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Minnesota Health Reform

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Minnesota's Accountable Health Model: State Innovation Model Grant: ***Building Toward the Vision***

60% of fully insured population in ACO/TCOC models	200,000 Medicaid enrollees in ACOs	Evidence of better health and lower costs from first round ACO models
67% of primary care clinics are HCH or BHH	15 Accountable Communities for Health	Quality measures and payment structures that align across payers
ACO/ACHs begin to integrate behavioral health or LTC or social services/public health	Providers and communities partner in new and deeper ways	ACHs identify health and cost goals and sustainability to continue work beyond grant funding.

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A Better State of Health

Minnesota Department of Human Services

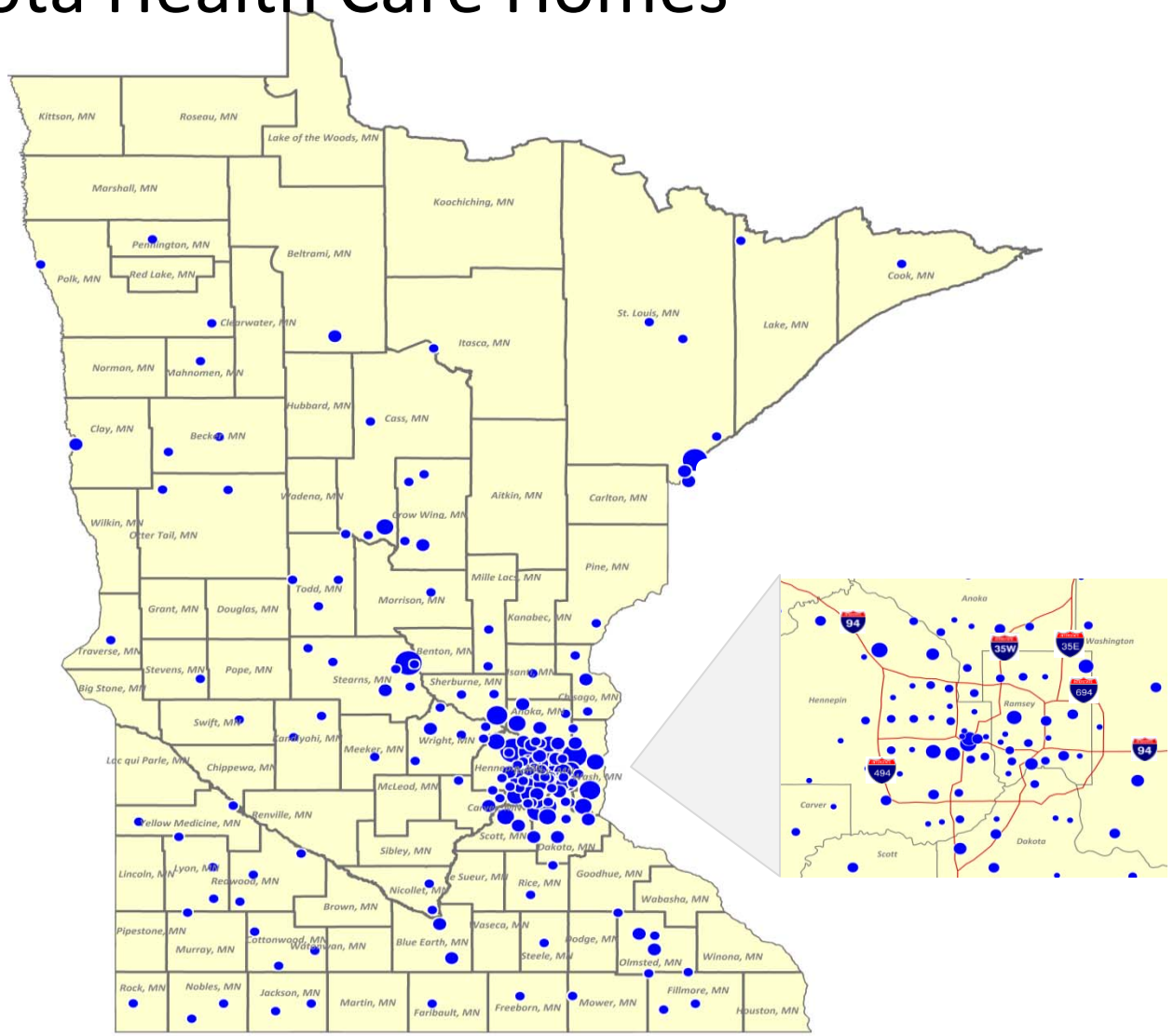
MINNESOTA MDH DEPARTMENT of HEALTH

Minnesota Health Care Homes

322 certified HCHs, 42% of primary care clinics

3,429 certified clinicians

Serving 3.3 million Minnesotans



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What Is Working for Minnesota?

- **Statewide approach, public/private partnership**
- Standards for certification all types of clinics can achieve
- Support from a statewide learning collaborative
- Development of a payment methodology
- Integration of community partnerships to the HCH
- Outcomes measurement with accountability
- Statewide HCH Evaluation supported by legislation.

Focus on patient- and family-centered care concepts

Standards that Support Development of Practice Tools, All Types of Clinics Participate

Access & Communication
Health care for all, population based.
Same day access
After hours access
Race/Language Data
Preferred Communication

Prepared practice team

Community Partnerships

Activated patient

Quality
Evidence based practice
"Triple Aim" Quality Plan
Quality improvement Team, includes patients/ families
Learning Collaborative
Benchmarking / Evalution

Care Coordination
Collaborative Team
Dedicated time for care coordinator
Panel management
Community resources
Care transitions

Care Plan
Patient Centered Goals
Emergency After Hours Plan
Wellness promotion
Patient self management
Family Involvement
"Refrigerator Ready, Living Document"

Registry
Population Management
Electronic Registry
Prevent GAPS in Care
Pre-Visit Planning

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Statewide Learning Collaborative

An investment in practice transformation:

Regular statewide learning activities, presented by clinic teams, patients & families and experts.

"We couldn't have done it without learning from other teams"

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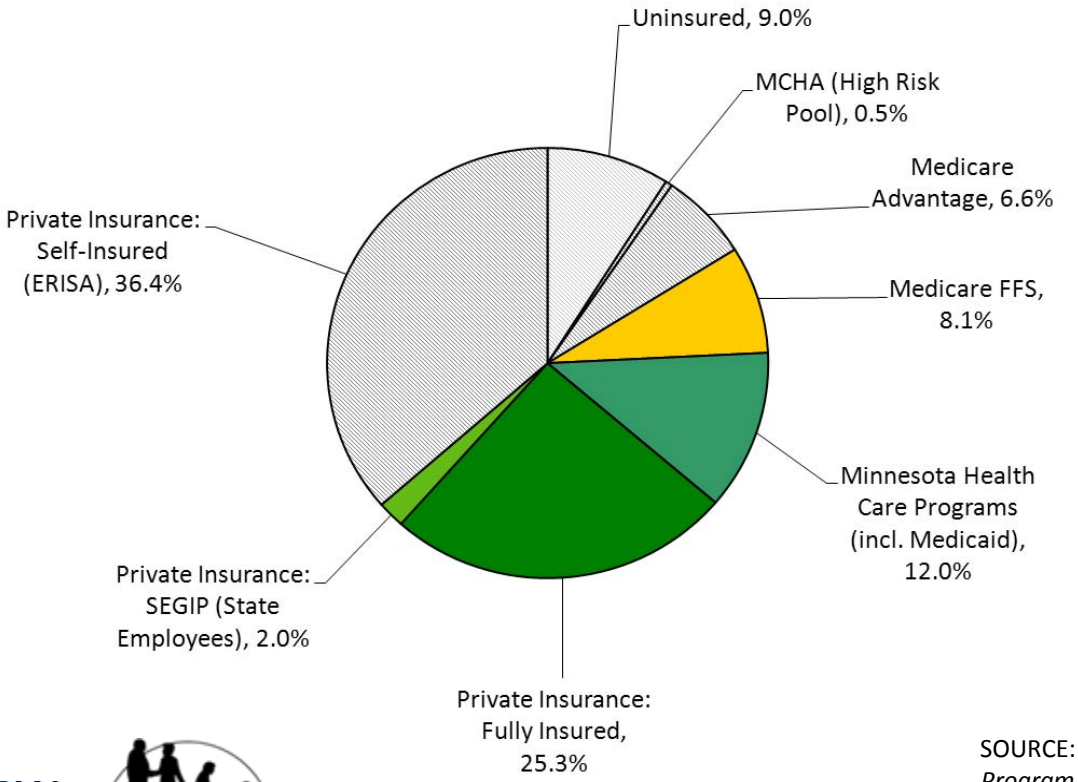
Multi-Payer Investment in Primary Care Transformation

- ***Legislation to promote development of payment methodology***
- ***Focus on "critical mass"***
- ***Started with population management, tiering based on risk complexity***
- ***Foundation to future ACO and TCOC payment methods***



SOURCE: *Adapted from MDH Health Economics Program, Medicare enrollment data and SEGIP enrollment data*

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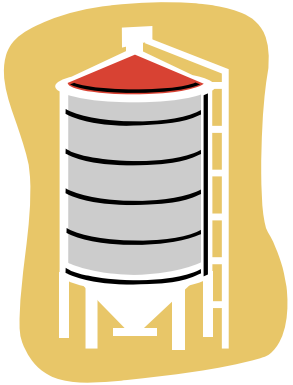
Deliberate Focus Community Partnerships

Implementation Partners

- Primary Care Professional Associations
- Health Professionals, Clinics
- ICSI, Stratis, U of M
- Consumers
- Medicaid & Payers
- Behavioral Health, NAMI
- Senior Linkage Line
- Aging Services
- Alzheimer's Association
- Title V, Youth with Special Health Needs & MCH

Strategies:

- Ongoing workgroups
- Stakeholder events
- Grants / Contracts
- Safety Net Transformation /FQHC grants
- Community Care Team Grant
- Alzheimer's Legislation
- SHIP, REACH, BEACON, DPP
- SIM



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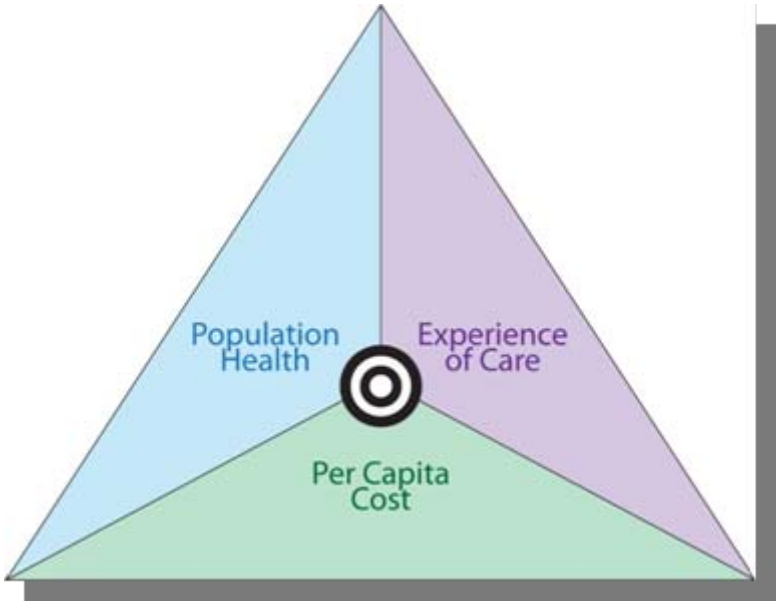
Performance Improvement Evaluation

- Legislative Required Evaluation at year 3 & 5
- Build evaluation with triangulation into certification processes with data collection support
- Developed benchmarking methodology using statewide quality measures
- AHRQ, Transformation Evaluation
- Included consumers, customers in development of QI & evaluation plan / processes.

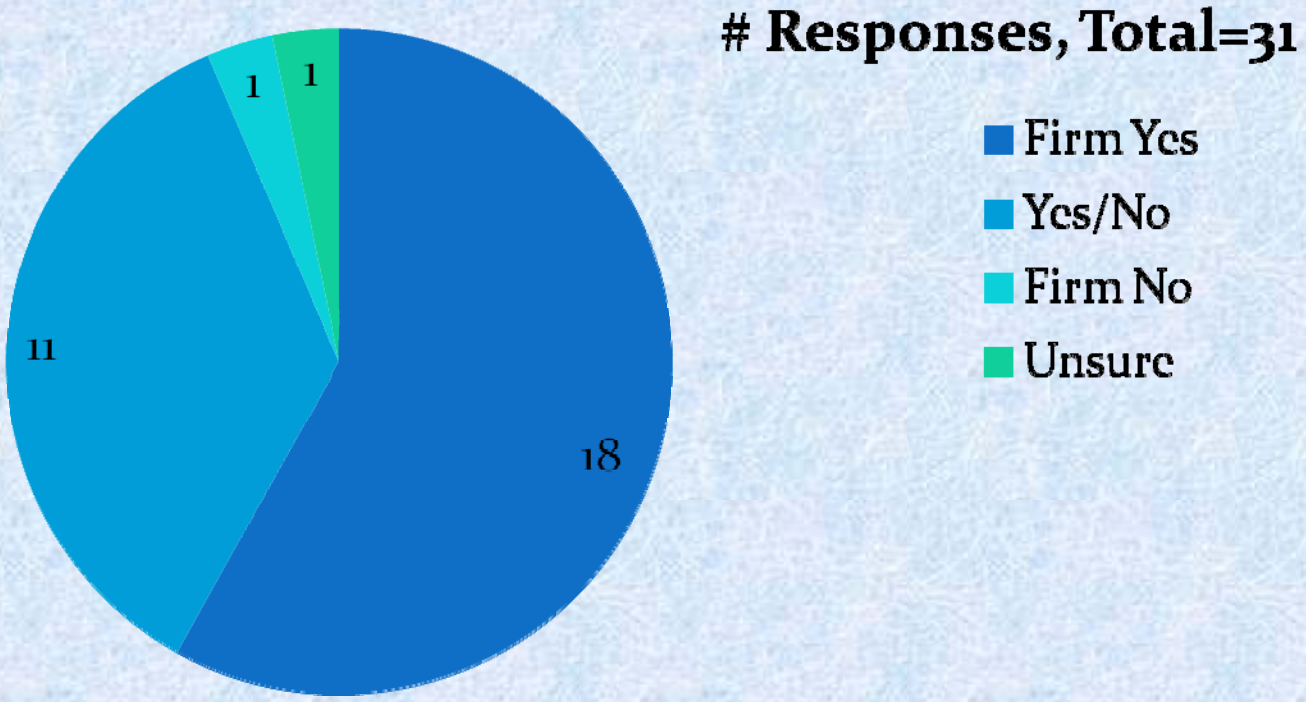


Patient and Family Centered Care

- Emphasis in policy implementation.
- Consumers engaged at state, and locals levels.
- PFCC integrated into HCH legislation and rule.
- Consumers participate in evaluating HCHs.
- Statewide consumer engagement.

Transformation: Would you do it again?

Was it worth the effort for your clinic to become a Health Care Home?



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Transforming Primary Care Clinics into Health Care Homes in Minnesota:
What Have We Learned? The TransforMN Study: 2013
HealthPartners Research Foundation

Health Care Homes Contact Information

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