

# MN Health Reform

In 2008 MN legislature passed health reform legislation that takes a comprehensive approach.

- Public health investment
- Market transparency
- Care redesign and payment reform
- Consumer engagement

# Health Care Home Initiative Components

## ***“Real Transformation”***

- Statewide certification process with Learning Collaborative support
- Creation of a patient- and family-centered care system

## ***“Real Reimbursement”***

- Multi-payer payment methodology

## ***“Real Results”***

- Measurement of “Triple Aim” outcomes with provider accountability

# Health Care Home Standards

- **Access:** facilitates consistent **communication** among the HCH and the patient and family, and provides the patient with **continuous access** to the patient's HCH
- **Registry:** uses an electronic, searchable **registry** that enables the HCH to identify gaps in patient care and manage health care services
- **Care coordination:** coordination of services that focuses on **patient and family-centered care**
- **Care plan:** for selected patients with a **chronic or complex** condition, that involves the patient and the patient's family in care planning
- **Continuous improvement:** in the **quality** of the patient's experience, health **outcomes**, cost-effectiveness of services

# Health Care Home learning activities underway!

- Regional workshops through out State
- Monthly webinars continue
- Payment methodology train the trainer
- ICSI is Learning Collaborative Vendor
  - Goal **1,300** participants in learning collaborative
  - Curriculum development peds / adults
  - Establish Learning Collaborative Leadership Committee

# Primary Care Delivery Redesign, What is different?

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

# What We Know About Care in Health Care Homes:

- **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

*Center for Medical Home Improvement*

# Patient Engagement

## Health Care Home

- Care coordination that focuses on patient and family centered care required in statute
- Evaluation and recertification includes patient satisfaction/ experience survey
- Statewide Learning Collaborative, spring 2011

## Families and Consumers

- Statewide HCH Consumer Family Council Advisory Board
- Participate on MDH site evaluation and certification committees
- Are interviewed as part of HCH certification process
- Active members on HCH clinic advisory committees and QI committees

# Legislative Requirements for HCH Care Coordination Payment

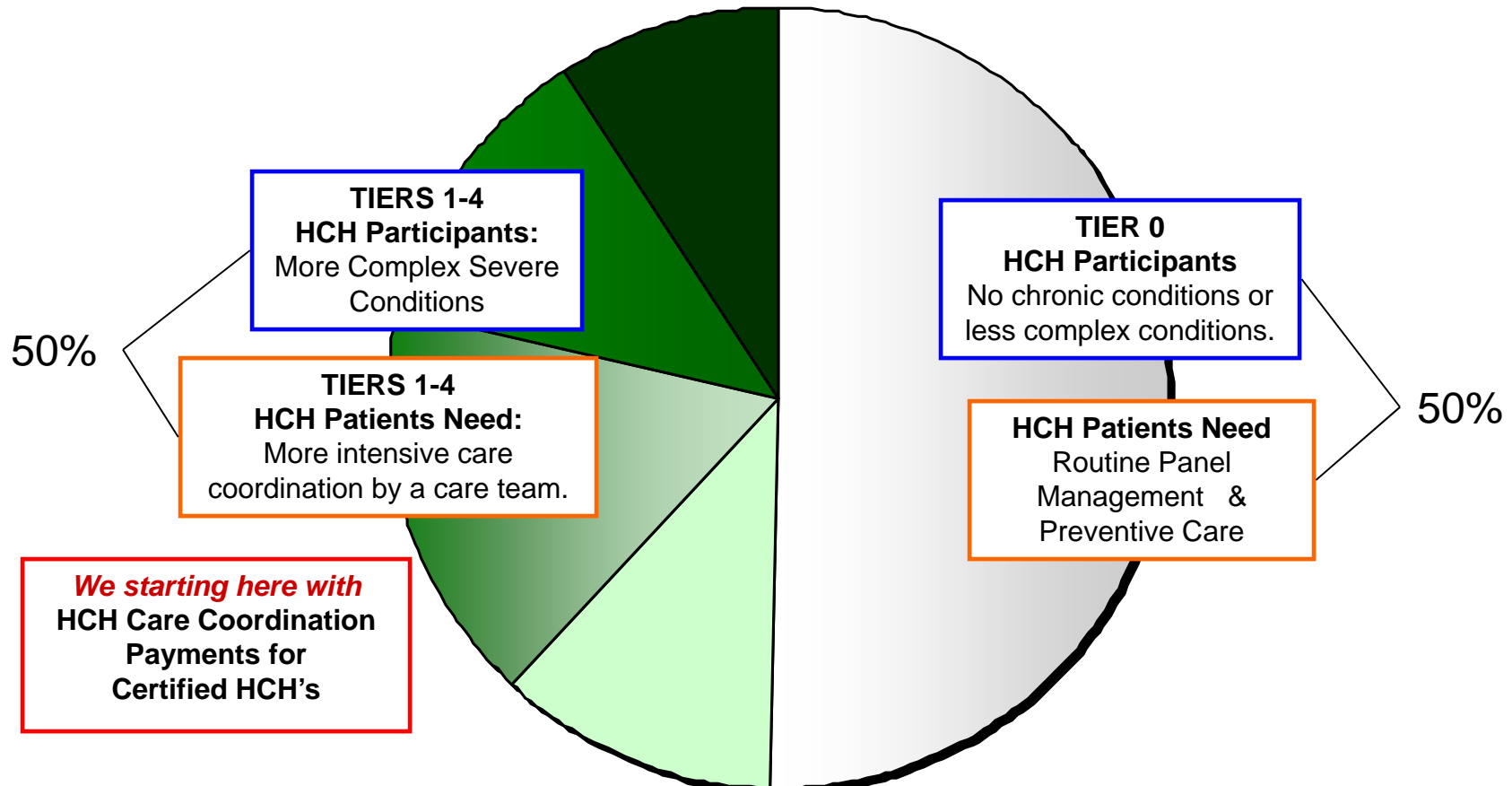
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- DHS and MDH develop a system of per-person care coordination payments to certified HCHs by January 1, 2010
- Fees vary by thresholds of patient complexity
- Agencies consider feasibility of including non-medical complexity information
- Implemented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

# Complexity Tiers

- Based on the number of condition groups (e.g. endocrine, cardiovascular) that providers identify as:
  - Chronic
  - Severe
  - Requiring a Care Team for Optimal Management

# HCH's Population



*We starting here with*  
**HCH Care Coordination Payments for Certified HCH's**

**HCH CERTIFICATION AND OUTCOMES MEASUREMENT**

# Outcomes Measurement Requirements

- HCHs must submit data to the statewide measurement reporting system
- Outcomes measures are based on the clinic's total certified population
- The commissioner announces annually:
  - HCH outcome measures
  - Benchmarks to determine whether a HCH has demonstrated sufficient progress
- These are determined through a community work group process.

# Improvement in Patient Health

The technical team recommended two quality measures:

## 1. Optimal vascular care

Low-Density Lipoprotein (LDL) cholesterol (less than 100 mg/dl)

Blood pressure control (less than 130/80 mm Hg)

Daily aspirin use as appropriate

Documented tobacco free

## 2. Optimal asthma care

Asthma is well controlled

Patient is not at increased risk of exacerbations

Patient has a current written asthma action/management plan

# Patient Experience and Cost Effectiveness

The measurement technical team recommended:

The use of the CG-CAHPS survey tool for patient experience measurement and transition to the PCMH-CAHPS tool when available

Cost effectiveness measures should focus on population-based health measures, e.g., avoidable hospital readmissions, ER visits, and hospitalizations.

# Health Care Home Activity: Multipayer Advance Primary Care Demonstration Program Sites Awarded in November 2010

Michigan

**Minnesota**

New York

North Carolina

Maine

Pennsylvania

Rhode Island

Vermont

# Health Care Home Activity: Consumer-Based Messages

- Conducted electronic survey and in-person focus groups with more than 700 patients and family members to inform and develop outreach messages for HCH
- Based on this information we created a consumer family friendly:
  - Descriptor (tagline)
  - Definition
  - Message Platform

# Certification Updates

**# Certified: Clinics: 90**

**# Certified Providers: 972**

**Patients Participating in certified clinics: 1,346,905**

# Clinics final stages: 46

# Providers 343

# Clinics early process: 15

# Providers: 165

- Applicants are from all over the State
- Variety of practice types such as solo, rural, urban, independent, community, FQHC and large organizations.
- All types of primary care providers are certified, family medicine, peds, internal med, med/peds and geriatrics.

***Thank you from your HCH team!***

Marie, Cherylee, Jan, DeAnn, Karen, Cheryl  
Sue, Nadine, Jean, Joan, Barbara  
Ross, Rachel, Muree, Dean

***Please contact us any time!***

• Web sites MDH/ DHS

- [www.health.state.mn.us/healthreform/homes/index.html](http://www.health.state.mn.us/healthreform/homes/index.html)
- [www.dhs.state.mn.us/healthcarehomes](http://www.dhs.state.mn.us/healthcarehomes)
- [Health.healthcarehomes@state.mn.us](mailto:Health.healthcarehomes@state.mn.us)



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Health Care Homes

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