MINNESOTA
HEALTH CARE HOMES

Request for Information (RFI) Analysis of Health Care Homes Stakeholders.
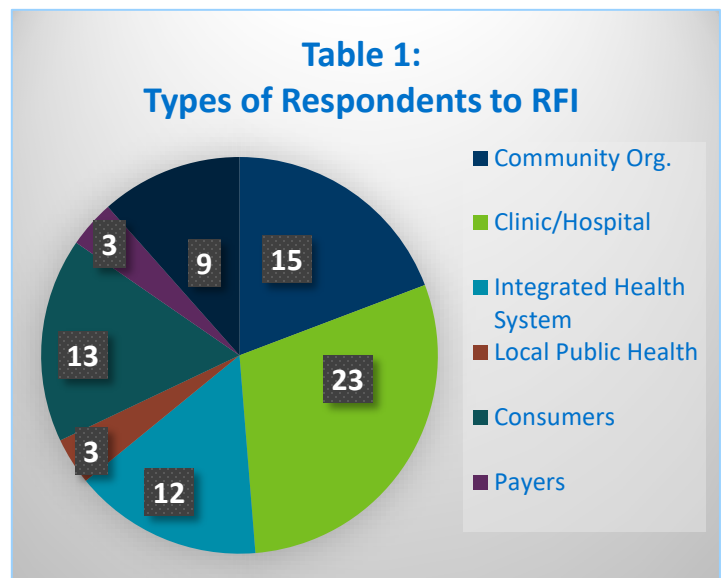
WHAT IS THE BACKGROUND?

In 2016, the Health Care Homes (HCH) Advisory Committee and its workgroups were instrumental in helping the Minnesota Department of Health (MDH) clarify its vision for how the program could continue to evolve to meet changing needs and expectations related to state and federal health reform initiative2s. As part of that process, the HCH Advisory Committee worked with MDH to develop a Request for Information (RFI) for the purpose of obtaining broad community and stakeholder feedback from key stakeholders on potential enhancements to Minnesota's HCH program.

The RFI was distributed to certified and non-certified clinics, state and federal policymakers, community organizations, public health stakeholders, and consumers. It was broken into sections that included:

- Social Determinants of Health/health equity
- Partnerships and Data Exchange
- Financial Sustainability
- Learning Collaborative
- Communication and Evaluation
- Patient Engagement
- Longer term vision – Accountable Communities for Health

WHO RESPONDED?

A total of *78 respondents* responded to the RFI representing a wide array of groups and individuals interested in program improvements. Additionally, three public meetings were held in Mankato, Bemidji and St. Paul. Thirty-one participants attended the public meetings including patients, providers, administrators, public health representatives, and payers.

**Table 1:
Types of Respondents to RFI**

- Community Org.
- Clinic/Hospital
- Integrated Health System
- Local Public Health
- Consumers
- Payers

(values shown: 15, 9, 3, 13, 3, 12, 23)

WHAT WERE THE RESULTS?

RFI responses were coded to determine the major themes that respondents felt important for the program to address. These major themes will be discussed in each of the RFI sections. Respondent quotations are provided as examples of the important themes within a section.

SOCIAL DETERMINANTS OF HEALTH/ HEALTH EQUITY

In general, responses within this section indicated:

- The *majority of respondents* thought they would be able to conduct health inequity analyses.
- *Over half* of all respondents are including socio-economic factors in risk stratification of their patient population.
- *Over half* of all respondents participate with local public health and/or hospitals and other partners when conducting Community Health Needs Assessments.
- Need for strong partnerships between community organizations and clinics.

Stronger community/clinic partnerships*:*

"Clinics and community partners need to design and implement a community care model that ensures that families receive communications that effect health care in a timely, efficient and complete manner." (Clinic)

Additionally, major themes for this section showed that it is important to document community/clinic linkages, addressing language and socioeconomic/race, ethnicity and language (SES/REL) barriers related to care delivery.

PARTNERSHIPS AND DATA EXCHANGE

In general, responses within this section indicated:
- Fewer than *half of respondents* use EHR data on social determinants of health to assess patient care needs.
- Health information exchange remains challenging due to redundancies in data collection, lack of knowledge in use of collected data, and the high costs for small and rural providers.

Themes related to data exchange focused on EHR functionality, the exchange of health information across organizations and clinics, barriers that persist when information is exchanged, and the burden that occurs as more information is required to be recorded and exchanged.

Integration of Health Information Technology (HIT):

"It would be useful to have a 'medical cloud' where all information can be accessed." (Community Org.)

"The program could also make sure all providers are collecting the data needed to assess social determinants of health and provide funding to support additional data collection requirements as needed." (Community Org.)

FINANCIAL SUSTAINABILITY

Responses to questions in this section showed broadly:
- *Half of all clinics* are currently *not billing* for HCH payments.
- *Half of all clinics* are *receiving payments* from payers for care coordination or chronic disease management.
- *4 out of 10 respondents* feel MACRA requirements will result in additional resource or capacity constraints.

Issues with Funding Sources

"Need some structure that allows for compensation of care coordination - otherwise the margins are so small or non-existent (in the case of MA) to allow productivity for this work." (Clinic/Hospital)

"Provide funding to support additional data collection requirements as needed." (Health System)

Financial burden focused on the need for an improved process for care coordination reimbursement, more general reimbursements for time spent by providers, and increased funding streams for better data collection and storage. Additionally, the cost of providing care for patients with complex and chronic diseases was cited as another area of financial burden.

LEARNING COLLABORATIVE

Responses to this section showed:
- The *majority of respondents* would like a tool to assess HCH team members' knowledge and skills in relation to certification/recertification standards.
- Respondents felt organizational leaders need increased funding, more education opportunities, and defined leadership roles to champion a learning environment.

A major theme that emerged from this section was related to education concerning the integration of health care professionals and mental health.

Understanding of health professionals / mental health

"Staff needs better training in the area of mental health disabilities as well as skills in active listening." (Clinic/Hospital)

COMMUNICATION AND EVALUATION

Within this section, responses broadly show that communicating the efficacy of the HCH program will require more stakeholder meetings, general information, improving webinars/public materials, and greater connections with payers.

HCH concept not understood:

"The HCH concept is still not widely understood even within healthcare. Healthcare and local public health have to make opportunities to increase understanding and buy in. "(Consumer)

A theme that came from the communication questions was the need to better understand what Health Care Homes is as a program and how patients benefit from it.

Responses that focused on the evaluation of the program cited major themes related to measurement burden, standardization of measurement requirements, and policy changes related to current measurement criteria.

Measurement burden:

"The current patient experience tool deployed in Minnesota (CG-CAHPS) is an ineffective and expensive tool for Health Centers to use for their patients." (Community Org.)

PATIENT ENGAGEMENT

A prominent theme within this section was that patients have transportation issues when they are trying to get access to their clinic. This was echoed by clinic and community partners that indicated transportation to be a barrier for patients.

Issues with transportation:

"Our patients have transportation issues as many do not own reliable vehicles. Even when patients do have cars, the extensive trip to a clinic in some rural areas can prevent a patient from accessing care. " (Clinic/Hospital)

Another theme was related to the development of individual patient goals. In general, responses showed:

- Patients are not sure who to talk to about creating individual care plans.
- Patients are not sure how to go about sustaining health goals outside of the clinic.
- Patients have issues with access to healthy food and are not sure who to talk to at the clinic.
- Patients have issues with physical activity and are not sure who to talk to at the clinic.

Patient Involvement:

"Our education participants receive tours of clinics and learn about the services available helping to reduce their anxiety about seeking care." (Clinic/Hospital)

"Having staff hear directly from the families has been very enlightening and helpful as we are making decisions." (Clinic/Hospital)

ACCOUNTABLE COMMUNITIES FOR HEALTH

Serving diverse patient populations:

"Cultural competency in health care describes our ability to effectively provide care to patients with diverse values, beliefs and behaviors." (Clinic/Hospital)

Responses to this final section cited these themes:

- Respondents cited a number of barriers that prevent them from offering optimal services to these populations.
- HCH clinics and affiliated community partners continue to serve a diverse population that represents a wide array of racial, ethnic, cultural and socioeconomic backgrounds.
- As a result of this diverse population, differences in language, culture and class are important themes to consider in relation to the population that the HCH program serves.

Socioeconomic /Race, Ethnicity, Language Barriers:

"Health Center patients are diverse and consequently many more languages are spoken by our patients. Additionally, low-income population's housing changes frequently, and mail is not the most effective means to communicate with our patients. (Community Org.)

NEXT STEP

In general, responses have shown that the program is headed in the right direction. The HCH program, Advisory Committee, and its workgroups are currently strategizing about future goals and potential changes that can be made to strengthen support to primary care providers, as well as build more collaborative partnerships with community services.

The input obtained through this Request for Information is helping to inform discussions related to potential enhancements, opportunities and barriers for implementation, and resource and support considerations to help HCHs meet program goals. Additionally, the program is using these responses to inform a strategic plan for the future that focuses on the continued transformation of primary care based on the needs of certified clinics, the patient population, and overall advancement of the program.

HEALTH CARE HOMES / STATE INNOVATION MODEL

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