





What is a Patient-Centered Medical Home? In Minnesota a Health Care Home


The Patient-Centered Medical Home is an approach to providing comprehensive primary care for children, youth and adults... that facilitates partnerships between individual patients, their personal physicians and when appropriate the patient's family ... and includes patients and families participating in quality improvement at the practice level ...



 *2007 Medical Home Consensus Statement by ACP, AAFP, AOA, and AAP*



Attributes of system redesign



- ★ An approach to providing primary care
 - Accessible
 - Continuous
 - Comprehensive
 - Family centered
 - Coordinated
 - Compassionate
 - Culturally effective



 *American Academy of Pediatrics* 

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

- ★ 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* 

Two foundational pieces of legislation

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



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



Legislative Requirements for HCH Care Coordination Payment

[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



Opportunity and Goals for HCH payment methodology

- Create alignment across the marketplace through transparent public development of the payment methodology
- Lay the groundwork for improved risk stratification
- Minimize duplication of administrative processes



In Minnesota a Health Care Home is defined as:

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.



2008 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



Health Care Homes Outcomes the Driver

IHI Triple AIM:

- * Improve the individual experience of care.
- * Improve the health of the population.
- * Contain the per capita cost of providing care.

HCH: Outcomes

- * Consumer / Patient Experience Outcomes
- * Health Outcomes
- * Cost / Utilization
- * System Outcomes



Future HCH certification based on outcomes, HCH report thru statewide data reporting system



National Standards: PCMH, Patient Centered Primary Care Collaborative:

Center for e-Health Information Adoption and Exchange Core principles:

- * Health data and information must be accessible to primary care medical home practices, physicians and patients.
- * Standards, protocols and rules for health data exchange on the network should be fully open and supportive of data portability and interoperability
- * Information technology will support the enhanced practice efficiency and quality of care that is required by the PCMH model
- * Confidentiality of data is imperative



National Standards: NCQA Recognition Standards, PPC-PCMH-CMS

Tier I, required, The practice



- * has patient tracking / registry functions that are electronic and searchable

Tier II, required, The practice:

- * has an electronic health record, certified by the Certification Commission for Healthcare Information Technology (CCHIT), that captures clinical patient information in searchable data fields as defined.
- * uses electronic information to generate lists of patients and take action to remind patients or clinicians proactively of services
- * uses an electronic system for E-Prescribing

Tier I, Electronic or Paper Based: The practice:

- * uses charting tools to organize and document clinical information in the medical record.
- * uses an electronic or paper-based system to identify population based diagnoses and conditions.






MN Capacity Assessment Survey

Total survey respondents: 373
Total clinics in MN: 707
Response rate: 52.76% 5/09

Patient Tracking and Registry Functions
Does your clinic have patient tracking and registry functions (electronic, searchable list of patient data to identify, track, and coordinate care) for the following?

Questions / Responses	Yes		No		Working to implement		I don't know	
	#	%	#	%	#	%	#	%
A patient database or registry to manage preventive care (e.g. mammography, colonoscopy, etc.)	257	68.9	47	12.6	66	17.6	3	0.8
A patient database or registry to manage chronic disease (e.g. diabetes, hypertension, etc.)	288	77.2	21	5.6	60	16.0	4	1.0
Secure email for your patients to communicate with the clinic/providers	96	25.7	197	52.8	77	20.6	3	0.8
Telemedicine for your patients	68	18.2	230	61.6	52	13.9	23	6.1

MN Capacity Assessment Survey



Total survey respondents: 373
Total clinics in MN: 707
Response rate: 52.76% 5/09

Does your clinic have a fully implemented electronic health record (EHR)?




Yes	253	67.8 %
No	119	32.0 %
I don't know	1	0.2 %

If "No" to the above question (n=119), is your clinic working to implement an EHR within 6 months?

Yes	70	58.8 %
No	47	39.5 %
I don't know	2	1.7 %
N/A	254	N/A

Minnesota's focus for HCH Patient / Family Centered Care EMR / EHR, components

Minnesota's HCH E-Health Perspective

- ★ Support interoperable electronic health record implementation as highly desirable but not a requirement for certification for now
- ★ Focus on successful implementation of electronic components / tools such as registries that directly support goals of care coordination
- ★ Prevent barriers to small and rural health clinics for certification / implementation of HCH
- ★ Minnesota has already legislated mandates in for interoperable health record implementation 2015 & e-prescribing by 2011



Health Care Homes 0040: Standards Categories:

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



Electronic technology is recommended to achieve efficient workflows in the health care home

Access:

- ★ patient / provider communication
- ★ Phone / scheduling technology
- ★ Secure email for patient and clinician consultations

Registries:

- ★ tracking / prevention of gaps

Care Coordination:

- ★ Enhances communication of results / email for patient questions
- ★ Interactive web capabilities

Care Planning:

- ★ Efficient summary tools
- ★ Use of evidence based guidelines

Quality Improvement:

- ★ data collection, outcomes measurement



Access and Communication Standards At Certification

The designated clinic staff, on-call provider or phone triage system representative has continuous access to participants' medical record information, which must include the following for each participant:

- ★ contact information, personal clinician's name and contact information, and designated enrollment in a health care home
- ★ racial or ethnic background, primary language, and preferred means of communication,
- ★ consents and restrictions regarding the release of medical information, including release of information to specific family members
- ★ diagnoses, allergies, medications related to chronic and complex conditions, and whether a care plan has been created for the participant

the designated clinic staff, on-call provider, or phone triage system representative who has continuous access to the medical record information will determine when scheduling an appointment for the patient...



Patient Tracking and Registry Functions Standards

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



Certification Assessment Tool:

Example: Patient Tracking and Registry Standard

Rule: uses a searchable, electronic registry to record participant information and track participant care...The registry must contain sufficient data elements to be capable of producing a report that reflects the gaps in care for specific subgroups of patients with a chronic or complex condition.

Verification:

- ★ The clinic defines the population of patients and data elements required for their registry.
- ★ Clinic develops a process on how the registry is used and a method which patients are identified and contacted.

Documentation:

- ★ Submit an example of clinic process and blinded example of the registry report.
- ★ At interview, clinic staff shows how the registry report is used
- ★ At the clinic leadership interview, leaders describe how the registry is used to support their quality goals.



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.



Health Care Home Opportunities and Challenges

- ★ Transformational change in care delivery
 - Changes in HIT infrastructure and culture
 - Creation of a patient and family centered health care system
- ★ Measurement must evaluate all three goals of the IHI Triple Aim
 - Measures will be developed concurrent with the program and refined over time
- ★ Payment must blend payments for services, coordination of care, and improved outcomes
 - Payment mechanisms will evolve



Health Care Homes

Jeff Schiff MD, MBA
Medical Director
Minnesota Health Care Programs
Department of Human Services
Jeff.Schiff@state.mn.us

Marie Maes-Voreis RN, BSN, MA
Health Care Homes, Program Manger
Minnesota Department of Health
Minnesota Department of Human Services
marie.maes-voreis@state.mn.us

Health Reform Web Site Link:
<http://www.health.state.mn.us/healthreform/index.html>

