Health Centers (CCBHCs) to collaboratively learn about and take action to increase integration of primary and behavioral health care and improve health equity in Minnesota using a multi-faceted approach that includes video conferencing sessions, in person sessions, self-reflection journaling exercises, and the availability of individualized coaching support.

Building Capacity for Practice Transformation

The HCH program cultivates ongoing, supportive relationships across the State to build capacity among clinics for achieving certification. A significant benefit of the HCH program is free access for clinics, organizations, and other stakeholders, regardless of certification status, to an array of learning, technical assistance, coaching, and other resources and supports.

"When asked to rate which aspects of certification or recertification they find the most useful or easiest to understand, 78 percent of survey respondents selected 'MDH staff'.

Quote from Management Analysis and Development report, *Health Care Homes Program & Process Assessment*, June 25, 2019.

Technical Assistance

HCH staff with expertise in practice facilitation and coaching work with clinics and organizations to implement the HCH model. HCH acknowledges the work required of clinics to improve access to services, proactively engage patients in high quality preventive and chronic care, and create systems to coordinate care with specialists and other community resources in new ways. Each clinic is at a unique stage of readiness for implementing the HCH model, and HCH staff specialists are sensitive to dynamics at the clinic that may require a slower pace or temporary halt in seeking certification.

All primary care clinics are eligible for HCH support and assistance – clinics may be certified, preparing for certification, or interested in learning about transforming their practice into a PCMH model such as HCH. Staff conduct individual outreach with clinics to offer support, and help certified clinics maintain and improve their practices through periodic check-ins. HCH capacity-building services and activities are voluntary and tailored to clinic needs.

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Table 1: Capacity building supports and services

Coaching	Consultation & Technical Assistance	Sharing & Networking
• Encourage insights, solutions, strategies, plans for achieving goals • Help identify and choose steps to take • Support follow-up on task completion	• Share information and expertise • Skills training, presentations • Consulting services • Resources and tools	• Connect and convene clinics to share strategies, tools, ideas • Explore alternative methods

2019 included enhancements to capacity building services:

- HCH staff participated in a coach training program to expand the support offered to clinics and organizations with which they work. Coaching is a useful approach at all stages of model progression and aligns with a new MDH HCH learning series, *Building Systems of Culturally Responsive Integrated Care,* beginning January 2020.

- HCH designed a web-based technical assistance (TA) tracking tool to log the TA requests by source, topic, and follow-up for a more systematic analysis and response to TA and learning needs.

Besides helping clinics achieve practice transformation goals and certification as a HCH, staff support clinics in seeking and attaining certification as a BHH services provider and provide ongoing specialized support to clinics that are dually certified as a HCH and BHH (see Behavioral Health Homes (BHH) Services for more detail).

The program supports primary care clinics and behavioral health providers and their community partners to build relationships that promote integrated approaches to coordinated, whole person care through interagency collaboration on learning plans and activities.

Learning

Certified health care homes must demonstrate that they are continually learning and redesigning their practices to meet the standards for patient-centered, team-based care and improved community health and health equity. The HCH program supports this ongoing process with accessible learning opportunities.

In 2019, HCH implemented learning activities (see Table 2) to address the needs of an increasingly complex range of stakeholders at all stages of learning, and added new learning opportunities to the portfolio of in-person training, on-demand eLearning courses, webinars and an annual conference. Central to achieving these goals was applying best practice for eLearning design and delivery, engaging stakeholders and strategic partners for curriculum development, and facilitating opportunities for primary care providers and community partners to connect and learn from each other through regional training events and learning communities.

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Table 2: 2019 Learning Activities

Topic	Activity	Month	Registered
Tenth Annual Learning Days	Annual Conference – St. Paul	April	335
Leadership and Organizing in Action	Regional Training – Marshall	May	24
Leadership and Organizing in Action	Regional Training – Duluth	June	30
Foundations of Care Coordination	eLearning Course	July	80
Expanding the Team: Emerging Professions	eLearning Course	August	31
Quality Improvement Foundations	eLearning Course	January	60
Risky Business: One Health Care System's Model of Risk Stratification	Webinar	September	46

Learning Center

The HCH program was one of the first MDH programs to offer free, accessible, on-demand learning through the MDH Learning Center. In 2019, HCH staff designed, developed and launched three on-line learning courses, and adopted the Learning Center as the gateway for all HCH learning related activities. The system is an efficient platform for tracking, evaluating and analyzing learning activities, and offers opportunities for peer-to-peer learning through on-line discussion boards.

Training for Community Health Partnerships

In an effort to support peer-to-peer learning and community partnership, HCH held regional trainings for clinics and their partners in the Marshall and Duluth area. Facilitated by Stratis Health, these two trainings helped regional clinics, behavioral health service providers, Certified Community Behavioral Health Clinics and partner organizations forge connections and learn how to exercise leadership to engage others in population health and quality improvement.

Learning Community Grants

Learning Community grants that started in 2018 continued their work in 2019. The focus of the three funded Learning Communities was to increase and strengthen partnerships between certified Health Care Home clinics, local public health, and behavioral health organizations through the use of data and information to support shared population health goals. The leads for the three learning community grantees were North Memorial, Lakewood Health System, and Children's Mental Health Alliance of Anoka County. Each learning community was required to have local public health, social service agencies and behavioral health providers as partners. The Learning Communities were supported by an external vendor, ACET, and MDH subject matter experts using the

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[Connecting Communities with Data: A practical guide for using electronic health record data to support community health-version 1.0 (PDF)](#) as a roadmap.

Using the MDH guide as a roadmap helped the partners in the learning community identify useable data to identify areas of need and develop shared goals to address them. One grantee noted that without the data sharing and review process they would not have been able to have a focused population intervention, and could have been working on an intervention that potentially wouldn't have affected anyone.

The importance of the learning community is the relationship it built and understanding how working outside of one's own agency can increase the capacity of each of the partners to meet the needs of the community. The learning communities started in different places and with different ideas of the priorities. As one grantee noted, at the beginning of the project their expectation was that the impact would be at an administrative level, but as the project proceeded it was clear that the more important goals were to promote collaboration across agencies, add value by integrating database use and help individuals.

The learning communities generated three very different implementation plans that they will use to further the work they started. For one grantee the recognition of how the partnership furthered their ability to provide more effective and efficient services to patients/clients has helped the partners to see the importance in continuing the work. As part of their implementation plan they included strategies to identify potential funding opportunities to sustain the work and alleviate costs for low-income populations. All three learning communities have prioritized continued support for the partnership.

HCH Advisory Work Group Key Strategic Areas

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

Program Innovation Work Group

"Program Innovation is the nuts and bolts of HCH, it speaks to care delivery."

Health Care Home Advisory Committee Member

Minnesota's healthcare delivery environment is transforming through the implementation of the HCH model. Since 2017 the 26-member Program Innovation Work Group has advised HCH on technical aspects of practice delivery with an eye on innovation. With broad stakeholder representation, including rural and urban, certified and uncertified, quality leaders, community entities, patients, and DHS, the work group helps HCH stay close to stakeholder and patient needs and priorities to inform learning, innovation, best practice and progression of the model for the future.

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In 2020, the Program Innovation Work Group and Learning and Technical Assistance Work Group will combine to form the Program Learning and Innovation Work Group. This change will facilitate stakeholder engagement into the learning and support that is needed as the program evolves.

2019 Outcomes

The Program Innovation Work Group in 2019 provided recommendations to the Health Care Homes program on:

- Changes to the HCH benchmarking process
- A Patient-Centered Outcomes Research Institute (PCORI) grant opportunity to conduct a care coordination study
- Process improvement recommendations based on input collected through a statewide stakeholder engagement process conducted by the State of Minnesota Office of Management Analysis and Development
- Creating a structure and prioritizing incentives for advanced levels of certification
- The HCH Progression Model and proposed HCH Rule amendments
- The 2020 HCH Learning Plan and engagement strategies

2020 Steps

Process Improvement:

- Redesign documentation submission/verification requirements for Level 1 certification and recertification while laying a foundation for certification and recertification at Level 2 and Level 3 in the future
- Improve documentation submission process for certification and recertification as a precursor to redesign of the data portal in the future
- Learning and Innovation: Assist HCH staff in evaluating learning tools and resources for best practice, usability and relevance to HCH program and standards

Monitor Environment:

- Consider and provide input on emerging opportunities, technologies, legislation, or other external factors that may impact the future of the HCH program.

Sustainability Work Group

"This [medical home and team based care] initiative will ready [our organization] for value-based care, increasing organizational risk, and increasing our focus on population health based quality outcomes.... This new model of care will result in improved outcomes, better patient experience and reduced patient costs."

Vice President, Sanford Sioux Falls Region, Cottonwood, Jackson, Lyon, Nobles, Pipestone, Redwood, Rock, and Yellow Medicine Counties

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Implementing and sustaining the transformative elements necessary for Health Care Homes certification at a clinic level requires resources. This can include learning, technical assistance, access to data, financial support, and partnerships with community organizations and other stakeholders. The purpose of the Sustainability Work Group is to assist the HCH program in identifying and leveraging resources that support clinics in implementing the HCH model.

Care Coordination Payments

Payment of a HCH claim as a billed service is one of the ways providers use to financially support their care coordination efforts. In the first six months of 2019, a total of 25,347 finalized claims for 10,385 Minnesota Health Care Program beneficiaries, totaling $497,519, were paid through HCH claims by DHS or the Medicaid Managed Care Organizations. Figure 2 reflects the quarterly trends of submitted and paid HCH claims for Minnesota Health Care Program members through the most recent quarter for which complete data is available. DHS or the Medicaid Managed Care Organizations have paid $7,910,704 between January 2013, when HCH care coordination payments first became a billed service, and June 2019.

Figure 1: Volume of HCH Claims from Public Health Care Program Members

Count of Health Care Home Claims and Beneficiaries
2013 Q1 - 2019 Q2
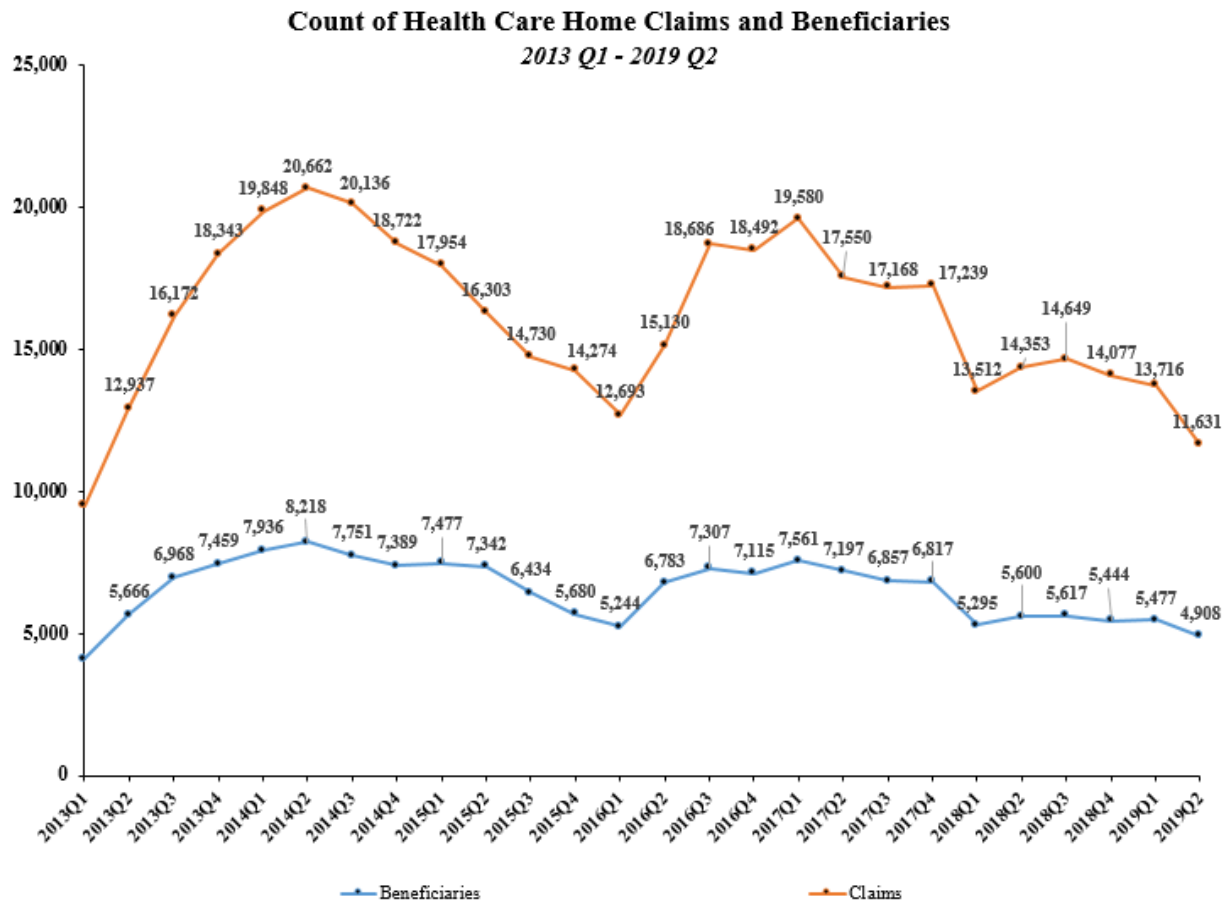
Note:

[1] Claim counts include all paid and finalized health care home claims across all programs and payers. Health care home claims are identified by procedure code S0280 and S0281 claims not having the procedure code modifier 'U5' (indicating BHH services).

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Figure 2: Providers Submitting HCH Claims for Public Health Care Program Members

Count of Billing Providers Submitting Health Care Home Claims
2013 Q1 - 2019 Q2
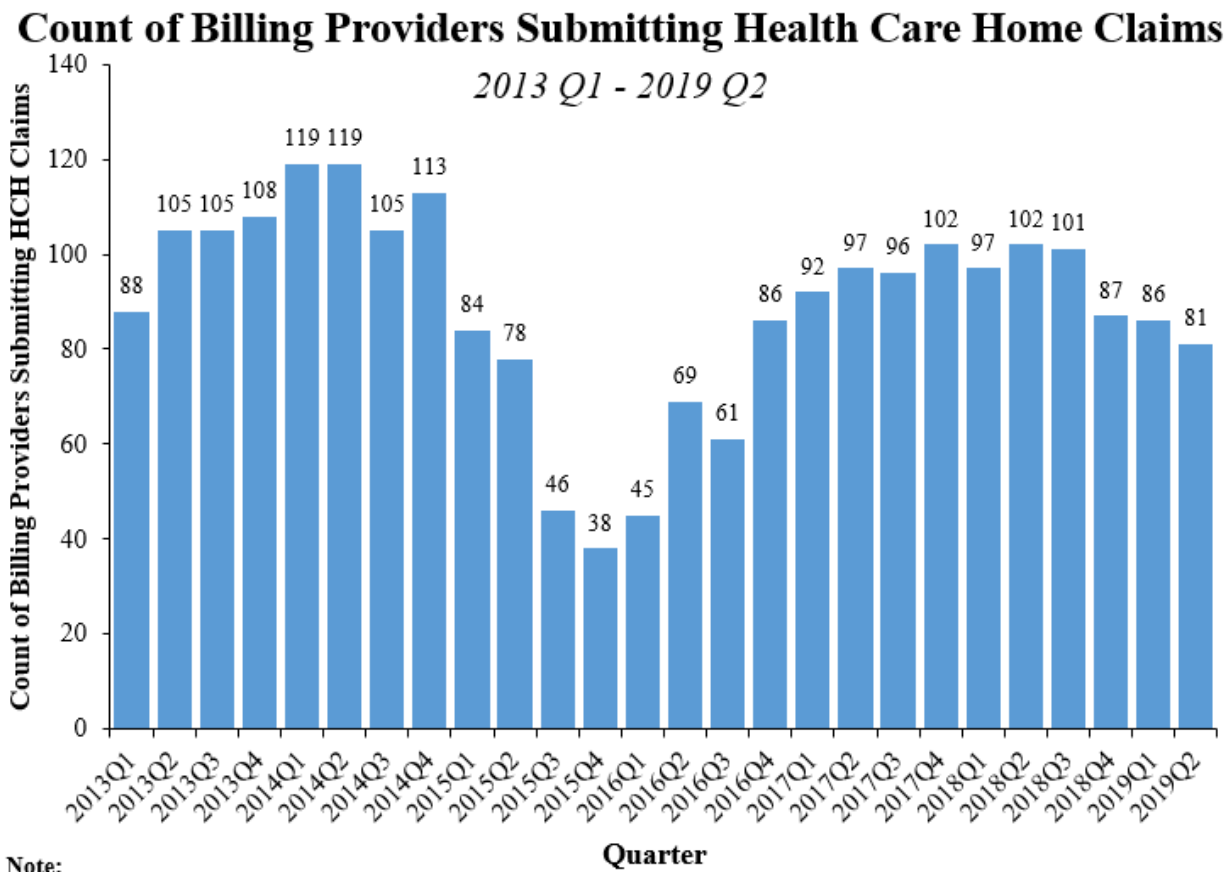
Note:
[1] Count of Billing Providers is the count of distinct providers submitting health care home claims within the given quarter. Health care home claims are identified by procedure code S0280 and S0281 claims not having the procedure code modifier 'U5' (indicating BHH services).

Submission of HCH claims peaked in 2014. Despite a rebound throughout 2016, claims peaked again in early 2017, with a relatively steady decline through the second quarter of 2018. As shown in Figure 2, this downward trend is echoed in the number of billing entities submitting claims.

Despite fewer billing entities submitting per-person HCH claims over the past two years, the number of certified HCH clinics participating in alternative payment reform initiatives, such as the Integrated Health Partnerships (IHP) demonstration, has continued to increase.

The Integrated Health Partnership program represents another way that many providers have enhanced the financial sustainability of their care coordination efforts. Beginning with 6 medical systems serving just over 100,000 Medicaid beneficiaries in 2013, the IHP program currently has 25 entities serving more than 450,000 beneficiaries participating. Over the initial six years for which shared savings settlement information is available (2013-2018), $146,476,158 in shared savings payments have been made to participating providers. Beginning in 2018, medical systems participating in the 2.0 model of the IHP program also received a population-based payment (PBP) – a per member per month payment to support care coordination, care management reform and

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related infrastructure needs. The total PBP in 2018 was $8,173,186 covering more than 155,000 beneficiaries (or about $4.37 per member per month).

2019 Outcomes

The Sustainability Work Group in 2019 provided recommendations to the Health Care Homes program on:

- Developing a business case aimed at commercial insurers
- Enhanced connections to employers and payers to provide education about the current program, program progression and sustainability needs for practice transformation
- Strategies to build a narrative about the HCH program that resonates with key stakeholders
- An approach to sustainability that contains numerous elements beyond just reimbursement
- Stakeholder groups who could influence the financial sustainability of HCH
- Improved understanding of how employers can support HCH certified clinics
- Developing a pilot project, in partnership with a payer, to demonstrate the ability of HCH to impact the social determinants of health

2020 Steps

- Provide assistance in strengthening public sector employer awareness of and engagement with HCH, including third party administrators
- Develop a plan for outreach to physician networks using Blue Cross Blue Shield of Michigan's model as a guide
- Advise on strategies to build broader stakeholder support for HCH

Learning and Technical Assistance Work Group

"The e-learning modules provide great information, and it is helpful that I don't have to take a day away from work to attend and can watch at my own pace."

-Sara Tollakson, RN Care Manager and Health Coach Coordinator, Ortonville Area Health Services

The HCH Learning and Technical Assistance Work Group provides expertise to guide planning and implementation of learning activities for HCH stakeholders. In 2019, the work group monitored implementation of the annual learning plan and provided input for future innovation. The work group operates in the spirit of continuous improvement to ensure alignment of learning with stakeholder needs, learning innovation and delivery of quality products and outcomes.

2019 Outcomes

The Learning and Technical Assistance Work Group in 2019 provided recommendations to the Health Care Homes program on:

- Implementation of 2020 HCH learning plan

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- Technical feedback on eLearning access, course content, webinars and learning promotion

- Development of new learning modalities, including videos and audiocasts

- ELearning innovations, including addition of a notes function and downloadable course outline

- Analyzing learning activity participation and feedback with recommendations to guide future planning

2020 Steps

- Monitor implementation of 2020 learning plan by providing input and evaluating feedback on learning content, delivery, usability and measurement

- Guide and monitor innovative concepts for enhanced learning through technical assistance, peer based learning, and supporting learning to drive organizational change

- Work with HCH staff to ensure that learning activities are attuned to stakeholder needs and deliver value

Measurement and Evaluation Work Group

"Benchmarking is most useful when we can compare to organizations that are similar. Applying a risk adjustment methodology or connecting us to other organizations with similar patient populations would make benchmarking more meaningful."

-Participant, HCH Benchmarking Brainstorming Session, February 27, 2019

HCH clinics are innovating and building evidence as they advance the PCMH model. Monitoring progress and evaluating results are key functions to improving performance. Measurement at the clinic level and communication of these results tell the story of practice transformation and the goals being accomplished. With the assistance of advisory and workgroup members, partners, and stakeholders, HCH is responding to the measurement and evaluation needs of clinics, in a rapidly changing health care environment, through the following activities.

2019 Outcomes

The Measurement and Evaluation Work Group in 2019 provided guidance on:

- The Measurement Framework in partnership with MDH's Statewide Quality Reporting and Measurement System team

- Initial evaluation of the current HCH benchmarking process

- Design of the HCH program evaluation plan

- A Patient-Centered Outcomes Research Institute (PCORI) grant opportunity to conduct a care coordination study

Redefining Health. Redesigning Care.

2020 Steps

- Discuss and develop plan to measure Joy in Practice
- Continue HCH benchmarking process review
- Provide guidance and feedback to PCORI research as requested
- Provide recommendations on implementation of the HCH program evaluation

Conclusion

"I want to take the opportunity to say how grateful I am for my care coordinator, she helps me so much.... I called her and she was able to get me an appointment even though all appointments were full. That's what I call patient-centered. Everyone here is making such a great effort to be patient-centered, you can see it everywhere, and that is not the way it used to be in health care."

Patient, Welia Health

Throughout 2019, the Health Care Homes program continued to support clinics through their practice transformation journey using strategies developed in collaboration with stakeholders, learning opportunities and ongoing technical assistance for achieving certification. This work is helping Minnesota move towards the goals of ensuring that all patients have access to patient-centered coordinated care, wherever they live.

Advanced primary care, as delivered in a HCH, is an important foundation for success in a value based care environment to achieve the Quadruple Aim of improving population health, improving patients' experience of care, reducing the total cost of care, and improving the work life of health care providers. Implementing and sustaining the transformative elements necessary for Health Care Homes certification at a clinic level requires resources. This can include learning, technical assistance, access to data, financial support, and partnerships with community organizations and other stakeholders. Investment in primary care is associated with lower costs, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality. The highest-performing systems, both domestically and internationally, invest a much higher percentage of total healthcare spending in primary care, which is associated with improved health outcomes and lower costs.[2] Almost 400 Minnesota primary care clinics have embraced an advanced primary care delivery model by becoming a Health Care Home, to meet patients where they are, from the most simple to the most complex conditions, to treat patients with respect, dignity, and compassion, to enable strong and trusting relationships with providers and staff and to focus on quality and safety.

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[2] Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of Primary Care to Health Systems and Health. Milbank quarterly Koller, 2017

Appendices

Appendix A: HCH Advisory Committee members

ACADEMIC RESEARCHER IN MINNESOTA
- **Rhonda Cady**
  Gillette Children's Specialty Healthcare

CERTIFIED HEALTH CARE HOME REPRESENTATIVE
- **Monica Aidoo-Abrahams**
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- **Rebecca Nixon**
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- **Tracy Telander**
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CONSUMER OR PATIENT
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- **Robert C. Jones**
- **Samuel Mwangi Sr.**
- **Melissa Winger**

EMPLOYER
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  UnitedHealth Group

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  HealthPartners
- **Christine Singer**
  West Side Community Health Services
- **David Thorson**
  Primary Care Provider

STATE AGENCY REPRESENTATIVE
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  State Member, State Employee Group Insurance Program

QUALITY IMPROVEMENT ORGANIZATION REPRESENTATIVE
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  Institute for Clinical Systems Improvement

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- **Jill Swenson**
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- **Joy May**
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- **Kristen Godfrey Walters**
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- **Kristi Van Riper**
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- **Maggie Wacker**
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- **Melissa Winger**
  Consumer

- **Nancy Miller**
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- **Nicky Mack**
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- **Rachel Finley**
  Fairview Health Services

- **Rhonda Buckallew**
  Unity Family Healthcare

- **Savannah Aultman**
  Alexandria Clinic

- **Vimbai Madzura**
  Minnesota Department of Human Services

Appendix C: Financial Sustainability Work Group members

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  North Memorial

- **Andrew Whitman**
  Carlson School of Management

- **Dale Dobrin**
  South Lake Pediatric Clinic

- **David Thorson**
  Entira Clinics

- **Deb Krause**
  MN Health Action Group

- **Jeff Schiff**
  Department of Human Services

- **Jim Przybilla**
  Prime West

- **Jim Schowalter**
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- **Jill Swenson**
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- **Lorna K. Smith**
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Appendix D: Learning and Technical Assistance Work Group members

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- **Deb McKinley**
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- **Savannah Aultman**
  Alomere Health

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  Wayzata Children's Clinic, P.A.

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  MDH Statewide Quality Reporting Measurement System

- **Erica Schuler**
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- **Gena Graves**
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- **Joel Stegner**
  Consumer

- **Karolina Craft**
  DHS Care Delivery and Payment Reform

- **Maria McGannon**
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- **Michele Gustafsson**
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- **Miranda Cantine**
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- **Nate Hunkins**
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- **Nathan Shippe**
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- **Peter Harper**
  U of MN: Family Medicine

- **Rebecca Nixon**
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- **Susan Gentilli**
  Allina Clinics

- **Tessi Ross**
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Appendix F: Health Care Homes Certification Committee members

- **Becky Walsh**, CPC
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- **John Halfen**, MD
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- **Lisa Hoffman-Wojcik**
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- **Nicole Burrows**, RN
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Appendix G: Rule Advisory Committee members

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- **Beth Gyllstrom**
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  Altair ACO and Lutheran Social Service of Minnesota

- **Gena Graves**
  Park Nicollet

- **Isolina Soto**
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- **Jane Kluge**
  CentraCare Health

- **Jenny Kolb**
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- **Jill Swenson**
  Sanford Health

- **Jodi Painschab**
  Stellis Health

- **John Halfen**
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- **Mary Benbenek**
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- **Miranda Cantine**
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- **Naomi Samuelson**
  Murray County Medical Center

- **Nicky Mack**
  North Memorial Health

- **Rhonda Cady**
  Gillette Children's Hospital

- **Sandy Anderson**
  Sleepy Eye Medical Center

- **Sara Bonneville**
  DHS Integrated Health Partnerships

- **Sarah Horst**
 Institute for Clinical Systems Improvement

Appendix H: Counties based on number of Health Care Homes

| County	2010 Population	% of Population	Region	Total # of Clinics	# MN Current HCH	% of Clinics Certified	County has at least One HCH	County with at least one clinic
Aitkin	16,202	0.3%	Northeast	3	2	67%	1	1
Anoka	330,844	6.2%	Metropolitan	18	16	89%	1	1
Becker	32,504	0.6%	Northwest	7	1	14%	1	1
Beltrami	44,442	0.8%	Northwest	4	2	50%	1	1
Benton	38,451	0.7%	Central	1	0	0%	0	1
Big Stone	5,269	0.1%	Southwest	3	2	67%	1	1
Blue Earth	64,013	1.2%	South Central	14	6	43%	1	1
Brown	25,893	0.5%	South Central	5	2	40%	1	1
Carlton	35,386	0.7%	Northeast	4	0	0%	0	1
Carver	91,042	1.7%	Metropolitan	13	6	46%	1	1
Cass	28,567	0.5%	Central	10	1	10%	1	1
Chippewa	12,441	0.2%	Southwest	3	0	0%	0	1
Chisago	53,887	1.0%	Central	3	3	100%	1	1
Clay	58,999	1.1%	West Central	8	4	50%	1	1
Clearwater	8,695	0.2%	Northwest	4	0	0%	0	1
Cook	5,176	0.1%	Northeast	1	1	100%	1	1
Cottonwood	11,687	0.2%	Southwest	6	4	67%	1	1
Crow Wing	62,500	1.2%	Central	13	1	8%	1	1
Dakota	398,552	7.5%	Metropolitan	32	20	63%	1	1
Dodge	20,087	0.4%	Southeast	1	1	100%	1	1
Douglas	36,009	0.7%	West Central	3	2	67%	1	1
Faribault	14,553	0.3%	South Central	4	0	0%	0	1
Fillmore	20,866	0.4%	Southeast	6	4	67%	1	1
Freeborn	31,255	0.6%	Southeast	1	0	0%	0	1
Goodhue	46,183	0.9%	Southeast	8	3	38%	1	1
Grant	6,018	0.1%	West Central	2	1	50%	1	1
Hennepin	1,152,425	21.7%	Metropolitan	135	91	67%	1	1
Houston	19,027	0.4%	Southeast	4	0	0%	0	1
Hubbard	20,428	0.4%	Northwest	3	0	0%	0	1
Isanti	37,816	0.7%	Central	1	1	100%	1	1
Itasca	45,058	0.8%	Northeast	7	2	29%	1	1
Jackson	10,266	0.2%	Southwest	3	2	67%	1	1
Kanabec	16,239	0.3%	Central	1	1	100%	1	1
Kandiyohi	42,239	0.8%	Southwest	4	2	50%	1	1
Kittson	4,552	0.1%	Northwest	2	0	0%	0	1
Koochiching	13,311	0.3%	Northeast	6	0	0%	0	1
Lac qui Parle	7,259	0.1%	Southwest	3	1	33%	1	1
Lake	10,866	0.2%	Northeast	2	1	50%	1	1

County	2010 Population	% of Population	Region	Total # of Clinics	# MN Current HCH	% of Clinics Certified	County has at least One HCH	County with at least one clinic
Lake of the Woods	4,045	0.1%	Northwest	1	0	0%	0	1
Le Sueur	27,703	0.5%	South Central	6	1	17%	1	1
Lincoln	5,896	0.1%	Southwest	5	1	20%	1	1
Lyon	25,857	0.5%	Southwest	5	4	80%	1	1
McLeod	36,651	0.7%	South Central	5	5	100%	1	1
Mahnomen	5,413	0.1%	Northwest	3	1	33%	1	1
Marshall	9,439	0.2%	Northwest	1	0	0%	0	1
Martin	20,840	0.4%	South Central	6	1	17%	1	1
Meeker	23,300	0.4%	South Central	5	4	80%	1	1
Mille Lacs	26,097	0.5%	Central	5	2	40%	1	1
Morrison	33,198	0.6%	Central	6	3	50%	1	1
Mower	39,163	0.7%	Southeast	2	0	0%	0	1
Murray	8,725	0.2%	Southwest	3	2	67%	1	1
Nicollet	32,727	0.6%	South Central	2	2	100%	1	1
Nobles	21,378	0.4%	Southwest	3	3	100%	1	1
Norman	6,852	0.1%	Northwest	3	0	0%	0	1
Olmsted	144,248	2.7%	Southeast	14	12	86%	1	1
Otter Tail	57,303	1.1%	West Central	9	4	44%	1	1
Pennington	13,930	0.3%	Northwest	2	1	50%	1	1
Pine	29,750	0.6%	Central	6	3	50%	1	1
Pipestone	9,596	0.2%	Southwest	4	1	25%	1	1
Polk	31,600	0.6%	Northwest	10	4	40%	1	1
Pope	10,995	0.2%	West Central	2	0	0%	0	1
Ramsey	508,640	9.6%	Metropolitan	66	45	68%	1	1
Red Lake	4,089	0.1%	Northwest	3	1	33%	1	1
Redwood	16,059	0.3%	Southwest	3	3	100%	1	1
Renville	15,730	0.3%	Southwest	5	0	0%	0	1
Rice	64,142	1.2%	Southeast	7	4	57%	1	1
Rock	9,687	0.2%	Southwest	1	1	100%	1	1
Roseau	15,629	0.3%	Northwest	3	0	0%	0	1
St. Louis	200,226	3.8%	Northeast	34	13	38%	1	1
Scott	129,928	2.4%	Metropolitan	11	7	64%	1	1
Sherburne	88,499	1.7%	Central	7	7	100%	1	1
Sibley	15,226	0.3%	South Central	5	4	80%	1	1
Stearns	150,642	2.8%	Central	21	18	86%	1	1
Steele	36,576	0.7%	Southeast	2	0	0%	0	1
Stevens	9,726	0.2%	West Central	3	0	0%	0	1
Swift	9,783	0.2%	Southwest	2	0	0%	0	1
Todd	24,895	0.5%	Central	6	4	67%	1	1

County	2010 Population	% of Population	Region	Total # of Clinics	# MN Current HCH	% of Clinics Certified	County has at least One HCH	County with at least one clinic
Traverse	3,558	0.1%	West Central	1	1	100%	1	1
Wabasha	21,676	0.4%	Southeast	4	2	50%	1	1
Wadena	13,843	0.3%	Central	3	1	33%	1	1
Waseca	19,136	0.4%	South Central	3	0	0%	0	1
Washington	238,136	4.5%	Metropolitan	19	17	89%	1	1
Watonwan	11,211	0.2%	South Central	2	0	0%	0	1
Wilkin	6,576	0.1%	West Central	0	0	0%	0	0
Winona	51,461	1.0%	Southeast	2	2	100%	1	1
Wright	124,700	2.4%	Central	11	10	91%	1	1
Yellow Medicine	10,438	0.2%	Southwest	3	1	33%	1	1
State of Minnesota	5,303,925			683	378	55%	64	86

Appendix I: Dot Map of HCH Clinic Locations
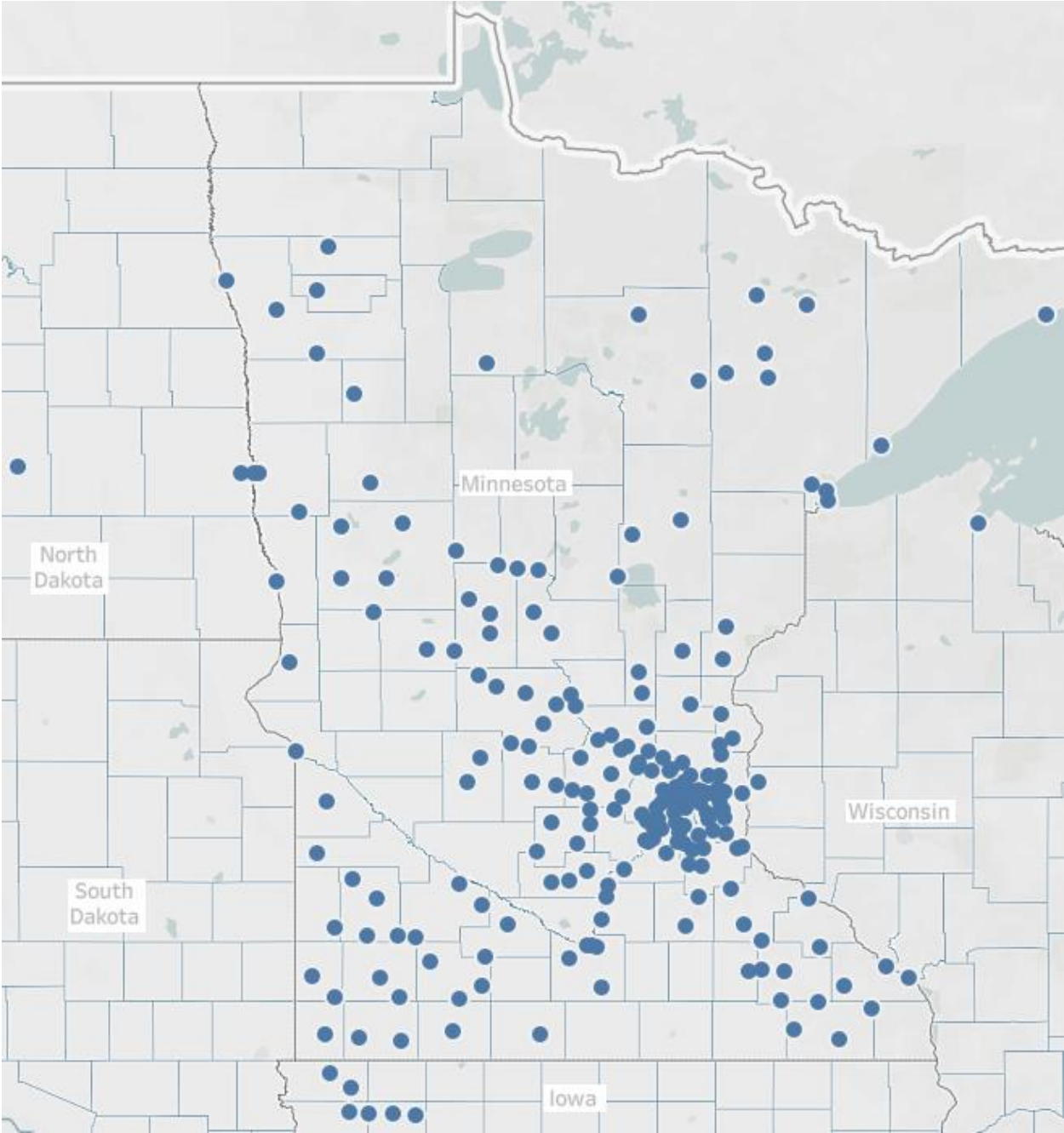
Appendix J: Map of HCH Clinic Locations by County in Minnesota and Border States
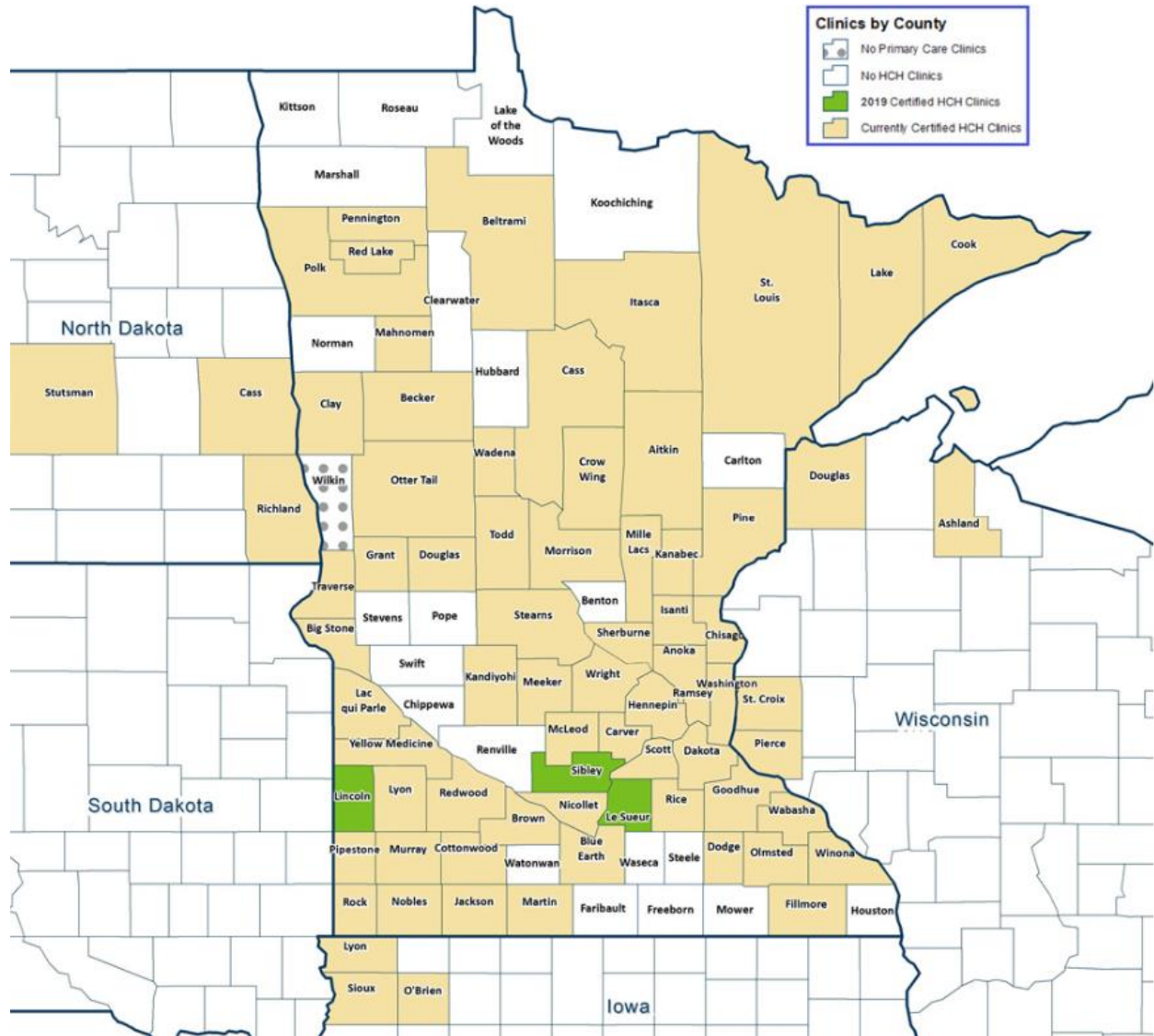
Appendix K: Certification, Recertification, and Spread

Type of Certification	Organization*	Cities	Counties
Certified	Ridgeview Medical Center & Clinics	Arlington, Belle Plaine, Chanhassen, Chaska, Delano, Excelsior, Gaylord, Henderson, Howard Lake, Le Sueur, Spring Park, Winsted, Winthrop	Carver, Hennepin, Le Sueur, McLeod, Scott, Sibley, Wright
Certified	Gillette Children's Complex Care Clinic	St. Paul	Ramsey
Spread	St. Luke's Hospital and Clinic – Medical Arts Clinic	Duluth	St. Louis
Spread	Scenic Rivers Health Services	Cook, Tower	Cook, St. Louis
Spread	Avera Medical Group	Pipestone, Tyler	Lincoln, Stearns
Recertified	NorthPoint Health & Wellness	Minneapolis	Hennepin
Recertified	Indian Health Board of Minneapolis	Minneapolis	Hennepin
Recertified	Avera Medical Group	Marshall, Windom, Worthington	Lyon, Cottonwood, Nobles
Recertified	United Family Medicine	St. Paul	Ramsey
Recertified	Richfield Medical Group	Richfield	Hennepin
Recertified	North Memorial	Blaine, Brooklyn Center, Brooklyn Park, Minneapolis, Elk River, Golden Valley, Maple Grove, Minnetonka, New Hope, Plymouth, St. Anthony	Anoka, Hennepin, Sherburne
Recertified	CHI St. Gabriel's Health	Little Falls, Randall	Morrison
Recertified	Olmsted Medical Center	Byron, Cannon Falls, Chatfield, Lake City, Pine Island, Plainview, Preston, Rochester, Spring Valley, St.	Fillmore, Goodhue, Olmsted, Wabasha, Winona

Type of Certification	Organization*	Cities	Counties
		Charles, Stewartville, Wanamingo	
Recertified	Alomere Health	Alexandria, Osakis	Douglas
Recertified	Children's Hospital & Clinics of MN	Minneapolis, St. Paul	Hennepin, Ramsey
Recertified	Lake Superior Community Health Center	Duluth, Superior (WI)	St. Louis, Douglas (WI)
Recertified	Sawtooth Mountain Clinic, Inc	Grand Marais	Cook
Recertified	St. Luke's Hospital and Clinic	Duluth, Hermantown, Two Harbors, Ashland (WI), Superior (WI)	Lake, St. Louis, Ashland (WI), Douglas (WI)
Recertified	Open Door Health Center	Mankato	Blue Earth
Recertified	HealthEast Care System	Cottage Grove, Hugo, Maplewood, Oakdale, Roseville, Stillwater, St. Paul, Vadnais Heights, Woodbury	Ramsey, Washington
Recertified	Fairview Health Services	Andover, Apple Valley, Blaine, Bloomington, Brooklyn Park, Burnsville, Chisago City, Columbia Heights, Eagan, Eden Prairie, Edina, Elk River, Farmington, Fridley, Hibbing, Hugo, Lakeville, Lino Lakes, Maple Grove, Milaca, Minneapolis, Mountain Iron, Nashwauk, New Brighton, North Branch, Pine City, Princeton, Prior Lake, Rogers, Rosemount, Savage, St. Paul, Wyoming, Zimmerman	Anoka, Dakota, Hennepin, Chisago, Sherburne, St. Louis, Washington, Mille Lacs, Itasca, Ramsey, Pine, Scott

Type of Certification	Organization*	Cities	Counties
Recertified	Lakewood Health System	Browerville, Eagle Bend, Motley, Pillager, Staples	Cass, Morrison, Todd
Recertified	Lake Region Healthcare Clinic Services	Ashby, Barnesville, Battle Lake, Fergus Falls	Clay, Grant, Otter Tail
Recertified	Sanford Clinic Fargo Region	Bemidji, Fargo (ND), Detroit Lakes, East Grand Forks, Jamestown (ND), Mahnomen, Moorhead, Pelican Rapids, Perham, Thief River Falls, Wahpeton (ND), West Fargo (ND), Wheaton	Beltrami, Becker, Clay, Mahnomen, Pennington, Polk, Otter Tail, Traverse, Cass (ND), Richard (ND), Stutsman (ND)
Recertified	Life Medical, PA	St. Louis Park	Hennepin
Recertified	Mayo Clinic – Employee and Community Health	Kasson, Rochester	Olmsted
Recertified	AALFA Family Clinic	White Bear Lake	Ramsey
Recertified	St. Paul Family Medical Center	St. Paul	Ramsey
Recertified	South Lake Pediatrics	Chaska, Eden Prairie, Maple Grove, Minnetonka, Plymouth	Carver, Hennepin
Recertified	Open Cities Health Center	St. Paul	Ramsey
Recertified	Mankato Clinic	Lake Crystal, Mankato, Mapleton, North Mankato, St. Peter	Blue Earth, Nicollet
Recertified	Minnesota Community Care	St. Paul	Ramsey
Recertified	Welia Health	Hinckley, Mora, Pine City	Kanabec, Pine
Recertified	Hutchinson Health	Dassel, Hutchinson	Meeker, McLeod
Recertified	Ortonville Area Health Services	Clinton, Ortonville	Big Stone

Type of Certification	Organization*	Cities	Counties
Recertified	CentraCare Health System	Albany, Becker, Belgrade, Big Lake, Clearwater, Cold Spring, Eden Valley, Long Prairie, Melrose, Paynesville, Richmond, Sauk Centre, St. Cloud, St. Joseph	Meeker, Sherburne, Stearns, Todd, Wright
Recertified	University of Minnesota Physicians	Minneapolis, St. Paul	Hennepin, Ramsey
Recertified	Stellis Health, PA	Albertville, Buffalo, Monticello	Wright
Recertified	Tri-County Health Care	Wadena	Wadena
Recertified	Park Nicollet	Bloomington, Brooklyn Center, Burnsville, Champlin, Chanhassen, Eagan, Eden Prairie, Golden Valley, Lakeville, Maple Grove, Minneapolis, Minnetonka, Plymouth, Prior Lake, Rogers, Shakopee, Shorewood, St. Louis Park, Wayzata	Carver, Dakota, Hennepin, Scott
Recertified	Native American Community Clinic	Minneapolis	Hennepin
Recertified	Madison Healthcare Services	Madison	Lac qui Parle
Recertified	Hennepin County Medical Center	Brooklyn Park, Golden Valley Minneapolis, Richfield, St. Anthony	Hennepin
Recertified	Zumbro Valley Health Center	Rochester	Olmsted

* Listed in calendar order of certification/recertification.