DEPARTMENT OF HEALTH

Health Care Homes: Redefining Health | Redesigning Care

2024 YEAR END REPORT

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2024 Health Care Homes Year End Report

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Health Care Homes Certification

The Minnesota Department of Health (MDH) Health Care Homes (HCH) program offers guidance and educational opportunities to primary care clinicians, their organizations, and community partners. It promotes a team-based, coordinated, and patient-centered care delivery model, striving to enhance health equity and the overall health of all Minnesotans.

Capacity Building

The HCH program offers capacity building for all Minnesota primary care clinics, focusing on certification and recertification. This includes technical assistance, coaching, and various training methods to enhance organizational skills and address their specific needs.

- Initial Certification: 3 organizations.
- Recertification: 12 organizations.
- Spread: 7 clinics.
- Check-in: 25 contacts with certified organizations.
- Technical Assistance: 211 contacts with certified primary care organizations.
- Outreach to uncertified organizations: 165 contacts with primary care organizations for general help and guidance.

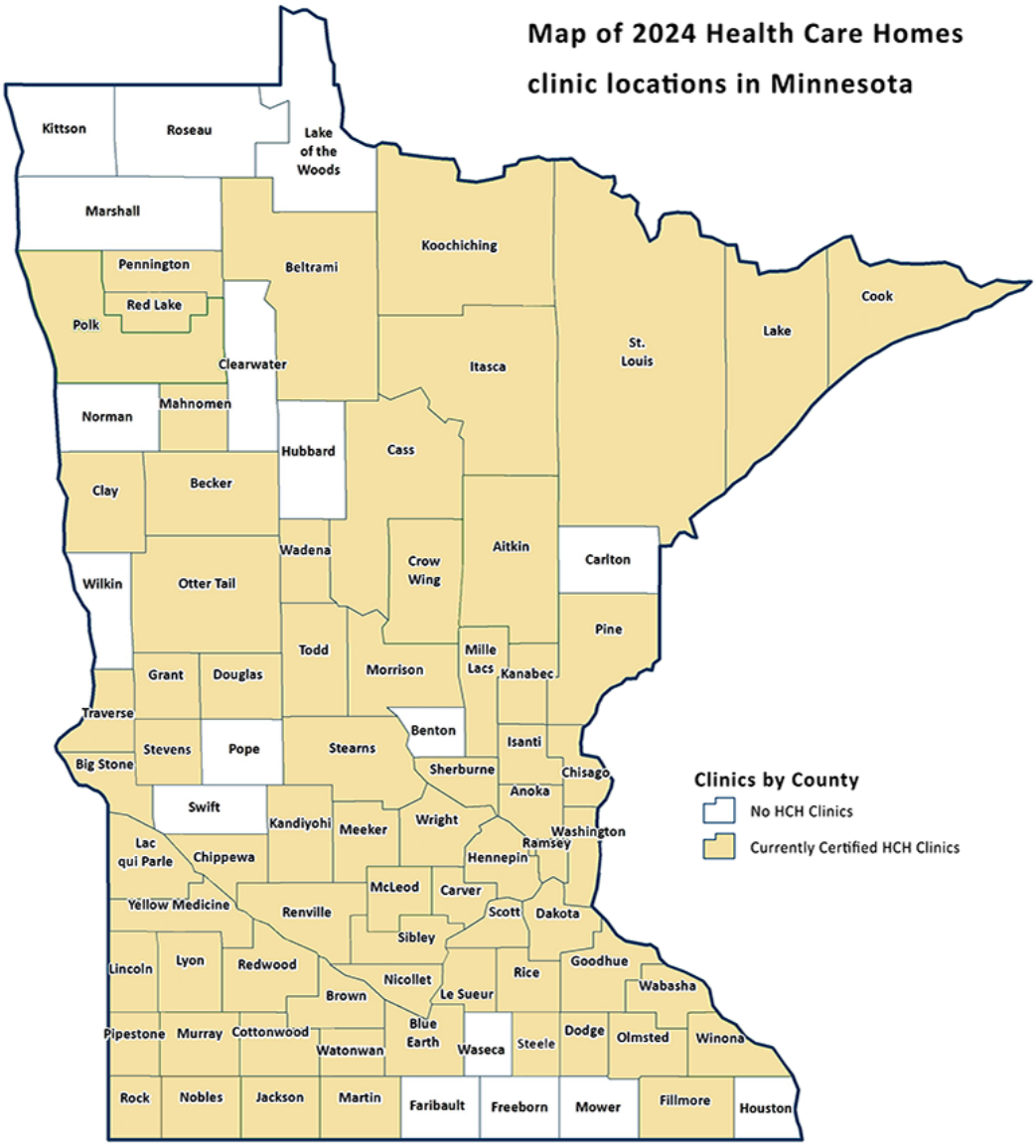
From a recertifying organization contact

The assistance from HCH staff was amazing. It could not have been clearer. Their flexibility allowed us to meet deadlines. Their early feedback allowed us to clarify our answers. Their expressed belief in our programs gave us the confidence we needed to continue the recertification. Thank you!

Minnesota Counties with Certified HCH

Certified HCH are key contributors to improving population health and health equity in all regions of Minnesota.

- 70 of 87 Minnesota counties (80%) have at least one certified HCH clinic.
- 408 Minnesota primary care clinics and 21 additional border state clinics are certified for a total of 429 certified HCH clinics. Of these, 313 are certified at the Foundational Level, 12 at Level 2, and 104 at Level 3.


Map of 2024 Health Care Homes clinic locations in Minnesota
Kittson
Roseau
Lake of the Woods
Marshall
Pennington
Red Lake
Polk
Beltrami
Clearwater
Koochiching
Itasca
St. Louis
Lake
Cook
Norman
Mahnomen
Hubbard
Cass
Clay
Becker
Wadena
Crow Wing
Aitkin
Carlton
Wilkin
Otter Tail
Todd
Morrison
Mille Lacs
Kanabec
Pine
Grant
Douglas
Traverse
Benton
Isanti
Stevens
Pope
Stearns
Big Stone
Sherburne
Chisago
Anoka
Swift
Kandiyohi
Meeker
Wright
Washington
Ramsey
Lac qui Parle
Chippewa
Hennepin
McLeod
Carver
Yellow Medicine
Renville
Scott
Dakota
Sibley
Lincoln
Lyon
Redwood
Nicollet
Rice
Goodhue
Brown
Le Sueur
Wabasha
Pipestone
Murray
Cottonwood
Blue Earth
Waseca
Steele
Dodge
Olmsted
Winona
Watonwan
Rock
Nobles
Jackson
Martin
Faribault
Freeborn
Mower
Fillmore
Houston
Clinics by County
No HCH Clinics
Currently Certified HCH Clinics

Level Progression

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 certified clinic advanced to Level 2.
- 27 certified clinics advanced to Level 3.

From a certifying organization contact

HCH staff was so helpful in explaining the process and the levels. They made our choice easy to understand.

Certification Features

- Certification remains voluntary and free.
- Encourages flexibility in implementation, allowing clinics to take an approach that aligns with existing processes, organizational culture, and needs of the individuals served.
- Delivers personalized support from HCH experts for model implementation, certification, program sustainability, connection to resources, and ongoing technical assistance.
- Grants access to an array of learning opportunities, free continuing education units, and peer networking.
- Provides infrastructure to deliver organized and coordinated care, and positions organizations for success in integrating behavioral health, substance abuse programs, palliative care, and other programs into this model.
- Offers recognition through advanced levels of certification to clinics addressing social determinants of health and working to advance health equity and community health.
- Aligns with and prepares organizations to successfully participate in value-based reimbursement models such as Accountable Care Organizations and Integrated Health Partnerships.

- Qualifies organizations:
  - to bill for care coordination services through the Minnesota Department of Human Services (DHS) HCH Care Coordination Billing methodology.
  - to receive full credit for the Improvement Activities performance category under the Centers for Medicare & Medicaid Services Merit-based Incentive Payment System.
  - that are Community Health Centers to earn a Patient Centered Medical Home badge from the Health Resources and Services Administration.

Health Equity

The HCH program continues to prioritize health equity through certification, learning opportunities and partnerships. Levels 2 and 3 HCH certification add requirements for clinics to identify and address health disparities and advance health equity through access and culturally responsive care delivery strategies. HCH staff support these efforts through learning opportunities, peer networking and sharing of best practices, resources, and technical assistance. The learning collaborative has implemented a new standard that ensures elements of health equity are included in all offerings. A three-part Health Equity webinar series was created in partnership with MDH's Office of Diversity, Equity, Inclusion and Belonging. It was well attended and received positive reviews.

Minnesota Care Coordination Effectiveness Study

MNCARES
Informing Care Coordination Strategies

The HCH program collaborates with HealthPartners Institute, payers, certified clinics, 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 referred to as the Minnesota Care Coordination Effectiveness Study (MNCARES). 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 four-year study ended in 2024, producing multiple published MNCARES papers with a few papers still in process. Publication descriptions and links, along with more information and preliminary study findings, are available on the HCH MNCARES webpage. A final report with study findings will be available and disseminated in 2025.

Learning Collaborative

The HCH Learning Collaborative was established through legislative statute, providing an opportunity for certified health care homes and their partners to share information related to quality improvement and best practices. Certified health care homes must demonstrate that they are continually learning and advancing their care delivery model through participation in the HCH Learning Collaborative and/or other learning opportunities. The HCH program supports this by planning and offering learning opportunities through a variety of modalities.

The year focused heavily on health equity, care coordination, and specialized health care topics. Major themes included cultural competency, dissemination of information about availability of new codes for billing care coordination/community health worker services, and patient engagement. Notable concentrated programming occurred in October with multiple health equity learnings.

HCH Learning

Month	Topic	Webinar	E-Learning	In Person Learning
February	Care Coordinators: Bridging Care for Diabetes Management	x		
March	Colorectal Cancer Screening	x		
May	Learning Days			x
June	Deep Dive: Using New Codes for CHW billing	x		
July	Trends in Mental Health and Levels of Care (Learning Days 2024 presentation)	x		
August	It's Not a Health Care Home Without Oral Health	x		
September	Guiding Principles and Innovative Ideas for Engaging Patients and Families	x		
September	Deep Dive: Medicare Billing for CHW's	x		
October	The Case for Weight Inclusive Health Care (Learning Days 2024 presentation)	x		
October	Care Coordinator - Bridging Care for Diabetes Management *Created with MDH Health Promotion and Chronic Disease Division		x	
October	Health Equity: Advancing Health and Racial Equity	x		
October	Health Equity: Fostering Belonging within the Workplace and within Health Systems	x		
November	Health Equity: Opportunities for Community Engagement in Health Care Systems	x		

Quality Improvement

Health Care Homes is a continuous quality improvement program dedicated to consistently seeking improved methods to support certified clinics and other partners. Improvements include:

Benchmarking

MDH HCH is continually refining the updated benchmarking process that was rolled out July 1, 2023. This year, HCH Practice Improvement Specialists (PIS) have started compiling community demographic data and other supporting information to share during the recertification team meetings. When it is relevant and appropriate, sharing information about the communities served enables broader discussions around population health and community priorities. While Statewide Quality Reporting and Measurement System (SQRMS) measures are still shared during benchmarking discussions, HCH certified organizations value the flexibility to present their own measurement priorities.

Patient Information

The HCH program is working with HCH certified organizations to engage with their already established patient-family advisory councils, with conversations scheduled to occur in early 2025. We will ask these consumer groups for input in shaping our strategic plan and to provide feedback on the use of a HCH tagline.

Internal Process Improvement

Multiple internal process improvement initiatives have been implemented in the past year, including the following:

Portal Reports

Internal reports have been developed using data from HCH certification/recertification applications, technical assistance feedback, and check-in documentation. These reports shed light on emerging learning needs, the use of multi-disciplinary care team members, and how clinics are identifying and addressing health related social needs and health disparities, among other areas.

HCH Promotion

Based on clinic responses to an online survey which gathered input about using a HCH tagline, it was identified that 25% of respondents were not actively promoting their HCH certification status. To better understand this, MDH HCH has added a question in the post-certification/recertification survey. Ideas and tools for promoting HCH certification are highlighted in a follow-up email sent to each organization, along with electronic copies of their

official HCH certification/recertification documentation. Refer to the Sustainability section below, 'HCH Statewide Promotion', for many more ways in which we are promoting the HCH program.

Ongoing refinement of the HCH Certification Application

Potential additions or revisions to the HCH certification/recertification application are vetted internally as we seek to balance any program need for additional information with administrative burden for clinics. Changes this year include the addition of an attestation to ensure all clinics within an organization are accurately represented in the application and meet HCH certification/recertification requirements.

Certification and Recertification Checklists

In response to feedback and suggestions from clinics, user-friendly certification and recertification checklists with step-by-step instructions and links to online resources were introduced in March 2024.

Learning Center

Beginning in July 2024, registration for HCH e-learning courses transitioned from the MDH Learning Center to the HCH website. While a MDH Learning Center account and log in are still required, learners can now easily find and register for courses directly from the HCH website instead of searching on the MDH Learning Center.

Partners

Public Sector Purchaser

State Employee Group Insurance Program (SEGIP)

- Following an initial project that integrated HCH certification status into the open enrollment clinic directory, SEGIP and the HCH Sustainability Work Group (SWG) have expanded their partnership scope. Ongoing collaboration with SEGIP now includes discussions on enhancing member education about the HCH program, assessing the impact of Level 2 and Level 3 on tiering determination, and exploring the potential for integrating quality outcomes into clinic analysis.
- SEGIP provided updated data to the HCH SWG from open enrollment in 2023. Data revealed that 62% of clinics in Minnesota were certified, and 75% of members chose a certified HCH clinic for primary care. Results were further broken down by zip codes and categorized into rural, micropolitan, and metropolitan areas to illustrate the distribution of members and HCH certified clinics across different regions of Minnesota.
- The HCH Sustainability team created two fact sheets in 2024 related to this successful partnership. One fact sheet describes the partnership of HCH and SEGIP during open enrollment, including project background, data from open enrollment, and an invitation to other employers to connect with HCH for a similar collaboration. In addition, a Business

Case for Employers fact sheet was developed to showcase the advantages of choosing a certified HCH clinic for employees' primary care.

- In September, SEGIP made presentations to the HCH Advisory Committee, the Sustainability Work group, and the Learning and Innovation Work group on the latest open enrollment partnership. An additional session, 'Why is it so Hard to Reduce Low-Value Care,' was also included. In October, HCH staff shared information on the HCH background, program components, level progression, and certification benefits to the Minnesota Management and Budget (MMB) leadership team.

Minnesota Department of Health (MDH) Programs

The Asthma Program

HCH maintained its partnership with the MDH Asthma Program, linking certified clinics to asthma education, camps for pediatric patients, an environmental impact project, and Asthma Home-Based Services. The Asthma Program continues to engage with HCH certified clinics focused on asthma outcomes, offering gap analysis and educational resources for their team members.

Healthy Brain Initiative

The Healthy Brain Initiative, part of MDH Center for Health Promotion, presented 'Practice Tools and Resources for Age-Friendly and Dementia-Friendly Care' at Learning Days. Discussions related to the development of healthy aging assessments, education, and resources for providers of certified HCH remain ongoing.

Office of Statewide Health Improvement Initiatives (OSHII)

The HCH team continues its work with OSHII, aiming to strengthen connections between certified clinics and local public health (LPH). This partnership involves developing a Statewide Health Improvement Program (SHIP) project with HCH and LPH, leveraging LPH to enhance clinic support in addressing health related social needs and fostering collaboration around community health improvement.

Statewide Quality Reporting and Measurement System (SQRMS)

HCH continued its partnership with SQRMS on the Measurement Framework Pilot. This project brings together HCH certified clinics, local public health, and community partners to apply innovative measurement strategies aimed at supporting quality improvement efforts and reducing health inequities. The pilot is a true intra-agency effort, with various MDH programs providing support and expertise. HCH staff played leadership roles in the pilot this year and continued to provide technical assistance to health care systems.

Health Economics Program (HEP) - All Payer Claims Database (APCD)

The HCH program worked with HEP staff to analyze billing patterns using data from MDH's APCD. The resulting comprehensive report details clinic billing of HCH care coordination codes over several years, including providing information about which health organizations are billing and which payers are reimbursing for these, as well as rates and volume of claims. The certified

clinic billing information for care coordination services has already proven valuable in enhancing understanding and will help guide further partnership endeavors related to financial sustainability.

Minnesota Department of Veteran Affairs (MDVA)

Veteran Health Navigator Program

This project is the result of a concerning increase in active and retired veteran rates of suicide in Minnesota. The program will fund a full-time care coordinator for two rural health care organizations who have achieved - or are in the process of - Level 2 or Level 3 HCH certification. These team members will coordinate care for veterans to improve access to care, with an emphasis on mental health services. Partners include MDH HCH, the Lee and Penny Anderson Hero Care for Veterans, MDVA Healthcare Division and Programs & Services, Veteran Affairs St. Cloud and Minneapolis (Sioux Falls and Fargo), the Minnesota Hospital Association, and MDH Office of Rural Health and Primary Care.

Minnesota Department of Human Services (DHS) Programs

Integrated Health Partnerships (IHP)

Throughout 2024, the HCH sustainability team collaborated with the IHP team on several projects. These included raising awareness of the Making Care Primary model, an environmental scan of collaboration across Medicaid payment and patient-centered medical homes in other states, and a joint legislative proposal (which was not selected for further consideration). Provisional discussion topics included IHP support of Level 2 and Level 3 HCH Certification, across the board increases in care coordination reimbursement rates, and endorsement and promotion of HCH certification with IHP participants not yet certified.

Child and Youth with Special Health Needs (CYSHN)

Representatives from HCH, DHS, and CYSHN have initiated discussions on enhanced payment. This effort stemmed from feedback received from certified HCH partners during sustainability reimbursement and billing conversations. Collaboration expanded to include the Minnesota Rare Disease Advisory Council, who is also advocating for revisions and enhancements in the HCH payment to better support care coordination for CYSHN related to rare diseases.

Behavioral health home (BHH) services

The HCH program has a long-standing relationship with the 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.

Primary Care Stakeholder Group

Throughout 2024, the HCH program continued to act as co-facilitator, with the Minnesota Academy of Family Physicians (MAFP), of the Minnesota Primary Care Stakeholder Group (MNPCSG). The Stakeholder group, formed in 2020, consists of individuals from an array of organizations including: health care providers, insurers, professional associations, government entities, and non-profits. While the viewpoints are many and diverse, all are unified by a shared interest in seeing primary care in Minnesota thrive.

This year, MNPCSG held several meetings, inviting either internal or guest presenters to speak and engage in Q & A. Among the topics covered were:

- The integration of behavioral health and primary care.
- Legislative agendas and proposals of Stakeholder Group members.
- The Equitable Health Care Task Force and the intersection between primary care and health equity.
- The work of the Governor's Health Cabinet.
- Recent initiatives by the Department of Commerce that impact primary care.

Recently, planning has been under way for the next round of meetings in 2025. The HCH program and MAFP continue to work on identifying relevant topics and areas of potential cooperation between MNPCSG members.

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 2024 related to pediatrics include:

Health Care Transition: Pediatric to Adult

HCH staff participates on the Health Care Transition Learning Collaborative (HCT LC) Steering Work Group whose focus is advancing pediatric to adult health care transitions in Minnesota. This opportunity is led by Minnesota's Gillette Complex Care Program, the National Alliance to Advance Adolescent Health, and the Got Transition program. The eight monthly Project ECHO sessions and the culminating June 2024 all-day hybrid Transition Summit were well attended, and participants valued the knowledge gained. This success led to continued funding of the HCT LC through December 2027 from the MDH CYSHN section. The goal for the next three and a half years is to identify and promote clinical, organizational, and system-wide improvements for HCT.

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. The interdisciplinary Community of Practice (CoP) has over 700 care

coordinating professionals representing medicine, public health, education, government, social work, and non-profit sectors. As care coordinators connect, they can improve positive health outcomes by building the capacity of all systems that serve families of children and youth with special health needs.

The CoP regularly offers professional development trainings, where participants have reported changed perceptions of the complexity of the system, as well as a better understanding of the challenges families face in managing their system of care. Regional meetings are also held to connect professionals across the state. Evaluation data from these events found that all attendees reported meeting someone new. These new connections have led to increased care coordination, as demonstrated by the following quote from a care coordinator.

From a care coordinator

I met a pediatric care coordinator from a primary care clinic. About a week later, one of her colleagues contacted me because we had a shared patient who was in our specialty care rehabilitation unit. I was able to connect the colleague with the staff from our unit who were working with the family, and they were able to hold a care conference over the telephone. If it hasn't been from that connection made at the meeting, I don't think the shared planning would have occurred, and the family wouldn't have had such a smooth transition back home.

Sustainability

Sustainability Roadmap

- It has been one year since the HCH program launched the Sustainability Roadmap. The Roadmap offers strategies, resources, and stories of success to support certified HCH leaders, providers, and team members in policy development, process improvement, and innovative action. Recent updates to the Roadmap feature improved navigation, refreshed content, links to the latest tools, and expanded descriptions of the five Essential Elements.
- The Sustainability Team monitors and tracks the Roadmap's usage and elements of interest every four months. Initially, Care Coordination was the most accessed element, but Finance has since taken and maintained the lead as the top element reviewed by Roadmap users. Usage has consistently increased throughout 2024 for all five Roadmap elements.

- To enhance access to the Roadmap, a printable brochure offering a high-level overview and a link to the comprehensive online tool is included in the packet that all organizations and clinics receive with their official certification/recertification documents.
- In February 2024, all uncertified primary care clinic contacts received a letter from the HCH Director detailing key program updates, including the introduction of the Sustainability Roadmap. The mailing also included the printable brochure.

Sustainability Conversations: Reimbursement and Incentives

- Sustainability team members engaged in discussions with employer-based primary care clinics sponsored by NeoPath Health and Mayo Clinic. They gathered insights and perspectives on the models of care used, the barriers faced, and the elements most important to employees as patients. This feedback was utilized to create and update both business case documents.
- Following up on the 2023 Reimbursement and Billing conversations with our clinic partners, HCH hosted a two-part series on billing for community health workers, in accordance with the new guidelines from the 2024 Medicare Physician Fee Schedule. Both webinars saw attendance and engagement that surpassed expectations.

HCH Statewide Promotion

Promotion of the HCH program to both providers and residents of Minnesota was the top priority identified by the Sustainability Work Group in January 2024 as a means of sustaining this model of care. The following actions are a result of that initiative.

HCH: The Choice for Primary Care

The HCH clinic business case was updated and expanded. These edits coincided with the development of the HCH employer business case, which was mentioned in more detail within the Partners section of this report.

HCH Communications Tool Kit

A HCH Tool Kit for clinic partners was initiated, designed to include templates for social media, websites, flyers, brochures, and other methods to enhance patient and community understanding of the HCH program. This project has been paused and will resume once a new HCH tagline is selected.

Conference Presentations

The HCH team, alongside Red Lake Indian Health Services, presented at the Minnesota Rural Health Conference. Additionally, the HCH team presented at the Many Faces Conference with Aspirus St. Luke’s. Both presentations featured HCH program components and demonstrated how the certified organizations have leveraged level progression requirements to improve health outcomes and equity.

MNPERLA Conference

A member of the Sustainability team attended the Minnesota Public Employer Labor Relations Association (MNPERLA) Conference to connect with public-sector employers. The team plans to leverage these connections to establish new public-sector employer partnerships in 2025, similar to the collaboration with SEGIP.

University of Minnesota Duluth (UMD)

HCH was invited to present to UMD Business and Health Care Administration students on the HCH model, level progression, the success of team-based patient-centered care, and how it can be leveraged to improve health equity and outcomes.

PrimeWest Health 2024 Providers and Partners Fall Conference

HCH PIS traveled to Alexandria, MN, to attend and exhibit at PrimeWest's annual fall conference. This event offered a valuable opportunity to connect with providers and representatives from other organizations while listening to expert speakers discuss a wide range of topics important to rural health care.

Minnesota Care Conference

HCH PIS attended and exhibited at the Minnesota Care Conference in Brooklyn Center, MN. During the event, they shared insights on how the HCH care delivery model supports both organizational and patient wellbeing.

HCH Tagline

In response to community feedback, HCH staff identified a significant communication challenge regarding Health Care Homes: many individuals confuse Health Care Homes with traditional home health care services or nursing home facilities. To address this misconception, a rebranding initiative was launched to clarify program messaging and highlight the clinic-based, coordinated care model that defines Health Care Homes. HCH continues to collaborate with stakeholders to develop a new tagline and create clearer descriptions of Health Care Homes as places where health care teams work together to coordinate patient care. The initial response to the tagline options has been encouraging, and HCH anticipates rolling out a new communication strategy in the coming year. This rebranding effort supports programmatic commitment to improving health care accessibility across all communities served.

References

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

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

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

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