

# 2008 Health Reform Law: Minnesota's Vision

MINNESOTA'S  
**VISION**  
*A Better State of Health*

*Health Care  
Homes* | **HCH**

# What is a health care home?

- ★ Also known nationally as the patient centered medical home or federally as APC, advanced primary care.
- ★ A health care home is 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 or complex health conditions.

# In Minnesota its a Health Care Home

Health care home means a clinic or a personal clinician that is certified. A certified health care home:

- A. **facilitates** consistent and ongoing communication among the health care home and the patient and family and provides the patient with continuous **access** to the patient's health care home;
- B. **uses** an electronic, searchable patient **registry** that enables the health care home to manage health care services, provide appropriate follow-up and identify gaps in patient care;
- C. includes **care coordination** that focuses on patient and family-centered care;
- D. includes a **care plan** for selected patients with a chronic or complex condition and involves the patient, and if appropriate, the patient's family, in the care planning process; and
- E. reflects **continuous improvement** in the **quality** of the patient's experience, the patient's health outcomes and the cost-effectiveness of services.

# Transformation!

## Care Delivery Redesign

Today's Care	Health Care Homes
Patients are recipients of services by providers and clinics.	Patients and families are partners in the provision and planning of care.
My patients are those who make appointments to see me.	Our patients are those who have agreed to participate in our HCH and understand how to contact our HCH.
Care is determined by today's problem and time available today.	Proactive care planning is developed with the patient / family to anticipate patients needs.
Care varies by memory or skill of the provider.	Care is standardized with evidence-based guidelines and planned visits.
Patients are responsible to coordinate their own care.	A team, including the care coordinator, coordinates care with patients and families.
I know I deliver high quality care because I'm well trained.	We measure our quality and outcomes and make ongoing changes to improve it. We include patients / families in our quality work.
It's up to the patient to tell us what happened to them.	We use a registry to track visits and tests and we do follow-up after ED visits and hospital admissions.
Clinical operations center on meeting the doctor's needs.	A multidisciplinary team works at the top of our licenses to serve patients.

# What We Know About Access to Care in a Patient & Family-Centered Medical (Health Care) Home:

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- ★ Patient and family-centered care is increased
- ★ Family worry and burden are reduced
  
- ★ Care coordination and chronic condition management lead to:
  - ★ Reduction in emergency room use
  - ★ Reduction in hospitalizations
  - ★ Reduction in redundancy
  - ★ Efficiency and effectiveness are increased

# Two foundational pieces of legislation

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- ★ 2007- First “medical home” legislation- Provider Directed Care Coordination for patients with complex illness in the Medicaid FFS population (now Primary Care Coordination) PCC
- ★ 2008- Health Care reform legislations requires “health care homes” for all Medicaid/ SCHIP/ state employees/ privately insured in Minnesota, Health Care Homes, HCH

# Primary Care Coordination: PCC

## Health Care Homes: HCH

- ★ Both programs promote care coordination and focus on achievement of outcomes.
- ★ PCC: focuses on most chronically ill fee for service Medicaid patients
- ★ HCH: focuses on all patients who have or are at risk of chronic or complex conditions, can benefit from the services of a HCH and are interested in participation
- ★ Both have new payment options for per person care coordination

# 2008 HCH Legislation... the standards developed by the commissioners must meet the following criteria:

- ★ use of primary care
- ★ focus on high-quality, efficient, and effective health care services
- ★ encourage patient-centered care
- ★ provide consistent, ongoing contact with a personal clinician or team of clinical professionals
- ★ ensure appropriate comprehensive care plans for their patients with complex or chronic conditions
- ★ measure quality, resource use, cost of care, and patient experience;
- ★ use of scientifically based health care, patient decision-making aids
- ★ use of health information technology and systematic follow-up, including the use of patient registries

# Legislative Requirements for HCH Care Coordination Payment

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[256B.073]

- DHS and MDH develop a system of per-person care coordination payments to certified HCHs by January 1, 2010
- Fees vary by thresholds of patient complexity
- Agencies consider feasibility of including non-medical complexity information
- Implemented for all public program enrollees by July 1, 2010

# Legislative Requirements for HCH Care Coordination Payment

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[62U.03]

- Health plans include HCHs in their provider networks by January 1, 2010 and make care coordination payments by July 1, 2010
- Payment conditions and terms shall be developed “in a manner that is consistent with” the system under 256B.0753

# Medicare: An important partner to “critical mass”

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- ★ Medicare medical home pilot program legislation just passed for States to apply to participate.
- ★ Minnesota is positioned to apply and is evaluating options
- ★ Begun work with integrated Medicare and Medicaid programs such as MSHO

# Health Care Homes: Program Development Tasks

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- ★ Identification of *outcomes*
- ★ *Criteria* for participation
- ★ *Verification* process
- ★ Common *payment methodology*
- ★ Incorporation of *collaborative learning*
- ★ *Measurement* of results
- ★ Community-wide *communication*

# A Great Health Care Home ...

Is satisfying  
for  
patients,  
families,  
providers  
and clinic  
staff!



# Draft Rules Structure:

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## Parts

- ★ 0010      **Applicability and Purpose**
- ★ 0020      **Definitions**
- ★ 0030      **Certification and Recertification  
Procedures**
- ★ 0040      **Standards**
- ★ 0050      **Variances**
- ★ 0060      **Appeals**
- ★ 0070      **Revocation, Reinstatement and  
Surrender**

# Health Care Homes

## 0040: Standards Categories:

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- ★ Access / Communication
- ★ Patient Tracking and Registry Functions
- ★ Care Coordination
- ★ Care Plans
- ★ Performance Reporting & Quality Improvement

# Access and Communication Standards At Certification

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The HCH must be available to patients who have or

- ★ are at risk of developing or have complex or chronic conditions
- ★ are interested in participation

There is a system in place to tell them about the services of the health care home. Participation is voluntary

# Access and Communication Standards At Certification

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- ★ The patient knows how to access their health care home continuously (24/7, 365)
- ★ The person responding to the patient has access to the patient's health care home information, the triage system, on-call provider or clinic staff.
- ★ Access is addressed by protocol to avoid unnecessary ED visits or hospitalizations
- ★ There is a process to collect cultural, racial and primary language and it is used in providing care
- ★ The team knows the patient/ family preferred method of communication

# Access and Communication Standards At Certification

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There is a process in place to inform participants that they may choose specialty care resources without regard to whether a specialist is a member of the same provider group or network as the health care home.

Participants are responsible for determining whether specialty care resources are covered by their insurance.

# Access and Communication Standards At Recertification, end of year one

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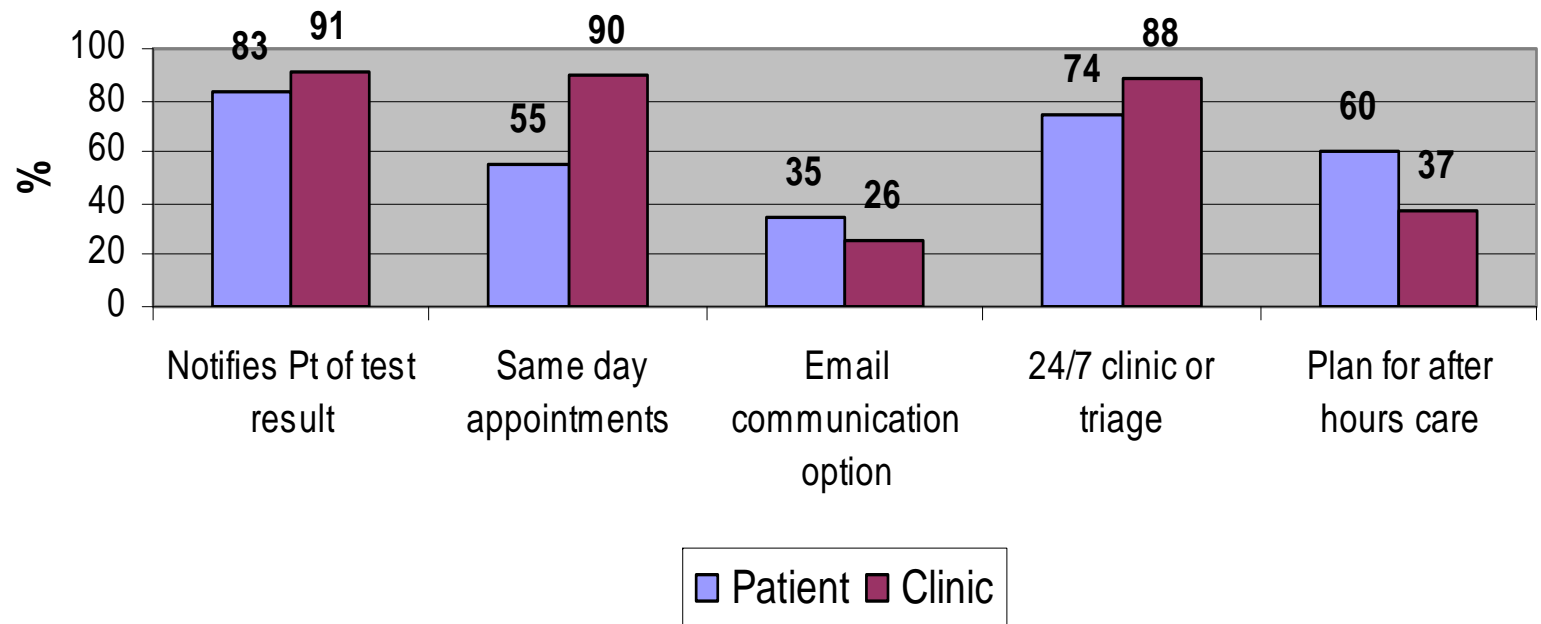
The HCH demonstrates that it encourages participants to take an active role in managing their health care.

The HCH has improved participant involvement and communication by addressing one of the following:

- ★ participants' readiness for change
- ★ literacy level
- ★ or other impediment to learning

# Access and Communication: Patient and Consumer responses

Access and Communication- Patient and Clinic Responses  
MDH 2009 HCH Capacity Assessment



# Patient Tracking and Registry Functions Standards

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## At certification:

- ★ Registry is searchable and electronic
- ★ There is sufficient data to identify gaps in care for patients with chronic or complex conditions that are identified by the clinic

## At recertification, end of year one:

- ★ Registry is “worked” by the HCH team to identify gaps in care and processes are in place to prevent gaps such as appointment reminders or pre-visit planning

# Care Coordination At Certification:

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- ★ Describes the role and requirements for the care coordinator.
- ★ Describes the role of the team and the personal clinician.
- ★ Establishes the processes in place to track referrals, tests, give timely results, and do post D/C planning

# Care Coordination

## At Recertification at end of year one:

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- ★ Patient and family centered care principles are in place, such as shared decision making.
- ★ Community connections are demonstrated with key community resources.
- ★ Team members are working at the top of their license.
- ★ There is planning for transitions.

# Definition: Care Plan

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- ★ Subp. 6. **Care plan.** “Care plan” means an individualized written document, including an electronic document to guide a participant’s care.
- ★ Subp. 12. **Comprehensive care plan.** “Comprehensive care plan” means the care plan for a participant plus all available and relevant portions of any external care plans created for that participant.

# Care Plans

## At Certification:

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- ★ The HCH implements a policy that guides the team on which patients with chronic or complex conditions needs a care plan and identifies the assessment and care planning process.
- ★ Participants are considered a partner in care planning.
- ★ Evidence-based guidelines are used whenever available.
- ★ The care plan includes the participant's goals and the action plan as identified by the participant and the HCH team members.

# Care Plans

## At Recertification, end of year one:

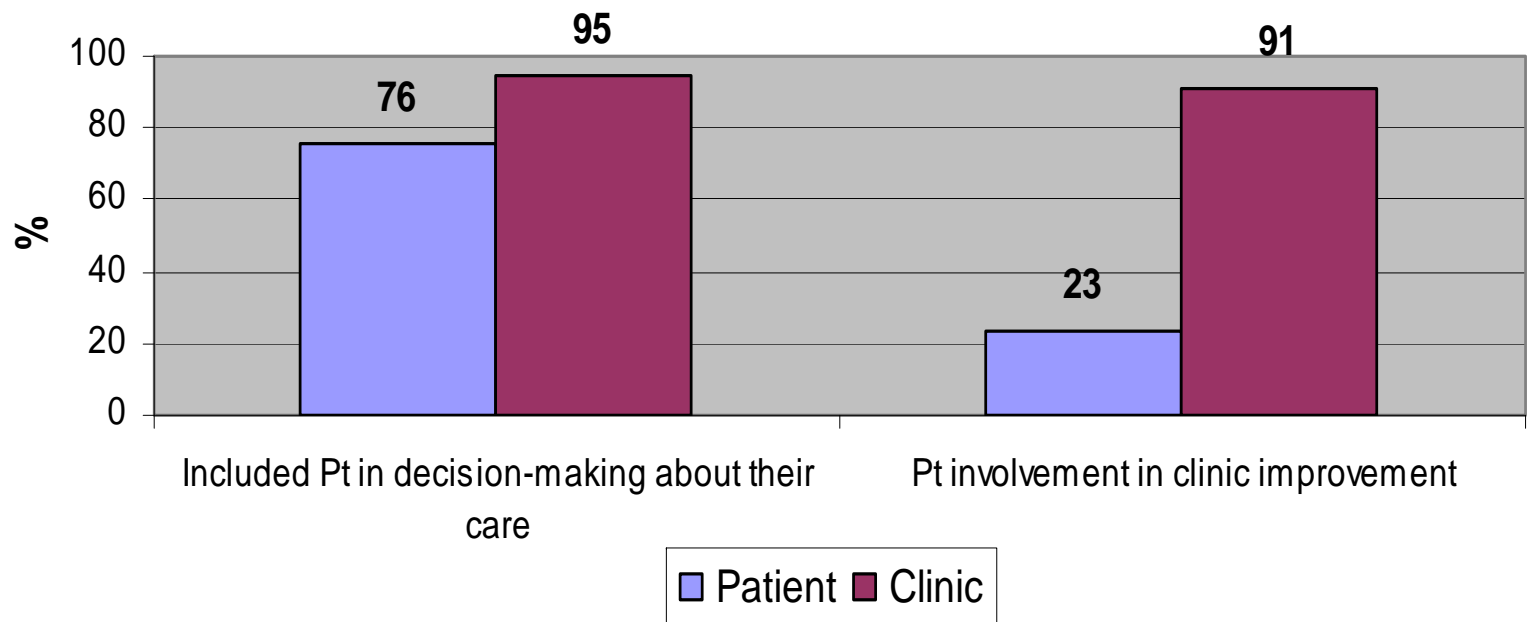
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- ★ The care coordinator and the participant determine whether the participant has any external care plans.
- ★ Together they create a comprehensive care plan with other members of the community team.
- ★ Such as, social services, mental health, home health, aging services, school services and many others.

# Capacity Assessment Survey: Do you feel like a partner in your care?

Patient/family involvement: Patient and Clinic Response  
MDH 2009 HCH Capacity Assessment



# Performance Reporting & Quality Improvement (QI) At Certification:

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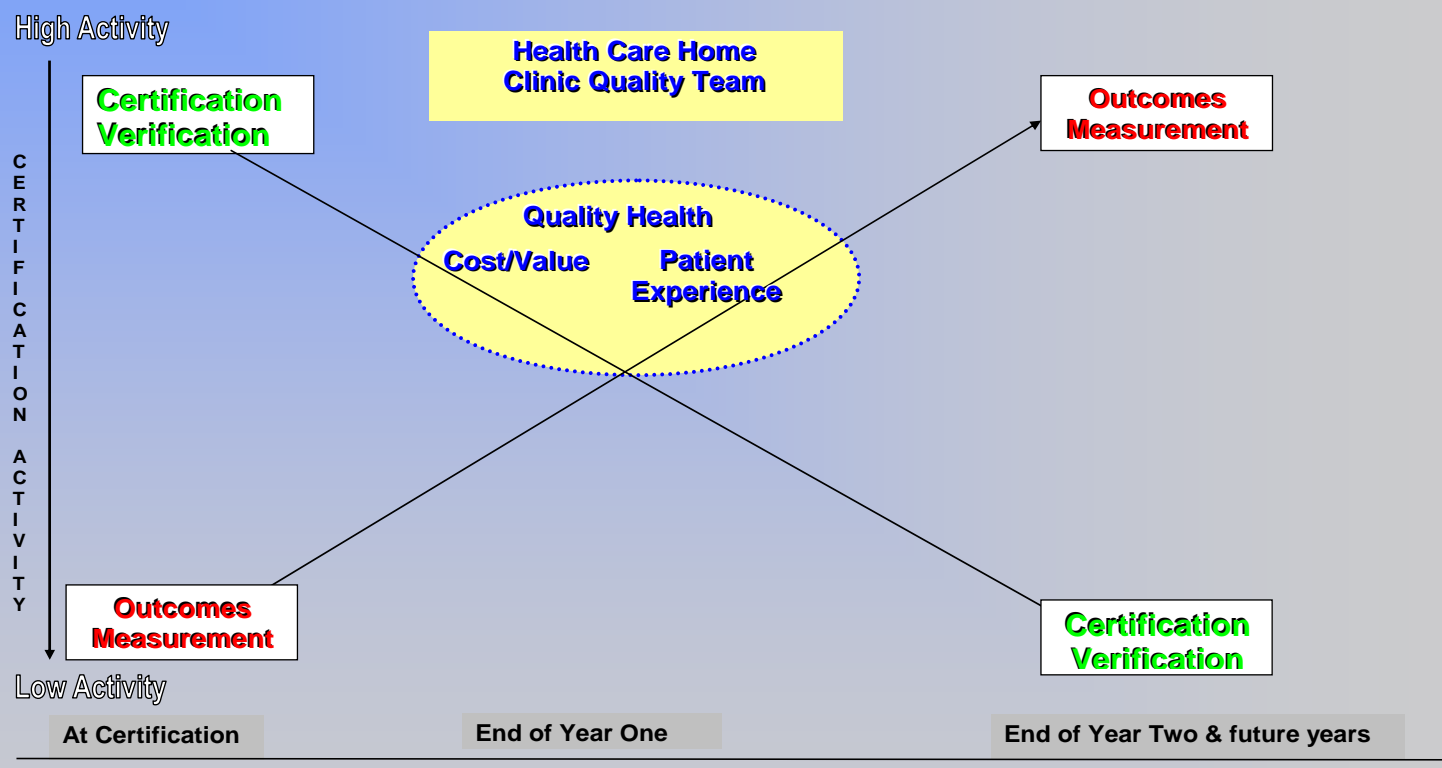
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- ★ QI processes are core to the health care home team.
- ★ There is measurement that includes analysis and tracking of at least one quality indicator.
- ★ There is meaningful involvement on the QI team by participants.

# Performance Reporting & Quality Improvement (QI) At Recertification:

- ★ HCH submits data to the statewide measurement reporting system.
- ★ The HCH selects a quality indicator for improvement in each of the quality outcomes areas; health, patient experience or cost / value.
- ★ Baselines are established for benchmarking at the end of year one.

# Health Care Homes Certification Measurement



**Certification Verification:**  
Process to verify clinic meets HCH certification standards

**Outcomes Measurement:**  
Measurement of improvement or decline in quality health, pt. experience or cost/value

HCH Certification Time Line



Minnesota Department of Human Services

# Learning Collaborative Participation

- ★ The HCH team participation in the learning collaborative reflects the structure of the organization and includes at minimum a HCH team clinician, care coordinator, manager and two or more participants at the clinic level.
- ★ Procedures are established by the HCH team to share information learned through the collaborative with other staff and participants in the HCH.

# Who Can Apply for HCH Certification?

An eligible provider is a physician, nurse practitioner or physician assistant that works as part of a team that takes responsibility for the patient's care and provides the full range of primary care services including:

- ★ first point of contact acute care
- ★ preventive care
- ★ chronic care

Providers are certified. A clinic is certified when all the clinic's providers meet the requirements for certification. An eligible provider works in a supported health care team structure.

# Certification as HCH is Voluntary

- ★ Certification requirements are met at certification, at the end of year one and annually thereafter.
- ★ A certified HCH meets all recertification requirements or applies for a variance for superior outcomes.
- ★ A variance may be granted for good cause or when failure to grant a variance would result in hardship.

# Minnesota's Vision for Health Care Homes: Opportunities and Challenges



## Transformational change in care delivery

- Changes in clinic / community infrastructure and culture
- Creation of a patient- and family-centered care system

## Measurement focused on “IHI Triple Aim”

Payment blends payments for services and coordination of care

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