MINNESOTA
HEALTH CARE HOMES

Health Care Homes: Redefining Health, Redesigning Care

2020 YEAR END REPORT

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Minnesota Department of Health
Health Care Homes
PO Box 64882
St. Paul, MN 55164-0882
651-201-5421
health.healthcarehomes@state.mn.us
www.health.state.mn.us

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Executive Summary

"Care coordination works to help patients prevent unnecessary visits and achieve better health outcomes through a holistic team approach. Care coordination's goal is to provide the best care possible from everyone that is involved with care." (CCM Health)

2020 Unprecedented Challenges

Sixty percent of Minnesota primary care clinics are certified as a Health Care Home (HCH). The program certified an additional 39 primary care clinics in 2020. Since 2010, Minnesota HCH primary care clinics have used HCH certification to drive health care transformation by organizing and delivering care that is coordinated, patient-centered, and team based. During 2020, certified HCH organizations met unprecedented challenges and had to pivot their care delivery models to focus primarily on COVID 19 response efforts.

In 2020, during the COVID-19 pandemic, 30 Health Care Homes primary care clinics closed their doors. Minnesota primary care clinicians and their teams stepped up to manage the crisis amongst many challenges. The clinics faced shortages of personal protective equipment and testing supplies, absence of a viable vaccine, delays in usual care, colleague furloughs and layoffs, and other challenges while seeking to understand the best ways to treat and protect Minnesotans. COVID-19 has disrupted the entire care delivery system, exposing care fragmentation, heightening the visibility of gaps within the system, and highlighting inequities for black and brown communities. Patients afraid to seek care were postponing necessary and routine care and procedures, exacerbating current and chronic medical conditions.

Together, although in different ways, certified clinics and the HCH program staff strived to meet the needs of Minnesotans. The unprecedented barriers to providing care using the HCH model, has impeded the ability of certified HCH and the program in many ways. Due to COVID-19, some of the usual HCH clinic activities including targeting disease prevention, managing chronic conditions, population health improvement, and care coordination lessened due to priority tasks centered on COVID-19. In the same manner, the HCH program staff were reassigned to support the Minnesota Department of Health's response to COVID and took on response duties outside of the HCH program.

During 2020, HCH embarked on two new initiatives. One with HealthPartners Institute and MN Community Measurement, on a Patient Centered Outcomes Research Institute (PCORI) comparative research study comparing a medical and a medical social model of care coordination. Secondly, with the Minnesota Academy of Family Physicians and the MDH Office of Rural Health and Primary Care, convening a primary care stakeholder group to discuss the goal of increased investment in primary care that is equitable, person-centered, team-based, and community-aligned to help achieve the goals of better health, better care, and lower costs.

Making a Difference: 2020 HCH Program Outcomes

Through all the challenges presented in 2020 the HCH Program continued to take important steps to advance the program by:

- Certifying 39 new clinics, ending the year with a total of 409 certified Health Care Homes, 389 Minnesota clinics and 20 border state clinics, that are part of a Minnesota health care organization
- Increasing the number of Minnesota counties with HCH clinics to 68 (78 %) by adding four new counties: Chippewa, Koochiching, Renville, and Watonwan
- Offering capacity building support towards HCH certification to all uncertified Minnesota primary care clinics and supporting all certified clinics through technical assistance, coaching, and other training methods to strengthen organizational skills to meet their unique needs
- Working with the Minnesota Department of Human Services (DHS) to certify 4 additional Behavioral Health Homes (BHH) bringing the total of certified provider locations to 52
- Beginning work in partnership with HealthPartners and Minnesota Community Measurement on a PCORI award to compare 2 models of care coordination
- 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, and the Statewide Health Improvement Partnership program
- Continuing work on program process quality improvements to decrease certification administrative burden for clinic partners
- Working with a Primary care Stakeholder group to advance Minnesota primary care
- Continuing work on advancement of the HCH Rule
- Working towards a new HCH benchmarking process that will provide timely information and peer comparison, trending over time, comparison of quality outcomes to other HCHs and the state average

Introduction

"Patients, families and staff all feel ownership in this clinic. We are invested to make it the best it can be." (Winona Health)

Redefining Health, Redesigning Care in 2020 with Unprecedented Challenges

Sixty percent of Minnesota primary care clinics are certified as a HCH. Minnesota HCH primary care clinics have used 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) is a primary care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand. The HCH aims to improve quality, reduce cost, and improve the experience of patients, caregivers, and health care professionals and is committed to quality improvement (QI), performance improvement, and population health management. (reference: Module 25: The Patient-Centered Medical Home: (ahrq.gov))

In 2020, as the COVID-19 pandemic took hold of the entire United States, Minnesota primary care clinicians and their teams stepped up to manage the crisis amongst many challenges. The clinics faced shortages of personal protective equipment and testing supplies, absence of a viable vaccine, delays in

usual care, colleague furloughs and layoffs, and other challenges while seeking to understand the best ways to treat and protect Minnesotans. COVID-19 has disrupted the entire care delivery system, exposing care fragmentation, heightening the visibility of gaps within the health care system, and highlighting inequities for black and brown communities. Also, patients afraid to seek care were postponing necessary routine care and procedures exacerbating current and chronic medical conditions.

Race and ethnicity data indicate the COVID-19 pandemic is having a disproportionate impact on racial and ethnic minority groups. Black people account for 25% of COVID-19 hospitalizations in Minnesota but 7% of the state's population, while Hispanic people make up 16% of hospitalizations but 6% of the population, according to the University of Minnesota study, published Monday, August 17, 2020 as a research letter in JAMA Internal Medicine. Health services and health policy research indicate major disparities exist across race, ethnicity, and socioeconomic status in terms of access to new treatment, access to care, and insurance. Disparities are also related to underlying health conditions that are prevalent in certain racial and ethnic groups because of complex social and economic factors. (https://www.startribune.com/covid-19-study-finds-racial-disparity-in-hospitalizations-in-minnesota/572137962/?refresh=true)

Together, although in different ways, certified clinics and the HCH program staff strived to meet the needs of Minnesotans. The unprecedented barriers to providing care using the HCH model, has impeded the ability of certified HCH and the program in many ways. Due to COVID-19, some of the usual HCH clinic activities including targeting disease prevention, managing chronic conditions, population health improvement, and care coordination have subsided due to priority tasks centered on COVID-19. In the same manner, the HCH program staff have dedicated time to supporting the Minnesota Department of Health's response to COVID by taking on response duties that are not a usual part of the HCH program.

Minnesota Care Coordination Effectiveness Study

In 2020, HealthPartners Institute, in collaboration with the Minnesota Department of Health HCH program and MN Community Measurement, has been awarded $4 Million of funding from PCORI to study the effect of care coordination on patient outcomes. The purpose of this study called Minnesota Care Coordination Effectiveness Study (MNCARES) is to compare two approaches to care coordination for patients with high health care costs and multiple morbidities. The goal is to learn what approaches to care coordination in primary care settings produce the best care quality, utilization, and patient-centered outcomes. The first model includes care coordination performed by a nurse or other clinical staff. The second model includes a social worker as part of the care team.

MNCARES was developed with input from patients, clinic leaders, state government officials and additional experts in health and quality care. The study aligns with PCORI's priority area of patient's access to care, high quality of care, support of self-care and coordination of care across healthcare settings. Leif I. Solberg, MD, a Senior Advisor from HealthPartners Institute, leads the project along with Steve Dehmer, PhD, Health Economist.

The purpose of MNCARES is to compare two approaches to care coordination for patients with high health care costs and multiple morbidities. The goal is to learn what approaches to care coordination in primary care settings produce the best care quality, utilization, and patient-centered outcomes. The first model includes care coordination performed by a nurse or other clinical staff. The second model includes a social worker as part of the care team.

Invitations for Certified Health Care Home clinics to participate in the study were distributed in October 2020 and over 78 % of certified HCH have agreed to participate. Participating care systems and clinics will complete a survey to provide information about the approach to care coordination at their organization, and to submit data for adult patients at their clinics who are receiving care coordination services. The patient lists will be used to secure necessary utilization data from participating health plans, add quality data from MNCM, and to disseminate surveys to collect patient-centered/reported outcomes.

One care coordinator from each clinic will complete a short survey about the details for care coordination for their clinic, and a few coordinators and clinic leaders will participate in a short interview about their perspectives on the care coordination process.

Participating clinics have an opportunity to request nominal financial reimbursement for expenses, receive reports on overall study outcomes, and individual reports that can help understanding on how the clinic compares to its peers and receive a variance to forego one recertification. More information can be found at https://www.health.state.mn.us/facilities/hchomes/mncares.html

Primary Care Stakeholders

In January 2020, a large primary care stakeholder group formed to discuss investment in Minnesota primary care. The Minnesota Academy of Family Physicians, Office of Rural Health and Primary care and the HCH program, leads this work. A large diverse and multi-specialty group formed (see Appendix E) with the objective and goals of:

Objectives: Supporting the goal of investing in primary care for better health, better care and lower costs. The stakeholder group will:

- Engage stakeholders that represent all parts of the community and healthcare delivery system.
- Work to strengthen the ability of primary care to improve population health.
- Promote primary care workforce to ensure access to all:
    - Support diverse workforce that reflects communities served.
    - Promote team-based care and adequate primary care workforce to address the needs of all Minnesotans.
    - Improve access in underserved areas.
    - Promote healthcare staff engagement, recruitment, and retention.
- Keep the patient at the center of care by supporting strategies that will:
    - Support efforts to improve health and community outcomes:
        - Empower consumers.
        - Increase coordination with community partners.
        - Integrate behavioral health services.
        - Allow clinicians to focus on the most appropriate outcomes by eliminating administrative burdens.

        - Promote investments in human assets, infrastructure and care integration that strengthens care delivery.

- Implement primary care through value-based models that promote and align incentives across participants, including consumers.

Goal: Increasing investment in primary care that is equitable, person-centered, team-based, and community-aligned to help achieve the goals of better health, better care, and lower costs.

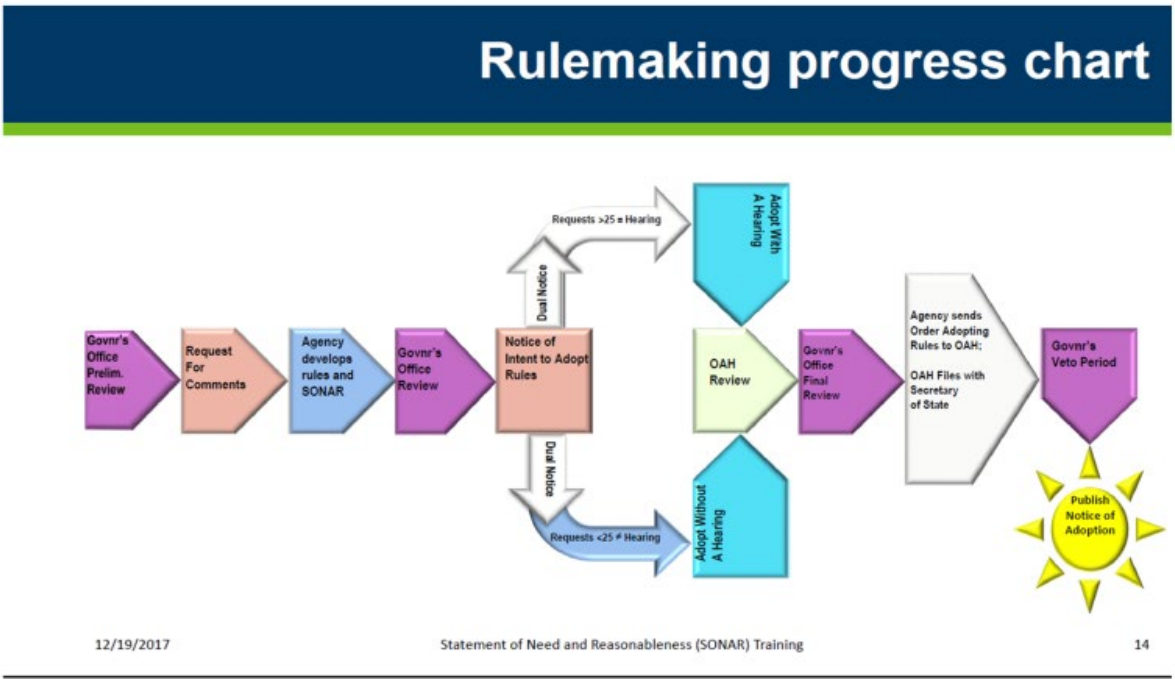
The work of the primary care stakeholder group is ongoing at this time and has experienced a few setbacks due to the pandemic and its impact on participants. A report discussing the work so far and current findings from ongoing discussions with various stakeholders is under development. The findings will be posted at a later date.

This work aligns with national work around primary care investment. Greater investment in primary care is associated with lower costs, higher patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality. Despite current high levels of healthcare spending in the United States, the proportion spent on primary care is insufficient. A shift in resources to support greater access to comprehensive, coordinated primary care is imperative to achieving a stronger, higher-performing healthcare system. https://www.pcpcc.org/primary-care-investment

Health Care Homes Model Progression

MDH initiated a 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. The rule and the Statement of Need and Reasonableness (SONAR) are developed. Currently, the rulemaking process is delayed due to MDH's part in the COVID response efforts and is currently waiting for legal review. Following legal review, the rule can then enter the next phase of the rulemaking process by seeking a review by the Governor's office. Once the review is complete, the program's rule can move to Notice of Intent to Adopt the Rule.

Figure 1: Rulemaking Progress Chart



Current State to Future State

The health care context has changed since the program began, and HCH (in consultation with an established advisory committee and other stakeholders) engaged in rulemaking to update the rules and improve the program. 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.

Certification Activity

"I am so happy to have my doctor come to me in the comforts of my apartment. I do not have to leave the building to get my medical care. I know that he is taking good care of me and understands my situation. My family and I are thrilled with this arrangement." (Manna Health)

Health Care Homes

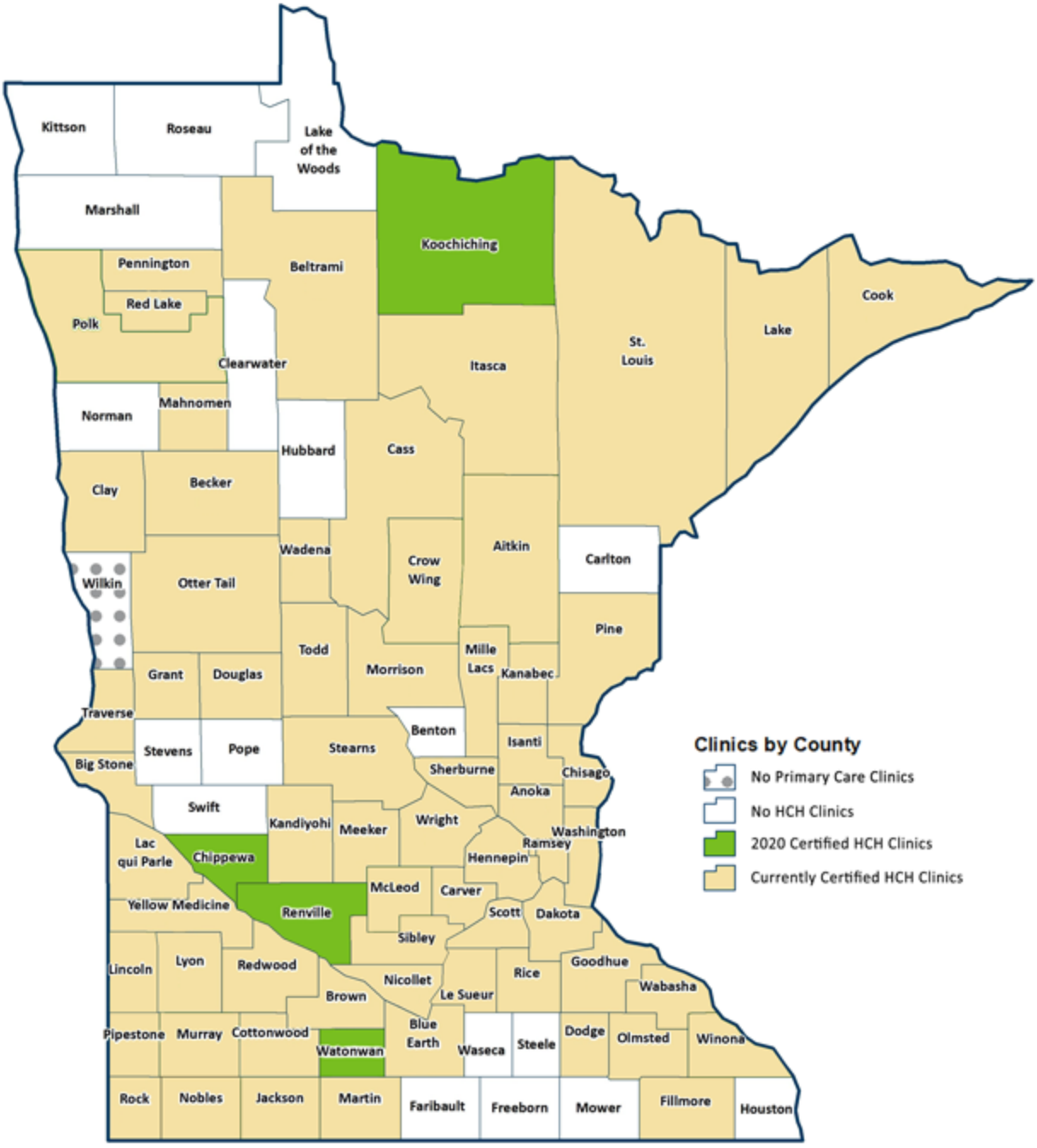
During calendar year 2020, 39 clinics achieved certification for the first time and 7 clinics were recertified for a total of 389 certified clinics in Minnesota. The number of currently certified clinics represents 60 percent, or over half of the 653 primary care clinics in the State. 20 additional clinics in bordering states are certified as a HCH because of they are part of a Minnesota organization, bringing the overall total of certified HCH to 409.

30 certified HCH primary clinics closed their doors this year related to the COVID-19 pandemic. Since 2010, 91 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.

Prior to 2020, clinic participation in HCH was stable and a small portion of clinics and organizations had surrendered their certification or opted to not recertify every three years. The 30 clinic closures this year, demonstrates an increase of clinic closures and the impact of the COVID pandemic on clinic/organization finances, staffing and a shift to more use of telehealth. In the summer of 2020, program staff reached out and spoke to certified primary care organizations about their care practices and how they had been impacted by COVID. Certified organizations reported staff furloughs, staff turnover, moving care coordination to virtual methods or putting aside care coordination altogether pulling staff members to COVID response duties. One clinic care coordinator stated, “COVID has impacted every corner of the clinic.” There is an acknowledgement among organizations that there will be a deterioration in reported quality outcome measures since many patients have not received care as usual for chronic and complex conditions. All clinics are looking forward to restoring care models and resuming HCH practices when it is safe to do so.

68 of Minnesota’s 87 counties (78 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.

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

"Factors that have improved healthcare in the area include the integration of state-provided patient data and electronic health data and the combination of behavioral health services with county service providers. Data helps to target services to patients with the most need so that service partnerships can work together to approach care." (Lake Region Healthcare)

The Department of Human 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.

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 52 provider locations serving over 65 counties in Minnesota certified by DHS to provide BHH services. Of the 52 BHH services providers, 14 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.

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:

- 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. An eLearning course titled, "Integrating Primary Care and Behavioral Health: Approaches and Strategies", is an example of one such course that was developed.
- Working across agencies and with Minnesota providers, educators and community organizations to offer a collaborative, six-month learning initiative called "Building Systems for Culturally Responsive Integrated Care". This initiative supported 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 included video conferencing sessions, in person sessions, self-reflection journaling exercises, and the availability of individualized coaching support.

Building Capacity for Practice Transformation

"A family with several children with significant behavioral health and learning challenged children, the mother was overwhelmed with their needs and limited resources and support she perceived in this situation. The clinic care coordinator worked together with the school social worker and nurse to gather a collaborative care team (school, provider, and care coordinator) to develop a plan with one main contact and a broad team approach including behavioral health, primary care, and school with release of information in place." (Sawtooth Mountain Clinic)

The HCH program fosters ongoing, supportive relationships across the State to build capacity among clinics for achieving certification. Redesign efforts in primary care are closely tied to the concept of Health Care Homes, a patient-centered medical home model. According to the Agency for Healthcare Research and Quality, a critical element of the medical home is: "a commitment to quality and quality

improvement by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management." (reference: Creating Capacity for Improvement in Primary Care | Agency for Healthcare Research and Quality (ahrq.gov) The HCH staff work with each organization on an individual basis and meet the organization where they are, realizing that one size does not fit all allowing for flexibility and innovation as intended by the HCH standards and criteria.

HCH Support

HCH staff with expertise in practice facilitation and coaching work directly with clinics and organizations to implement the HCH model. 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. The HCH team of experts support practices in building capacity, transforming practice, and measuring and improving outcomes. HCH staff meet practices where they are to create individualized plans for achieving PCMH recognition, including one-to-one coaching, tools, resources, and support.

All primary care clinics are eligible for HCH support and assistance free of charge – 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.

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 continues to support 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 HCH standards to improve care for Minnesotans. The HCH program supports this ongoing process with accessible learning opportunities. In 2020, HCH learning plan activities were adapted due to the impact of COVID-19 on HCH stakeholders and staff, and focused on virtual learning. The Annual Learning Days Conference was cancelled and will return in 2021 as a virtual event. In the first half of 2020, MDH and DHS partnered in offering a 6-month, team-based learning experience for providers to learn about and collaboratively take action to strengthen care and reduce Minnesota's health disparities. The initial meeting in January was an in-person event with over 100 individuals attending, and quickly switched to an on-line experience for the remaining time.

Throughout 2020, HCH staff designed, developed, and launched seven on-line learning courses accessible through the MDH Learning Center, supplemented by several micro learnings through an

emailed Learn bulletin to all certified HCH clinics. HCH e-learning courses are offered free of charge, available on demand, and CEU eligible. Please see Table 1 below to view the original and modified learning plan.

Table 1: 2020 Learning Plan Progress

2020 Learning Plan Progress

Monthxx	Topic	Micro Learning	E-Learning	Event
Jan-June	Health Equity -Write on Race			x
January	Risk Stratification - Parts 1/2	x	x	
~~February~~	~~Social Determinants of Health~~			
March	*Strategies for Hypertension Management*	x	x	
~~April~~	~~Learning Days~~			
May	*Prediabetes Assessment, Planning & Referral*	x	x	
~~October~~	~~Peer to Peer Networking– North and South~~			
~~June~~	~~Change Management~~			
~~July~~ December	*Strategies for Arthritis Management*		x	
September	Integrating Primary Care and Behavioral Health	x	x	
~~September~~	~~Community Partnerships~~			
~~October –~~ July	E-Health Tools (Sailing Toward Telehealth)	x	x	
~~November -~~ October	~~Updated HCH Foundations (for rule alignment) -~~ *State of the HCH Program*	x	x	

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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 following key strategic areas; Sustainability; Measurement and Evaluation; and Learning and Innovation amongst many challenges and barriers for work group and staff participants.

Learning and Innovation Work Group

In 2020, the Program Innovation Work Group and Learning and Technical Assistance Work Group combined to form the Program Learning and Innovation Work Group. This change facilitates stakeholder engagement into the learning and support that is needed as the program changes over time. Since 2017, the 26-member 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 clinics, 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.

While COVID-19 placed barriers to the meeting schedule, this group was able to meet two times during 2020 to provide input on the 2021 learning plan and to better understand the experience and changes in the delivery of primary care across the state.

2020 Outcomes

The Program Innovation Work Group in 2020 provided recommendations to the Health Care Homes program on:

- The 2021 HCH Learning Plan and engagement strategies
- Information needed to better understand care delivery changes and what is needed to grow and sustain primary care
- A Patient-Centered Outcomes Research Institute (PCORI) award opportunity to conduct a comparative care coordination study
- Ways to promote Health Equity
- Ways to include the patient in all aspects of the HCH program.

2021 Steps

- Review and provide recommendation on redesigned documentation for submission/verification requirements for Level 1 certification and recertification and for certification and recertification at Level 2 and Level 3 in the future
- Test and provide recommendations on processes for a new HCH data portal for certification and recertification
- Assist HCH staff in evaluating learning tools and resources for best practice, usability, and relevance to HCH program and standards
- Assist with development of peer-to-peer networking
- 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

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 and developing approaches to sustainability that contains numerous elements beyond reimbursement.

HCH practices put extra resources into care management, care coordination, and quality improvement initiatives. These extra resources come with extra costs in time, people, and money. Each practice implements the attributes based on its own unique characteristics, such as: the size of the practice; the location (i.e. urban versus rural setting); the composition (solo/small practice, mid-size primary care practice, large multi-specialty practice, academic-affiliated practice, etc.); the patient population it serves (health status, other social and economic characteristics); whether financial or performance incentives are provided. The HCH model provides higher quality coordinated care and communication for the patient. The structure enables the primary care physician to develop a long-term relationship with the patient, which has been proven to improve the quality of care. (What-is-a-PCMH-FAQ_0.pdf (pcpcc.org)

The sustainability work group met 1 time in 2020 due to the COVID-19 pandemic.

2020 Outcomes

The Sustainability Work Group in 2020 provided recommendations to the Health Care Homes program on:

- Using HCH certification as an indicator of quality, patient-centered care, which would provide state employees the opportunity to choose HCH clinics during open enrollment or when they are considering changing clinics Identifying research to support the business case for HCH
- Beginning development of a pilot project, in partnership with a payer, to demonstrate the ability of HCH to impact the social determinants of health

2021 Steps

- Develop 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
- Provide assistance in strengthening public sector employer awareness of and engagement with HCH, including third party administrators
- Strategies to build a narrative about the HCH program that resonates with key stakeholders, including patients
- An approach to sustainability that contains numerous elements beyond just reimbursement
- Advise on strategies to build broader stakeholder support for HCH
- Identify stakeholder groups who could influence the financial sustainability of HCH
- Ongoing development of a pilot project, in partnership with a payer, to demonstrate the ability of HCH to impact the social determinants of health
- Develop a plan for outreach to physician networks using Blue Cross Blue Shield of Michigan's model as a guide

Measurement and Evaluation Work Group

The Director of Quality states "the quality team's job is to bring all stakeholders together for discussion. Different individuals are assigned to facilitate our many quality team meetings. Our quality goes top down and frontline up." (Cuyuna Regional Medical Center)

The Measurement and Evaluation work group provides recommendations to the HCH team on what certified clinics need to improve care and identify and work to remove barriers to improved outcomes. This work encompasses a wide range of activities that include tools that clinics need at the point of care and evaluation of the core components of a health care home model of care delivery to identify and implement best practices.

HCH organizations demonstrate a commitment to quality improvement. Certified primary care practices employ a systematic approach to measuring, reporting, and improving population health, quality, safety and health equity, including partnering with individuals, families and community groups. (Shared Principles of Primary Care | Primary Care Collaborative (pcpcc.org)

Conducting quality improvement processes provides results about interventions that work best for the patients. Evaluating outcomes measures the effectiveness of current processes as well as informing future plans and strategies to improve outcomes. "Quality measures address the details of patient care, administrative processes and medical decision-making" and aim for benchmarks or goals. Health care

organizations use them to "accelerate clinical improvement" and to "gain an understanding of care gaps and the impact interventions have on closing those gaps." (AAFP Outlines Quality Measurement Strategy for Primary Care)

2020 Outcomes

The Measurement and Evaluation Work Group in 2020 provided guidance on:

- Development of the new HCH benchmarking process
- A Patient-Centered Outcomes Research Institute (PCORI) grant opportunity to conduct a care coordination study

2021 Steps

- Integrate health equity in HCH evaluation measurement and evaluation activities
- Discuss and develop plan to measure Joy in Practice and clinician burn out
- Implement and measure the impact of the new HCH Benchmarking application
- Provide guidance and feedback to PCORI research as requested
- Provide recommendations on implementation of the HCH program evaluation
- Provide tools and resources to support organizations and clinics across Minnesota

Conclusion

Described patient care during the time of COVID-19 and social unrest in Minneapolis: “The patient reported being in crisis due to their pharmacy closure due to looting. The care coordinator was able to help her deescalate and problem-solve the issue while communicating with her provider to update them of the situation. Working with the rest of the care coordination team, they worked towards supportive solutions and confirmed a different pharmacy option. The following week, the care coordinator called to check in and the patient was doing better.” (Community University Health Care Center)

2020 has been a challenging year for everyone across the country. Minnesota HCH providers have experienced unprecedented challenges due to the COVID-19 pandemic. They have demonstrated the ability to pivot quickly to telehealth and to setting up systems to test, treat and provide safe care without always having enough testing materials or personal protective equipment. Certified organizations and clinics have reported the disruption of care is seriously impacting their usual HCH activities.

In 2021, after the vaccine is administered to a majority of the population most clinics plan on resuming their normal routine and reinstatement of HCH required activities such as patient tracking with notification of overdue health care needs and care coordination activities. Lessons learned will be applied to processes going forward such as the continuation of telehealth visits.

This year has demonstrated fragmentation and the cracks in the healthcare system and has exposed the inequities in health and health care access for communities of color. The advancement of the HCH rule is an important tool moving forward to advancing whole person health and is inclusive of management of the social determinants, new tools to manage and improve quality outcomes and a strong focus on improving health equity across the care continuum.

Appendices

Appendix A: HCH Advisory Committee members

ACADEMIC RESEARCHER IN MINNESOTA

- **Steve Dehmer**
  HealthPartners

CERTIFIED HEALTH CARE HOME REPRESENTATIVE

- **Monica Aidoo-Abrahams**
  Hennepin Healthcare
- **Rebecca Nixon**
  North Memorial
- **Tracy Telander**
  HealthEast

CONSUMER OR PATIENT

- **Robert C. Jones**
- **Samuel Mwangi Sr.**
- **Melissa Winger**

EMPLOYER

- **Philip Deering**
  Consultant

HEALTH CARE PROFESSIONAL

- **Dana Brandenburg**
  U of MN Department of Family Medicine and Community Health
- **Dale Dobrin**
  South Lake Pediatric Clinic
- **David Thorson**
  Primary Care Provider

STATE AGENCY REPRESENTATIVE

- **Lorna K. Smith**
  State Member, State Employee Group Insurance Program

QUALITY IMPROVEMENT ORGANIZATION REPRESENTATIVE

- **Sarah Horst**
  Project Manager/Health Care Consultant

Appendix B: Learning and Innovation Work Group members

- **Alex Dahlquist**
  Office of Statewide Health Improvement Initiatives
- **Ben C. Bengtson**
  St. Luke's Health System
- **Brittney Dahlin**
  Minnesota Association of Community Health Centers
- **Charlie Mandile**
  HealthFinders Collaborative
- **Claire Neely, MD**
  Institute for Clinical Systems Improvement
- **Daniel Backes**
  CentraCare Health
- **Deb McKinley**
  Stratis Health
- **Eileen Weber**
  University of Minnesota School of Nursing
- **Jenny Kolb**
  Fairview Health Services
- **John Halfen, MD**
  Lakewood Health System
- **Joy May**
  Hutchinson Health
- **Kris Monson**
  Lac Qui Parle Clinic
- **Maggie Wacker**
  HealthPartners
- **Melissa Winger**
  Consumer
- **Miranda Cantine**
  Ortonville Area Health Services
- **Nicky Mack**
  North Memorial Health
- **Rachel Finley**
  Fairview Health Services
- **Rhonda Buckallew**
  Unity Family Healthcare
- **Sarah Horst**
  Institute for Clinical Systems Improvement
- **Savannah Aultman**
  Alexandria Clinic
- **Vimbai Madzura**
  Minnesota Department of Human Services

Appendix C: Sustainability Work Group members

- **Aaron Bloomquist**
  North Memorial
- **Andrew Whitman**
  Carlson School of Management
- **Dale Dobrin**
  South Lake Pediatric Clinic
- **David Thorson**
  Entira Clinics
- **Deb Krause**
  MN Health Action Group
- **Jim Przybilla**
  Prime West
- **Jill Swenson**
  Sanford Health
- **Lorna K. Smith**
  State Employee Group Insurance Program

Appendix D: Measurement and Evaluation Work Group members

- **Corinne L Abdou**
  Wayzata Children's Clinic, P.A.
- **Dan Schletty**
  Riverwood Healthcare Center.
- **Denise McCabe**
  MDH Statewide Quality Reporting Measurement System
- **Erica Schuler**
  Ridgeview Medical
- **Gena Graves**
  HealthPartners/ Park Nicollet
- **Jennifer Weiss**
  Sanford Health
- **Joel Stegner**
  Self employed
- **Karolina Craft**
  DHS Care Delivery and Payment Reform
- **Kristin Erickson**
  Partnership 4 Health
- **Lynn Balfour**
  Minnesota Academy of family Physicians
- **Maria McGannon**
  South Lake Pediatrics
- **Michele Gustafsson**
  Entira
- **Mina Iskandr**
  Sanford Health
- **Miranda Cantine**
  Ortonville Area Health Services
- **Nate Hunkins**
  Bluestone Physician Services
- **Nathan Shippe**
  U of MN: Public Health
- **Pam Mink**
  MDH
- **Peter Harper**
  U of MN: Family Medicine
- **Rebecca Nixon**
  North Memorial
- **Susan Gentilli**
  Allina Clinics
- **Tessi Ross**
  Sanford Health

Appendix E: Primary Care Stakeholders

- **Kerri Gordon**
  Allina
- **Ellen Hyser**
  BCBS
- **Karen Amezcua**
  BCBS
- **Lindsay Giese**
  BCBS
- **Lynn Price**
  BCBS
- **Julie Sabo**
  Board of Nursing
- **LaTanya Black**
  Community Health Worker Alliance
- **Tia Radant**
  Community Paramedics
- **Clarence Jones**
  Consumer
- **Melissa Winger**
  Consumer
- **Nate Chomillo, MD**
  DHS
- **Nate Chomillo, MD assistant**
  DHS
- **Kat Vue**
  DHS
- **Kate Zaker-Pate**
  DHS
- **Cary Zahrbock**
  Freelance (formerly at Optum)
- **Bonnie LaPlante**
  HCH
- **David Kurtzon**
  HCH
- **Rosemarie Rodriguez Hager**
  HCH
- **Carol Bauer**
  HCH
- **James M McClean**
  HealthPartners
- **Tia Radant**
  HealthPartners
- **Beth Averbeck, MD**
  HealthPartners
- **Barbara Cox**
  HealthPartners
- **Christopher George**
  Hennepin Healthcare System
- **Allyson Brotherson, MD**
  Hennepin Healthcare System
- **Tom Lyon**
  Hennepin Healthcare System
- **Susie Emmert, LGSW**
  Hennepin Healthcare System
- **Lisa Hoffman Wojcik**
  LEEP
- **Jami Burbidge**
  MAFP
- **Maria Huntley**
  MAFP
- **Dave Renner**
  MAFP
- **Peter Meyers, MD**
  MAFP
- **Diane Rydrych**
  MDH
- **Khatidja Dawood**
  MDH

- **Cara Broich**
  Medica
- **Stacy Ballard**
  Medica
- **Nick Schneeman**
  Metro Alliance
- **Rahul Koranne, MD**
  MHA
- **Danny Ackert**
  MHA
- **Bentley Graves**
  Minnesota Chamber of Commerce
- **Stu Lourey**
  Minnesota Farmers Union
- **Kristen Gloege**
  Minnesota Medical Association
- **Keith Stelter, MD**
  Minnesota Medical Association
- **Laura Sayles**
  Minnesota Nurses Association
- **Mark Jones**
  Minnesota Rural Health Association
- **Mark Price**
  Minnesota Rural Health Association
- **Sarah Greenfield**
  MN APRN Coalition
- **Jonathan Watson**
  MN Association of Community Health Centers
- **Brittney Dahlin**
  MN Association of Community Health Centers
- **Rochelle Westlund**
  MN Association of Community Health Centers
- **Elizabeth Huntley**
  MN Board of Medical Practice
- **Ruth M Martinez**
  MN Board of Medical Practice
- **Jeff Bauer**
  MN Chapter - American Academy of Pediatrics
- **Sheldon Berkowitz**
  MN Chapter - American Academy of Pediatrics
- **Katherine Cairns**
  MN Chapter - American Academy of Pediatrics
- **Julia Dreier**
  MN Council of Health Plans
- **Kyle Hoffman**
  MN Farmers Union
- **Stu Lourey**
  MN Farmers Union
- **Maureen O'Connell**
  MN Nurse Practitioners
- **Mary Benbenek**
  NP
- **Mary Dierich**
  NP
- **Sue Stout**
  Nursing Community Policy Forum
- **Lisa M Fink**
  O'Connell Consulting
- **Zora Rasdosvich**
  ORHPC
- **Nitika Moibi**
  ORHPC
- **Laura Schwartzwald**
  Pharmacy
- **Susan Paulson, MD**
  Prime West
- **Chris Singer**
  SoLaHmo/MN Community Care

- **Lauren Graber**
  SoLaHmo/MN Community Care
- **Patrick Lobejko**
  UCARE
- **Joel Ulland**
  UCARE
- **Ghita Worcester**
  UCARE
- **Jennifer Garber**
  UCARE
- **Julie Joseph-DiCaprio**
  UCARE

Appendix F: Health Care Homes Certification Committee members

- **Becky Walsh**, CPC
  PrimeWest Health
- **Ellen K. Ryan**, RN, MSN
  First Light Health System
- **John Halfen**, MD
  Lakewood Health Systems
- **Lisa Hoffman-Wojcik**
  Leisure Education for Exceptional People
- **Mary Benbenek**, PhD, MS, RN, FNP, PNP
  U of M School of Nursing
- **Mary Enright**, RN
  Winona Health
- **Melissa Winger**
  Patient and Family Advocate
- **Nancy R. Miller**, MBA, CPF
  Stratis Health
- **Nicole Burrows**, RN
  Lake Region Healthcare
- **Terri Healy,** BSN, PHN
  McLeod County Public Health & Hutchinson Health

Appendix G: Rule Advisory Committee members

- **Anne Schloegel**
  MDH Office of Health IT
- **Beth Gyllstrom**
  MDH Performance Improvement and Research
- **Bev Annis**
  HCH Site Visit Evaluator
- **Brittney Dahlin**
  Minnesota Association of Community Health Centers
- **Carolyn Allshouse**
  Family Voices of Minnesota
- **Cherylee Sherry**
  MDH Statewide Health Improvement Partnership
- **Clarence Jones**
  Consumer representative
- **Daisey Sanchez**
  Health Finders Collaborative
- **Dale Dobrin**
  South Lake Pediatrics
- **Dawn Simonson**
  Metropolitan Area Agency on Aging
- **Deborah Cushman**
  Minnesota Literacy Council
- **Eileen Weber**
  University of Minnesota School of Nursing
- **George Klauser**
  Altair ACO and Lutheran Social Service of Minnesota
- **Gena Graves**
  Park Nicollet
- **Isolina Soto**
  West Side Community Health Center
- **Jane Kluge**
  CentraCare Health
- **Jenny Kolb**
  Fairview Health Services
- **Jill Swenson**
  Sanford Health
- **Jodi Painschab**
  Stellis Health
- **John Halfen**
  Lakewood Health Systems
- **Kristen Godfrey Walters**
  Hennepin County Medical Center
- **Mary Benbenek**
  Minnesota Nurse Practitioners
- **Miranda Cantine**
  Ortonville Area Health Services
- **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

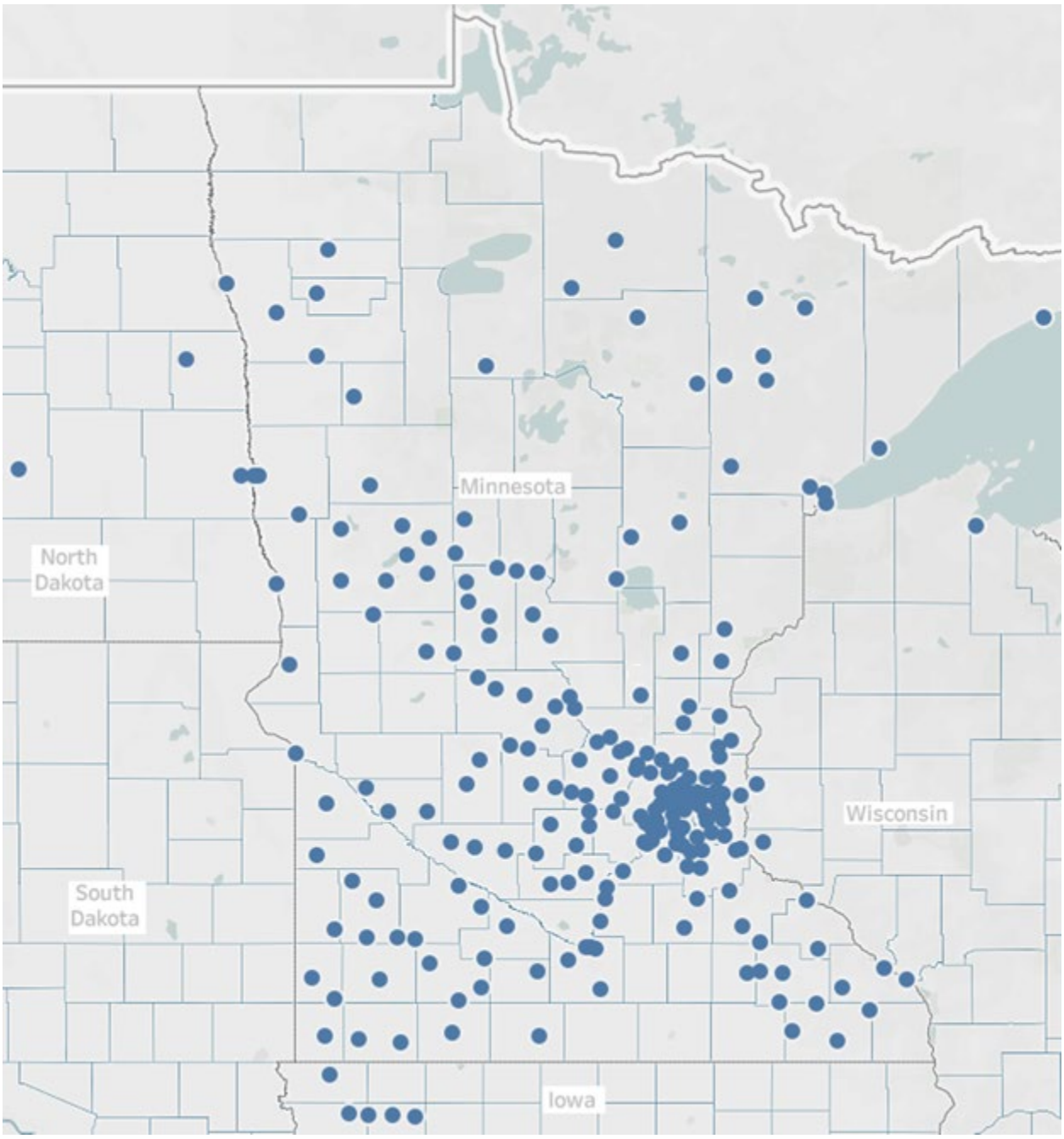
Appendix H: Counties based on number of Health Care Homes

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	2	2	100%	1	1
Anoka	330,844	6.2%	Metropolitan	16	14	87%	1	1
Becker	32,504	0.6%	Northwest	7	1	14%	1	1
Beltrami	44,442	0.8%	Northwest	5	2	40%	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	7	54%	1	1
Cass	28,567	0.5%	Central	10	1	10%	1	1
Chippewa	12,441	0.2%	Southwest	3	3	100%	1	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	3	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	2	15%	1	1
Dakota	398,552	7.5%	Metropolitan	30	22	73%	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	125	90	72%	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	2	2	100%	1	1
Itasca	45,058	0.8%	Northeast	6	2	33%	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	5	2	40%	1	1

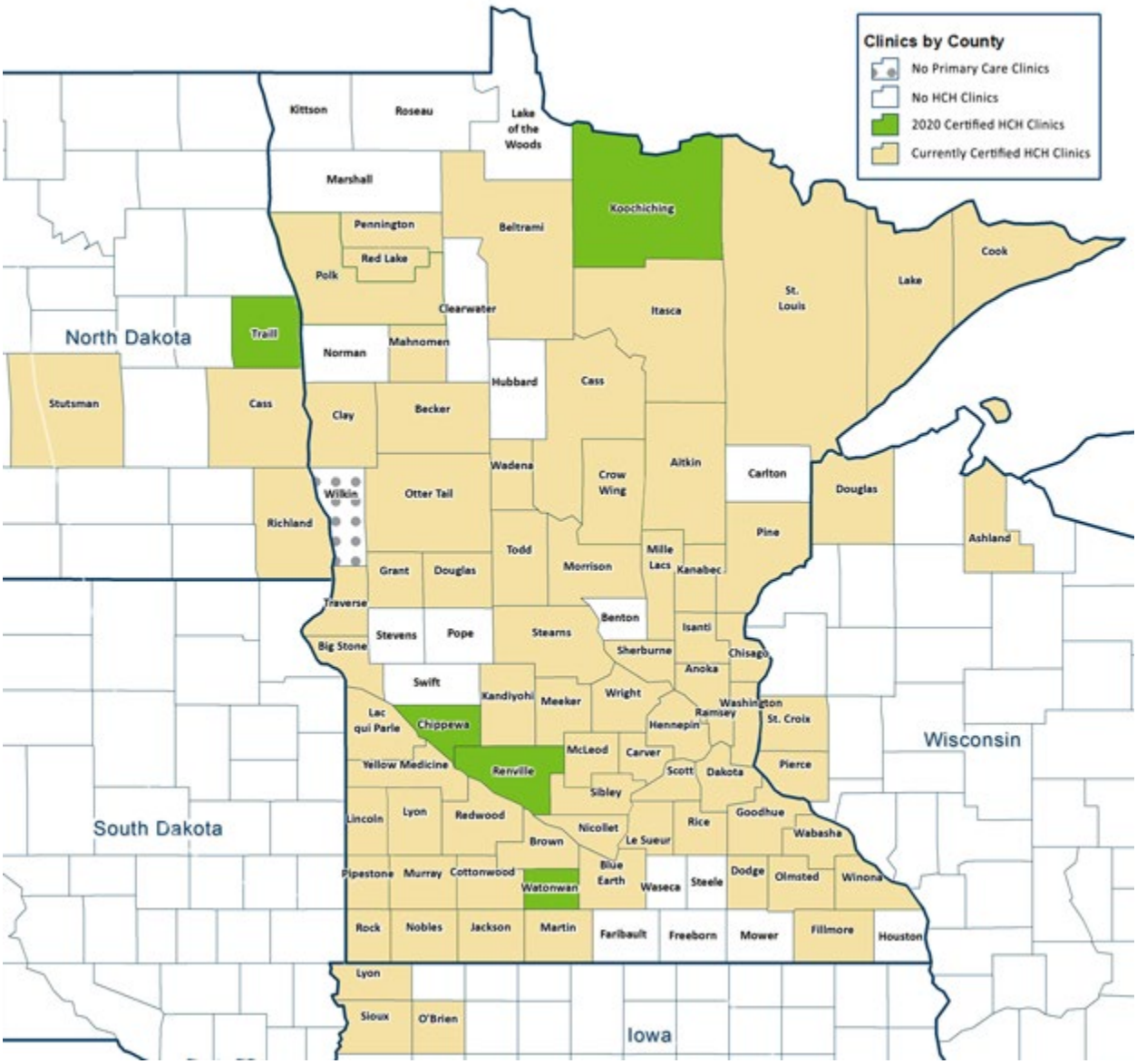
County	2010 Population	% of Population	Region	Total # of Clinics	# MN Current HCH	% of Clinics Certified	County has at least One HCH	County with at least one clinic
Lac qui Parle	7,259	0.1%	Southwest	3	1	33%	1	1
Lake	10,866	0.2%	Northeast	2	1	50%	1	1
Lake of the Woods	4,045	0.1%	Northwest	1	0	0%	0	1
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	3	1	33%	1	1
Morrison	33,198	0.6%	Central	6	4	67%	1	1
Mower	39,163	0.7%	Southeast	2	0	0%	0	1
Murray	8,725	0.2%	Southwest	2	1	50%	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	7	78%	1	1
Pennington	13,930	0.3%	Northwest	2	1	50%	1	1
Pine	29,750	0.6%	Central	5	2	40%	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	3	0	0%	0	1
Ramsey	508,640	9.6%	Metropolitan	60	44	73%	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	3	60%	1	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	8	73%	1	1
Sherburne	88,499	1.7%	Central	6	6	100%	1	1
Sibley	15,226	0.3%	South Central	5	4	80%	1	1
Stearns	150,642	2.8%	Central	18	16	89%	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

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
Swift	9,783	0.2%	Southwest	2	0	0%	0	1
Todd	24,895	0.5%	Central	5	5	100%	1	1
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	2	67%	1	1
Waseca	19,136	0.4%	South Central	3	0	0%	0	1
Washington	238,136	4.5%	Metropolitan	17	15	88%	1	1
Watonwan	11,211	0.2%	South Central	2	1	50%	1	1
Wilkin	6,576	0.1%	West Central	1	0	0%	0	0
Winona	51,461	1.0%	Southeast	2	2	100%	1	1
Wright	124,700	2.4%	Central	12	11	92%	1	1
Yellow Medicine	10,438	0.2%	Southwest	4	2	50%	1	1
State of Minnesota	5,303,925			653	389	60%	68	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	Meeker Memorial Hospital & Clinics	Litchfield	Meeker
Certified	Olivia Hospital and Clinic HealthPartners	Hector, Olivia, Renville	Renville
Certified	Madelia Community Hospital and Clinic	Madelia	Watonwan
Certified	Cuyuna Regional Medical Center	Crosby	Crow Wing
Certified	CCM Health	Clara City, Clarkfield, Milan, Montevideo	Chippewa
Spread	Catalyst Medical Clinic	Chaska	Carver
Spread	North Memorial	Minneapolis	Hennepin
Spread	CHI St. Gabriel's Health	Pierz	Morrison
Spread	Tri-County Health Care	Bertha, Henning, Ottertail, Sebeka	Todd, Otter Tail, Wadena
Spread	Sanford Clinic	New York Mills, Mayville (ND)	Otter Tail, Traill (ND)
Spread	Allina Health	Apple Valley, Bloomington, Buffalo, Burnsville, Edina, Fridley, Inver Grove Heights, Isanti, Jordan, Lakeville, Maplewood, Minneapolis, Oakdale, Savage, St. Paul, Vadnais Heights, River Falls (WI)	Anoka, Dakota, Hennepin, Isanti, Ramsey, Scott, Washington, Wright, Pierce (WI)
Spread	Scenic Rivers Health Services	Big Falls, Floodwood, Northome	Koochiching, St. Louis
Recertified	Winona Health	Rushford, Winona	Fillmore, Winona
Recertified	Manna Health	Fairmont	Martin
Recertified	Catalyst Medical Clinic	Watertown	Carver

Type of Certification	*Organization**	*Cities*	*Counties*
Recertified	Dakota Child and Family Clinic	Burnsville	Dakota
Recertified	Courage Kenny Rehabilitation Institute	Minneapolis	Hennepin

* Listed in calendar order of certification/recertification.