What do people want from primary care? They want whole-person care; coordination and communication; patient support and empowerment; and ready access, according to one study.¹ Yet, many providers lack the tools, resources, and incentives to reorganize their practices to deliver care in this manner.

The goals of the patient-centered medical home (PCMH) model—implemented broadly by public and private payers in demonstrations across the country²,³—are to support the delivery of patient-centered primary care while improving quality and containing costs. The majority of these initiatives utilize national certification tools, such as the National Committee for Quality Assurance (NCQA)’s PCMH tool,⁴ which assess practices’ PCMH “transformation” based on self-reported data. Some researchers and physicians have raised concerns about whether these tools are the best means to measure a high performing patient-centered primary care practice.⁵,⁶

Minnesota chose a different path when it passed health care reform legislation in 2008 that created the Health Care Home (HCH) program. The HCH program, which launched in 2010, is a PCMH model designed to improve health outcomes and consumer satisfaction, while also controlling costs for their population by increasing consumer engagement in their health care. It also provides readers with an opportunity to see how the policy decisions that created this initiative influence practice through a “Day in the Life” of the nurse planner beginning on page 2.

This is the fourth in a series of case studies exploring the evolving role of nurses in new delivery system models designed to better meet the needs of consumers with chronic health conditions. Each case study provides policy recommendations and showcases the work of a nurse in a new initiative. This study looks at how the Minnesota Health Care Homes (HCH) program utilizes nurse planners to coach and certify primary care clinics as HCHs. HCHs must meet specific standards of care that aim to help improve health outcomes and consumer satisfaction, while also controlling costs for their population by increasing consumer engagement in their health care. It also provides readers with an opportunity to see how the policy decisions that created this initiative influence practice through a “Day in the Life” of the nurse planner beginning on page 2.

Transforming the Workforce to Provide Better Care: The Role of Nurses in Certifying Minnesota Health Care Homes

Mary Takach and Rachel Yalowich
National Academy for State Health Policy
coordination, development of care plans, use of patient registries, and quality improvement (see text box). After initial HCH certification, clinics need to be re-certified every year. To be re-certified, clinics must show improvement by meeting more advanced benchmarks within these five domains.

To ensure that clinics are providing care that meets these standards, the Minnesota Department of Health employs regionally-based registered nurse planners. Nurse planners have three main components to their work. First, they lead the certification, and re-certification, of clinics as HCHs. The culmination of the certification and re-certification process is a site visit that assesses whether or not each clinic has processes and infrastructure in place to meet HCH standards. The site visit includes a series of interviews with clinic staff and patients and their families led by the nurse planner, along with a certification team, consisting of a clinician “peer” consultant—typically a nurse or a physician—and a consumer.

Overview of Minnesota HCH Standards

**Access & Communication:** increased access; culturally-appropriate care;

**Care Coordination:** coordinate care for patients and their families across providers and settings; promote connections to community resources and transitions of care;

**Care Plan:** patient- and provider-developed health care goals; wellness promotion;

**Use of Registries:** population management; pre-visit planning;

**Quality:** evidence-based practices; and quality improvement plan and performance measurement with benchmarking.


A Day in the Life of Nurse Planner Joan Kindt in the Minnesota Health Care Home Program

Health care reform goals established by the Minnesota Legislature call for all Minnesotans to have access to patient-centered care, accessible, comprehensive, and coordinated primary care. The HCH program is the path to these goals.

Becoming a health care home (HCH) in Minnesota means adopting “an approach to primary care in which primary care providers, families, and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health

...continued on page 3
Certifying that clinics are meeting standards that align with this definition is a priority for the state of Minnesota and it is the job of nurse planner Joan Kindt, RN. Of the 171 clinics in Joan Kindt’s 38-county region, 139 have yet to become a HCH.

Preparing Practices for Certification

At her home in Rock County, Joan Kindt is preparing for a HCH certification visit. During today’s visit, she will lead a team to certify whether or not a health system that provides primary care services on-site at assisted living and long-term care facilities meets HCH standards. She is concerned about the readiness of the health system, and therefore has asked Marie Maes-Voreis, Director of the Health Care Homes for the Minnesota Department of Health to accompany the team.

The role of the nurse planner starts with reaching out to clinics in his or her region of the state. Making the case to prospective HCH clinics is something that Joan does both on- and off-site. From home, she checks her list of clinics, provided by the Minnesota Department of Health, that have not gone through the HCH certification process and those that have expressed interest to become certified through a letter of intent.

For the former group of clinics, she often “cold calls” them aiming to arrange a time to go on-site to meet with the clinic staff, including the lead primary care provider, to answer questions and discuss the benefits of becoming a HCH. Joan and the other nurse planners provide free on- and off-site coaching about how to become more patient-centered and how becoming more

Second, nurse planners provide both prospective and current HCHs with resources, such as care coordination and patient and family engagement toolkits, and technical assistance to help them improve their capacity to function as a HCH. Third, nurse planners work within their region to recruit primary care clinics to become HCHs.

Initially, the state hired individuals with a non-clinical, planning background to fill this role, but found that they “did not fully understand clinic workflows and quality improvement,” according to Marie Maes-Voreis, Director of Health Care Homes. “It became apparent that registered nurses (RN) had the right background, clinical competencies, and experience with patient- and family-centered care to engage clinics as HCHs.”

As of April 2014, nurse planners have helped to engage 322 primary care clinics as certified HCHs—42 percent of primary care clinics in the state—serving over 3.3 million consumers. Primary care clinics are incentivized to participate through monthly payments from both commercial and public payers for providing care coordination to identified patients. Practices also receive technical assistance as part of the Health Care Home program, including learning collaboratives, and data and performance reporting.

As part of the program, Minnesota regularly collects cost and utilization data and requires HCH clinics to report data on a variety of clinical quality metrics. These measures are designed to capture the effect of medical homes on improving health outcomes and decreasing costs, which helps HCHs implement clinic improvements and prepare for HCH re-certification.

In February 2014, the University of Minnesota released its evaluation of
the HCH program, based on data from 2010–2012. This evaluation reported that HCH clinics outperformed non-HCH clinics in a range of clinical quality measures, including diabetes care. It also reported that emergency department utilization was significantly less among Medicaid beneficiaries in HCH clinics than in non-HCH clinics.¹¹

Lessons Learned and Remaining Challenges at the Health Care Homes Program

Staff from the Minnesota HCH program offer the following recommendations for further developing the nurse planner role in a PCMH initiative:

Lessons Learned

- **Conduct on-site certification visits.** Site visits give the HCH program a unique opportunity to ensure that clinics participating in the program are providing care that meets HCH standards. The nurse planner and the certification team visit clinics at the initial certification. They also meet with the team at each re-certification to interview providers, office staff, and patients and understand the clinic’s processes and workflows.

- **Engage consumers in health system transformation.** When Minnesota began developing the HCH standards, the state engaged consumers through their Consumer/Family Advisory Council. Minnesota continues to engage consumers by contracting with and training a few consumers to participate in the HCH certification process, including participating in certification and re-certification site visits. Consumers are valuable members of the nurse planner’s certification team, and they get paid accordingly; they lead interviews with patients and their family caregivers during the site visit to obtain valuable insight into how clinic transformation is affecting patients from their perspectives.

  - **Allow flexibility for innovation.** The certification process allows for innovation and the nurse planner has flexibility to evaluate how the clinic has integrated processes and infrastructure into the practice to achieve the standards of the HCH program.

Overcoming Remaining Challenges

- **Expand HCH participation.** Non-traditional primary care clinics, such as community mental health centers, HIV clinics, and long-term care facilities that have integrated primary care services are becoming certified as HCHs. Although the HCH standards were initially designed for primary care clinics, they can be adapted to fit non-traditional clinic models.

Role of State Policy

Minnesota has adopted a number of state policies that have shaped the development of the HCH program and its use of nurse planners to certify clinics as medical homes. The table below highlights these policies and notes persisting challenges as they relate to the nurse planner.
Table 1
HCH Nurse Planner Role—State Policy Facilitators and Challenges

<table>
<thead>
<tr>
<th>Facilitators</th>
<th>Challenges</th>
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<tr>
<td><strong>Model</strong></td>
<td>Some primary care clinics are inexperienced with how to improve practice processes and patient centeredness.</td>
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<tr>
<td>Regionally-based nurse planners oversee certification of HCH clinics, provide resources and technical assistance to clinics both before and after becoming HCHs, and recruit clinics to become HCHs.</td>
<td>More education is needed in nursing curricula about health care systems and policy; limited educational opportunities for care coordination and data analytics training in current nursing curricula, which are necessary skills for nurse planners.</td>
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<tr>
<td><strong>Education &amp; Qualifications</strong></td>
<td>New types of clinics are applying to become HCHs, such as long-term care and assisted living facilities and mental health centers that have integrated primary care. Although the HCH standards are flexible, it is potentially more challenging to evaluate these clinics based on current HCH standards.</td>
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<tr>
<td>Must be a registered nurse licensed in Minnesota and have significant health care experience; must be strong in communication and critical thinking; strong understanding of clinic operation and quality improvement; must be able to synthesize and apply varied information.</td>
<td>Nurse planners provide outreach to non-HCH primary care clinics in their community to explain the HCH program; most providers are interested in the changes but are challenged to find the time and resources to meet HCH standards.</td>
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<tr>
<td><strong>Training &amp; Resource Supports</strong></td>
<td>Nurse planners provide outreach to non-HCH primary care clinics in their community to explain the HCH program; most providers are interested in the changes but are challenged to find the time and resources to meet HCH standards.</td>
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<tr>
<td>Weekly meeting among nurse planners to discuss best practices and challenges; weekly certification meeting to discuss HCH standards and operational issues offers opportunity for peer-to-peer learning among nurse planners.</td>
<td>New types of clinics are applying to become HCHs, such as long-term care and assisted living facilities and mental health centers that have integrated primary care. Although the HCH standards are flexible, it is potentially more challenging to evaluate these clinics based on current HCH standards.</td>
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<tr>
<td><strong>Physician/Staff Acceptance</strong></td>
<td>State finances HCH certification process that benefits all payers, which may not be feasible or sustainable in other states.</td>
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<td>Almost half of primary care clinics in the state have become certified HCHs; clinics are incentivized to participate in the HCH program through supplemental monthly payments for care coordination for identified patients, technical assistance, and data and performance reporting to help improve quality.</td>
<td>Development of a statewide database has had its challenges; both the statewide database and utilization of quality and benchmarking data are new to both HCH staff and Minnesota clinics.</td>
</tr>
<tr>
<td><strong>Financing &amp; Payment</strong></td>
<td>Nurse planners provide outreach to non-HCH primary care clinics in their community to explain the HCH program; most providers are interested in the changes but are challenged to find the time and resources to meet HCH standards.</td>
</tr>
<tr>
<td>Nurse planner role financed through state's Health Care Access Fund, which is partially funded by a provider tax, and through Title V federal funding.</td>
<td>State finances HCH certification process that benefits all payers, which may not be feasible or sustainable in other states.</td>
</tr>
<tr>
<td><strong>Access to Data</strong></td>
<td>Development of a statewide database has had its challenges; both the statewide database and utilization of quality and benchmarking data are new to both HCH staff and Minnesota clinics.</td>
</tr>
<tr>
<td>Nurse planners and other members of the HCH certification team have access to a state database that stores any documents, including clinic applications and assessments, related to certification for each HCH clinic. Each clinic can log into this database to view its own certification documents; clinics have access to quality and benchmarking data through the statewide quality reporting system.</td>
<td>Development of a statewide database has had its challenges; both the statewide database and utilization of quality and benchmarking data are new to both HCH staff and Minnesota clinics.</td>
</tr>
<tr>
<td><strong>Consumer Input in Model Development</strong></td>
<td>Clinics may be initially challenged to find ways of engaging consumers and families in clinic operation and quality improvement.</td>
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<td>Minnesota's Consumer/Family Advisory Council provides input on health care developments, including the development of HCH certification standards; consumers have been trained and are paid by the state to participate in the certification process, including site visits with nurse planners; consumers and families must play an active role in each HCH.</td>
<td>Clinics may be initially challenged to find ways of engaging consumers and families in clinic operation and quality improvement.</td>
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A Day in the Life...
(continued from page 3)

Efficient will save the clinic money and improve quality. In addition, certified HCHs are eligible to receive monthly payments from both commercial and public payers for their patients receiving care coordination. Joan often organizes webinars and invites local certified HCH clinics to speak so that prospective clinics have an opportunity to learn first hand from their peers.

When a clinic decides that it wants to pursue HCH certification, Joan walks its staff through the certification process. The clinic sends a letter of intent to apply for certification, which prompts the Minnesota Department of Health to send an application and a self-assessment tool. The clinic uses the self-assessment tool to determine its readiness to apply. Joan then functions as a “coach” and guides each clinic through the certification process. Coaching requires both remote and face-to-face time to talk about the certification process, what the clinic needs to do to meet the standards, and what kind of documentation is necessary to demonstrate that it is meeting the standards.

Before the certification site visit today, Joan spent a fair amount of time providing technical assistance to the health system, especially on the care planning process—one of the core tenets of a HCH—because its model of integrating primary care services into assisted living facilities is quite different than the typical primary care clinic. Joan has found that many clinics have faced challenges in becoming more patient-centered, especially in developing processes that increase consumer and family engagement in the care planning process.

All HCH clinics need to design quality improvement projects in order to gain certification. The health system undergoing certification today chose to focus on advanced care planning and care coordination. Joan encouraged the health system to apply for a grant to help with those projects. Like other clinics, the health system also needed to develop a registry to help report data to the state and use the registry to better track care. Joan ensured that the facility attended a two-day learning collaborative that she also helps to organize and teach.

Leading the On-Site Certification

Joan briefed the certification team three weeks ago, sharing the data, and her concern about the health system’s readiness. The certification team consists of Joan, a consumer representative, and a clinician “peer” consultant—typically a nurse or a physician—and for today’s visit, Marie Maes-Voreis. Joan has developed the agenda, dividing the interviews among the certification team. These interviews typically include providers, nursing staff, care coordinators, and front-office staff. The interviews always include patients and often, family members. Today, family members both in-person and via conference line accompany the patients.

Joan arrives at the clinic and huddles with her site visit team before they fan out to begin the interviews. Joan first meets with the quality improvement coordinator. She sits down with the coordinator in front of the computer to review the health system’s use of a registry for reporting quality and utilization measures. Site visits...continued on next page
A Day in the Life…
(continued from page 6)

ensure that what the facility reports on paper is actually occurring at the clinic. She asks the coordinator, “tell me how you are tracking preventive care, and assigning risk scores to identify patients for care planning,” and the coordinator walks her through how the registry is used.

Next Joan meets with the reception staff and asks about their HCH vision and goals. The receptionist responds by describing facility policy for answering calls—an important aspect for meeting HCH access standards.

She also talks with the medical director of the facility and discusses how care delivery has changed since starting the HCH process. He describes transformational changes about embedding a nurse practitioner on-site and how the facility is better meeting the patients’ primary care needs. He explains that the facility is just beginning to put in place population-based panel management and Joan offers advice about how to help the facility advance to the next stage.

Meanwhile another member of the certification team meets with a nurse practitioner at the health system to discuss after-hours access to primary care. She requests that the nurse practitioner describe the processes in place to ensure that care coordination and referrals are being effectively made.

Joan also meets with the nurse supervisor at the facility who talks about newly formed care processes that include daily huddles with the primary care team. The nurse supervisor remarked, “we worked really hard with our care teams… we’ve had live lunch meetings to prepare. Every week was focused on one of the standards, such as access.”

Measuring Performance

At the end of the afternoon, the certification team reserves an hour to huddle to discuss what it observed. The consumer representative discusses how she interviewed two patients and their family members. Both families knew the names of their primary care provider, described strong communication between the primary care provider and the family, and were generally satisfied with their care. At the end of the day the certification team met with the health system seeking certification and reviewed examples of their positive work and areas for improvement.

Following the huddle, the certification team meets with the health system staff. Together, they review the positives from the site visit—strong team culture, commitment to patient-centered care, use of shared decision-making tools, and other innovative work. They discuss areas to improve, including the care planning process, after-hours care, communication, and focus on goals. The health system staff expresses appreciation for the feedback and its commitment to transforming care delivery.
Endnotes


About This Series

Transforming the Workforce to Provide Better Chronic Care: The Role of Registered Nurses
Susan Reinhard, AARP Public Policy Institute; Mary Takach and Rachel Yalowich, National Academy for State Health Policy

This series explores the evolution of primary care systems to better meet the needs of consumers with complex health conditions. It demonstrates that changes in the workforce are required to empower consumers to better manage their health.

The series is a collaboration of the National Academy for State Health Policy and the AARP Public Policy Institute. We recognize that it takes a team of skilled professionals to deliver improved chronic care. In this series, we focus on how registered nurses—who make up the largest segment of the health care workforce—are being deployed in ambulatory delivery systems to take on new roles. Future series will focus on other members of the health care team.

We selected six initiatives that offer replicable policy strategies to develop, implement, and sustain patient-centered approaches to care. Each case study highlights one of these initiatives and provides policy recommendations and an “on-the-ground” look at the work of its nurses.

We conducted site visits to:

- Rhode Island’s Chronic Care Sustainability Initiative: a multipayer medical home initiative that supports an embedded nurse care manager in each primary care practice.
- North Carolina’s Pregnancy Medical Home Program: a medical home program for high-risk pregnant Medicaid beneficiaries where obstetric nurse coordinators oversee program operation and quality improvement.
- Minnesota’s Health Care Homes: a multipayer medical home initiative where nurses play a crucial role ensuring that primary care practices meet state standards.
- Hennepin Health (MN): an accountable care organization where a behavioral health nurse care coordinator orchestrates care among primary care, behavioral health, and social service agencies.
- Yamhill (OR) Community Care Organization’s Community HUB: an accountable care organization where a nurse leads a program to improve care for super-utilizer patients.
- CareFirst’s (MD) Patient-Centered Medical Home Program: a commercial medical home program using nurse care coordinators to help consumers better manage their chronic conditions. CareFirst is also piloting this program with Medicare consumers through an Affordable Care Act “Health Care Innovation Award.”

These six initiatives offer replicable opportunities and lessons for other states and/or payers that are developing or considering patient-centered models of primary care delivery. All of these initiatives support consumer navigation of complex care systems, understanding of illnesses, and learning self-management skills.

Additionally, all of these initiatives have policies in place that facilitate roles where nurses are supporting practices to be more responsive to consumer needs. The final paper of this series will synthesize lessons learned across all cases studies and offer recommendations for states, policy makers, and educators.

For more information please visit our websites: http://www.aarp.org/transformingtheworkforce or http://www.NASHP.org.