DEPARTMENT OF HEALTH

Health Care Homes: Redefining Health | Redesigning Care

2023 YEAR END REPORT

Health Care Homes 2023 Year End Report

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Health Care Homes Certification

The Minnesota Department of Health (MDH) Health Care Homes (HCH) program offers and provides guidance and learning opportunities for primary care clinicians, their organizations and community partners to implement a care delivery model that supports team based, coordinated, patient centered care and improves health equity and the health of all Minnesotans.

Capacity Building

Capacity building around certification and recertification is offered to all Minnesota primary care clinics and includes technical assistance, coaching, and other training methods to strengthen organizational skills to meet their unique needs. Support was provided in 2023 included:

- **Initial Certification**: 3 organizations
- **Recertification**: 13 organizations
- **Spread**: 13 clinics
- **Check-in**: 24 contacts with certified organizations
- **Technical Assistance**: 175 contacts with certified primary care organizations
- **Outreach to uncertified organizations**: 132 contacts with primary care organizations for general help and guidance

From a MN Health Center CEO

Everyone has a role to play in caring for our patients and the community. Showing our commitment to patients, their care, and their health requires the entire team.

Minnesota Counties with Certified HCH

Certified HCH advanced primary care providers and their community partners are key contributors to improving population health and health equity in all regions of Minnesota.

- 70 of Minnesota's 87 counties (80%) have at least one certified HCH clinic.
- 401 MN Primary care clinics and 20 additional border state clinics are certified for a total of 421 certified HCH clinics.

Map of 2023 Health Care Homes clinic locations in Minnesota

Kittson
Roseau
Lake of the Woods
Marshall
Pennington
Beltrami
Koochiching
Red Lake
Polk
Cook
Lake
St. Louis
Itasca
Clearwater
Norman
Mahnomen
Hubbard
Cass
Clay
Becker
Wadena
Aitkin
Carlton
Crow Wing
Wilkin
Otter Tail
Pine
Todd
Mille Lacs
Grant
Douglas
Morrison
Kanabec
Traverse
Benton
Stevens
Pope
Stearns
Isanti
Big Stone
Sherburne
Chisago
Anoka
Swift
Kandiyohi
Meeker
Wright
Washington
Lac qui Parle
Ramsey
Chippewa
Hennepin
McLeod
Carver
Yellow Medicine
Renville
Scott
Dakota
Sibley
Lincoln
Lyon
Redwood
Goodhue
Nicollet
Rice
Brown
Le Sueur
Wabasha
Blue Earth
Dodge
Pipestone
Murray
Cottonwood
Olmsted
Winona
Watonwan
Waseca
Steele
Rock
Nobles
Jackson
Martin
Faribault
Freeborn
Mower
Fillmore
Houston

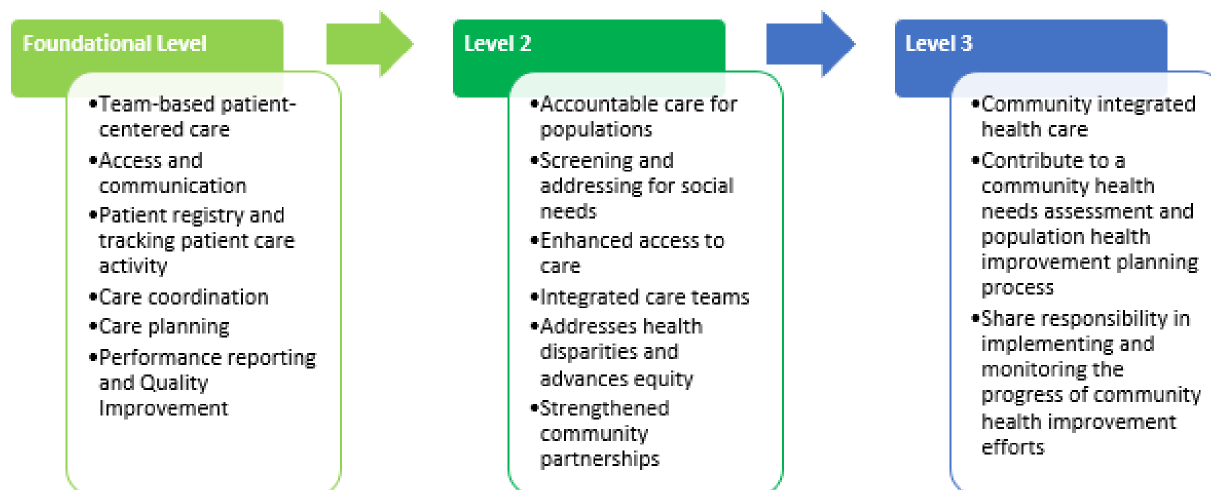
Clinics by County

- No HCH Clinics
- 2023 Certified HCH Clinics
- Currently Certified HCH Clinics

Level Progression

The HCH program implemented a progression model in October 2022 that builds upon its foundational certification to add two additional levels of certification.

The purpose of the HCH progression model framework is to recognize and support clinics that are advancing primary care models to reduce disparities, improve value, and address population health.



Level progression by clinic

- 1 clinic was initially certified at Level 2
- 1 clinic was initially certified at Level 3
- 11 certified clinics advanced to Level 2
- 67 certified clinics advanced to Level 3

Certification features

- Certification remains voluntary and free.
- Clinics report how they meet the HCH requirements unique to the population they served.
- Clinics enter at a level appropriate for them, no requirement to advance levels.
- Clinics can choose to change levels within the 3-year recertification period.
- Strengthens clinic-community linkages, population health, and health equity.
- Assists clinics in preparing for value-based care.
- Supports health information exchange (HIE) to improve data sharing and alignment with state goals.
- Aligns with existing and emerging models of care delivery.

Health Equity

Changes to the HCH Rule have led to a shift that embraces a broader vision of wellbeing, more inclusive of community and population health. The enhanced programmatic focus on

promoting health equity, reducing disparities, and addressing the social determinants of health has resulted in changes that include:

- Updates to resources such as COMPASS to ensure that they better represent underserved communities. COMPASS outlines the requirements and standards for being a certified HCH.
- The addition of questions to the check-in process aimed at determining whether and how clinics stratify their patient data. This information will better inform HCH as to clinic capacity to address health disparities.
- The identification of sources of social health data that can be shared with HCH certified clinics to promote a greater understanding of the community's needs. To support healthcare organizations in gaining such knowledge, HCH staff have built a table of data resources that provide community-level information on topics such as poverty, childhood education, and barriers to transportation. Using this data, HCH staff will be able to provide insight to clinics on community characteristics that impact health, better informing quality improvement strategies and efforts.
- Learning opportunities that focus on health equity strategies including the use of different types of data and presentations from other HCH clinics on what they have learned in addressing social determinants of health.

Minnesota Care Coordination Effectiveness Study

The Minnesota Care Coordination Effectiveness Study (MNCARES) entails working with HealthPartners Institute, payers, 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. The goal is to learn what approaches to care coordination in primary care settings produce the best care quality, utilization, and patient centered outcomes.

Three MNCARES papers have been published and many others are in process. Publication descriptions and links are available on the Health Care Homes website.

More information and findings about the study can be found at the HCH MNCARES webpage.

Learning Provided in 2023

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 learning opportunities which in 2023 included:

- Updating the Foundations of Health Care Homes Certification e-Learning course to align with the new certification levels.

- Auditing and updating the HCH library of e-Learning courses to ensure that content was up to date and functioning correctly.
- Offering several daylong workshops around the state.
- Learning Days in-person for the first time since 2019 with over 200 people in attendance.
- Stakeholder driven peer-to-peer networking continued in 2023 after a successful pilot in 2022. A learning survey conducted in the last quarter of the year will help us to shape learning opportunities as we move into 2024.

2023 HCH Learning

Month	Topic	Webinars	E-Learning	In Person Learning	Networking
April	Motivational Interviewing Workshop - Mankato			x	
April	Updated: Foundations of Health Care Homes Certification (series of 9 courses)		x		
April	Stakeholder Driven Peer to Peer Networking				x
May	Learning Days Conference – St Cloud			x	
June	Intercultural Effectiveness	x			
June	Motivational Interviewing Workshop – St. Cloud			x	
September	Overcoming Socioeconomic Barriers in Rural Minnesota	x			

Month	Topic	Webinars	E-Learning	In Person Learning	Networking
October	Intercultural Effectiveness Workshop – St. Paul			x	
November	Stakeholder Driven Peer to Peer Networking				x
November	Using the Connection Model to Bridge Clinic and Community	x			
December	Developing Innovative Models of Care Post COVID	x			

Quality Improvement

Health Care Homes is a continuous quality improvement program which is always looking for better ways to support certified clinics and other partners. Improvements in 2023 included:

Benchmarking

MDH Health Care Homes sought input from clinics, the HCH Advisory Committee, and other workgroups to identify opportunities for making the HCH benchmarking requirement more relevant to clinics seeking HCH recertification. A key takeaway was the importance of including clinic priorities when it comes to measurement and evaluation. Effective July 1, 2023, the Health Care Homes program implemented relevant changes. The updated benchmarking process uses the recertification team meeting to facilitate the sharing of information about how an organization prioritizes measures, the performance on those measures, which benchmarks an organization uses to assess that performance, and the process improvement work being done to impact outcomes.

Patient Information

The Patient Information webpage was created to help patients understand what a Health Care Home is and why they might want to select a Certified Health Care Home for their primary care. Although a patient page has been on the back burner for several years, it became a priority in

2023 when the State Employee Group Insurance Plan (SEGIP) began flagging HCH-certified clinics during fall open enrollment (SEGIP decided to take this step after meeting with HCH staff and concluding that certification was a valid indicator of clinic quality). Employees could link from the open enrollment information to the HCH patient page to learn more and read patient stories. It is hoped that other large employers will follow suit in the coming years.

Internal Process Improvement

Since launching the new HCH Portal and an updated HCH certification and recertification application process in 2022, HCH has deployed post application surveys to get feedback on user experience. Survey response to date has indicated an overall very positive response to the new application process. The program also implemented standard work procedures for the documentation of check-ins and technical assistance provided so that it could track and analyze capacity in implementing the HCH standards, innovations, successes, challenges, and learning needs. A future goal of the program is to create reports from the standardized data fields in the HCH portal applications and use these to share learnings, track progress, and identify opportunities for improvement.

Partners

One of the strengths of Health Care Homes is its ability to partner successfully with a diverse range of organizations. This continued in 2023 with the creation and continuation of partnerships involving MDH programs, other government agencies, and organizations active in enhancing the health of Minnesotans.

From a MN clinic manager

Partnering with our community is a necessity, just the way we operate. For example, we have a new county health director who came by last week with new mental health workers wanting to collaborate with us.

Public Sector Purchasers

- The HCH program continued its successful partnership with SEGIP. During open enrollment, clinic HCH certification is noted and information on what this means is provided. This year, a link to the new HCH Patient Information Website was added.
- Collaboration with public sector purchasers expanded to include working with the Public Employees Insurance Program (PEIP), whose mission is to make affordable health, dental and life insurance coverage available to all Minnesota's cities, townships, counties, school districts and other units of local government. In PIEPs 2023 open enrollment, information on HCH certification status was incorporated into the clinic directory and made available to its nearly 40,000 members. A link to the new Health Care Homes patient facing website was also provided.

MDH programs

- MDH Health Care Homes have partnered with staff in the Quality Reform Implementation and Public Health Practice sections to pilot the MDH Measurement Framework. The goals of the Measurement Framework pilot are to bring together local communities and partners to measure and address identified health and equity issues. HCH has facilitated recruitment of local collaboratives that include a certified HCH/s and the first pilot site recently got underway, intending to use the measurement framework concept to address adolescent and youth immunizations. The MDH project team is working with two other local community collaboratives as potential pilots.
- HCH staff worked with the Health Promotion and Chronic Disease (HPCD) Division on the Building our Largest Dementia (BOLD) Infrastructure grant. BOLD supports public health efforts to address Alzheimer's and dementia. HCH participation included monthly meetings and a presentation on work being done at the annual Learning Days conference.
- A member of the HCH team served on the CDC Grant Clinical Learning Collaborative team, a convening facilitated by the Office of Statewide Health Improvement Initiatives (OSHII). The team developed and facilitated two Clinical Strategies Learning Collaboratives in 2023. The preferred topics, content, and learning formats were driven by interviews and surveys of participants across the state. Subject matter experts led discussions on these topics, with the overarching focus of partnering with local public health to contribute to patient outcomes and care management.

DHS programs

- The HCH program has a long-standing relationship with the Minnesota Department of Human Services (DHS) Behavioral Health Homes (BHH) services program. From 2015-2022, an interagency agreement established a cross-agency effort in which the HCH Integration Specialist worked directly with DHS. Although this formal partnership has ended, HCH continues to work with DHS BHH policy staff to support HCH clinics who are also certified BHH services providers, and to collaborate around aligned priorities and learning needs.
- HCH partnered with DHS to host a webinar with the Center for Medicare and Medicaid Innovation (CMMI) on the new Making Care Primary (MCP) advanced primary care model. MCP, which will be implemented in Minnesota over the next 10.5 years, is a multi-payer initiative aimed at improving care coordination between primary care and other medical and social service providers, enhancing health equity, and moving towards a model of prospective, population-based payment.

Primary Care Stakeholder Group

The Minnesota Academy of Family Physicians and the HCH program in 2020 convened a group of primary care stakeholders with a shared interest in increasing investment in primary care in Minnesota. This gathering, known as the Minnesota Primary Care Stakeholder Group, agreed on the following purpose:

> *Increase investment in primary care services that are equitable, person centered, team based, and community aligned, and will help achieve the goals of better health, better care, and lower costs.*

The group collaborated in developing a report to the Minnesota legislature that included recommendations to expand payment for a broad range of primary care services, strengthen the primary care workforce, and improve population health.

In 2022, the group requested legislative support to do a comprehensive analysis on how Minnesota's health care payment system is impacting the quality of primary care throughout the state. Although the proposal did not advance, it continued the conversation about creating a sustainable future for primary care in Minnesota.

In 2023, in the wake of COVID, the group took stock of the primary care environment at the State and national level, and considered how best to come together to improve population health and advance health equity. This led to a series of meetings designed to inform membership on key topics including workforce, data sharing, and policy work being done in Minnesota to advance primary care.

Pediatrics

As a program whose original focus was the pediatric population, the health of children and young adults remains an important priority for Health Care Homes. Work in 2023 related to pediatrics included:

Health Care Transition: Pediatric to Adult

HCH staff participates on the Health Care Transition Learning Collaborative Steering Work Group whose focus is advancing pediatric to adult healthcare transitions in Minnesota. . Programs for clinics include a free monthly virtual pediatric to adult healthcare transition ECHO series and clinic grant funding. The ECHO learning model is an "all teach, all learn" approach. This opportunity is led by Minnesota's Gillette Complex Care Program, the National Alliance to Advance Adolescent Health, and the Got Transition program. Participants learn about best practices, Minnesota and national resources, and build skills to improve pediatric to adult transition in their practice setting. This 14-month initiative is supported by a grant from the MDH Child and Family Health Division.

Pediatric Care Coordination: Community of Practice

The Minnesota statewide Pediatric Care Coordination: Community of Practice (PCP CoP) provides a way for care coordinators to network, collaborate, share, and learn from each other. HCH staff are PCP CoP Advisory Group members. Through this partnership, HCH provides leadership and support to build a strong continuum of pediatric collaborative care through education and networking. As care coordinators connect, share, and learn from each other, they can improve positive health outcomes by building the capacity of all systems that serve families of children and youth with special health needs.

From a MN clinic provider

Having long term staff develops a high quality of care. Our relationships help our patients and their family connect and leads to successful outcomes. We consider that crucial to our success as an organization.

Sustainability

Sustainability Roadmap

The Sustainability Roadmap was launched in October 2023. With a printable brochure providing a high-level overview and a link to the comprehensive on-line tool, the Roadmap is a framework for action to support sustainability of certified HCH organizations across Minnesota.

The Roadmap recognizes the scope of sustainability extends beyond incentives and reimbursement to include other fundamental components. The five essential elements identified include Care Coordination, Finance, Learning, Partnerships and Workforce. Within each element, the Roadmap provides strategies, resources, and stories of success.

Primary care organizations can leverage the Roadmap to support policy development, aid process improvement, and foster innovative action steps unique to their organization, while being standardized in the commitment to this evidence-based model of care and improved patient outcomes.

IHP program

HCH team members met regularly with staff from the DHS Integrated Health Partnerships (IHP) program to discuss collaborative efforts. An approach was formulated to gather information from certified clinics on how they could best be supported and incentivized by DHS and other payers. Joint communication materials were created to increase understanding by clinics of IHP and how it can support the implementation of Health Care Homes.

Sustainability Conversations: Reimbursement and Incentives

In 2023, the HCH team received consistent feedback on the challenges of billing for the HCH program, including the lack of reimbursement and limited incentives for program elements like care coordination. HCH responded by hosting sustainability conversations around the topic of HCH reimbursement and incentives.

Six organizations from across Minnesota, varying in size, location, and affiliation, agreed to share their perspective and experiences. The conversations provided insightful, transparent, and open feedback as well as ideas and recommendations for sustaining the HCH model of care. In 2024, the Sustainability team will review all responses received, identifying trends and actionable ideas.

References

Health Care Transition ECHO series https://www.gillettechildrens.org/get-involved/health-care-transition-collaborative/hctlc-sessions

Health Care Transition Learning Collaborative https://www.gillettechildrens.org/get-involved/health-care-transition-collaborative/hctlc-sessions

MNCARES https://www.health.state.mn.us/facilities/hchomes/mncares.html

Patient information https://www.health.state.mn.us/facilities/hchomes/patient.html

Pediatric Care Coordination: Community of Practice https://www.mnpedcares.com/

Sustainability Roadmap
https://www.health.state.mn.us/facilities/hchomes/roadmap/index.html