

Participant Question	Bonnie LaPlante's Response
<p>1. Does the Community Paramedicine play a role in the Minnesota medical home program?</p>	<p>MDH is working to integrate Community Paramedics into team-based models of care, for example health care homes. It looks different in various communities based on population served. Two communities for example are using community paramedics in their Accountable Communities for Health model.</p> <p>More information can be found at: www.health.state.mn.us/healthreform/sim/</p>
<p>2. What is the prevention target?</p>	<p>An integral component of a HCH is the provision of comprehensive, team-based care that meets a patient's physical and mental health needs, through prevention and wellness, acute care, and chronic care to effectively manage the health needs of the population served.</p> <p>Although, HCH does not have a specific target, monitoring performance measurement and evaluation of health care homes is a requirement of the Minnesota health reform law.</p> <p>A statewide quality reporting system is used to collect the data necessary for monitoring compliance with certification standards and for evaluation of the impact of health care homes on outcomes.</p> <p>Benchmarking is used to:</p> <ul style="list-style-type: none"> • Measure improvement over time • Comparison between health care home clinics • Follow established state or federal standards • Use best practices, outcome-based measures • Allows for recertification with accountability • Establish a statewide framework for quality improvement <p>More information on the measures can be found at: http://www.health.state.mn.us/healthreform/homes/outcomes/index.html</p>
<p>3. What is the magnitude of payment differential for best versus worse performance for a primary care practice? What proportion of the practices' patient population is eligible for P4P?</p>	<p>The Minnesota Department of Human Services (DHS) and the Minnesota Department of Health (MDH) convened a payment steering committee and several work groups to help develop a system of per-person care coordination payments to certified health care homes. More information can be found on the HCH website at: http://www.health.state.mn.us/healthreform/homes/payment/index.html</p>

<p>4. I am curious, whether this effort has been prioritized using Health Professional Shortage Area (HPSA) information and score, that are calculated by Primary Care Offices in your states, and confirmed by the Health Resources and Services Administration--in determining where to put greatest attention in determining where to put attention in Ohio and Minnesota?</p>	<p>The HCH program is voluntary and there is a statewide approach to certification. A continued focus of the HCH program is to build capacity throughout the state and to assure that every county has a certified HCH to transform primary care. The HCH team identified development of this infrastructure through community partnerships as a key strategic priority for 2012 and this continued to be a focus in 2014. The HCH team developed initiatives that promoted these community partnerships to support implementation of HCH including:</p> <p>HCH nurse community outreach activities</p> <ul style="list-style-type: none"> • Educating community partners and interested parties throughout the state about quality improvement initiatives and patient- and family-centered care models. • Actively participating in the implementation of the State Innovation Model Grant through expansion of HCHs, practice transformation strategies and implementation of Accountable Communities for Health. • Supporting clinics through practice facilitation collaboration under the SIM grant to increase the number of certified HCH. • Aligning the work of the Minnesota Children and Youth with Special Health Needs (CYSHN) program with the HCH initiative in order to capitalize on existing resources and to contribute to the national core outcomes for Children and Youth with Special Health Needs. <p>More information can be found in the reports at:</p> <p>http://www.health.state.mn.us/healthreform/homes/background/index.html</p> <p>.</p>
<p>5. Bonnie, who hires and funds the site visitors?</p>	<p>The Minnesota Department of Health (MDH) contracts with the site evaluators. MDH staff provides initial screening and training. Also, there is always an MDH Planner/nurse on the site visit team so there is ongoing evaluation.</p>
<p>6. We have focused today on the medical home, but what about the medical neighborhood and progress in advancing that model?</p>	<p>The HCH model of care delivery utilizes a patient centered approach and care coordination activities to organize care across the health care system and with other community partners to minimize fragmentation. Minnesota's program has specific requirements to include external providers and their treatment plans in a patient's care plan, manage and close the loop on referrals, develop transition planning, and establish relationships with community partners that encourage the flow of information and to help navigate the system.</p>
<p>7. What are the next steps for primary care practices after they have achieved PCMH recognition?</p>	<p>The ultimate goal for a PCMH is to provide: patient centered care, proactive health care to the population served, and to improve clinical outcomes while reducing the cost of care. In Minnesota there is an ongoing recertification process with recertification based on outcomes. The PCMH continues to refine processes and build their foundation.</p>

<p>8. How does the PCMH model fit with efforts to form ACOs?</p>	<p>The HCH assists with building the infrastructure of the ACO. This infrastructure sets up processes and transforms care delivery to achieve the ability to be successful in attaining outcomes of lower cost, improved clinical outcomes, and patient satisfaction. The delivery of high quality care and lower costs allows the organization to enter into an ACO that require effective and successful management of the health of a population.</p>
<p>9. Is payment reform making the PCMH model sustainable in your state?</p>	<p>Minnesota’s State Innovation Model grant provides a unique opportunity for the State to test current payment reform initiatives. This includes exploring options for modifying total cost of care payment models to capture a broader range of services and partners, as part of a statewide goal of promoting accountable care payment models. Feedback from stakeholders, including what is learned from the efforts of Accountable Communities for Health, will help inform evolvement of payment reforms to sufficiently support care for persons with chronic conditions. DHS and MDH will continue to engage and work with payers to align payment methodologies with the broader payment reform context in mind so as to give careful consideration to the impacts and interactions with other reform efforts. (2014 Legislative Report, January 2015).</p> <p>For more information go to: http://www.health.state.mn.us/healthreform/homes/background/index.html</p>
<p>10. How else can public health be more engaged with primary care efforts at transformation?</p>	<p>Continue to capitalize on each other’s strengths and mission to successfully manage the social, community, environmental, and physical well-being of the population. Propose linkages and alignment between public health and primary care.</p>