

# An Overview of Health Care Homes in Minnesota

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## What is a health care home?

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.

The development of health care homes in Minnesota is driven by the Institute for Healthcare Improvement's Triple Aim, an initiative to simultaneously achieve the following goals:

- Improve the individual experience of care.
- Improve the health of the population.
- Improve affordability by containing the per capita cost of providing care.

## Background

**2007:** Minnesota passes first "medical home" legislation, called "provider directed care coordination," for patients with complex illness in the Medicaid fee-for-service population. (This is now called "primary care coordination.") More information is online at [www.dhs.state.mn.us/primarycarecoordination](http://www.dhs.state.mn.us/primarycarecoordination).

**2007:** The Governor's Health Care Transformation Task Force and Legislature's Health Care Access Commission both endorse medical homes.

**2008:** Health care reform legislation requires "health care homes" for all Medicaid, SCHIP, state employees and privately insured Minnesotans (statute 256B.0751).

## Minnesota's approach to health care homes

The health care home is a transformative change in the delivery of primary care. The design principles for health care homes in Minnesota focus broadly on the continuum of health and incorporate expectations for engagement of the patient, family and community. The health care home is a fundamental change in the patient-provider relationship augmented by financial structures and measurement of results. Expectations for transformative change must be sufficient to achieve these results. Among these expectations are:

- **Patient- and family-centered care** will be foundational to the health care home program in Minnesota. Patients/families/consumers will be involved in all aspects of program development.
- **Quality improvement teams** will be required at the practice level. A health care home will have an active practice-based quality improvement team that includes patients/families as equal team members.

- Participation in a **learning collaborative** to support and foster practice-level change is required.
- **Financial structures** must be aligned to promote this transformation and must include adequate risk adjustment for medical and non-medical complexity.
- **Recertification** is based on outcomes. Minnesota will be moving to an outcomes-based system in its recertification of health care homes. In the certification and recertification process, a balance will be sought between fidelity to the model (criteria) and flexibility for innovation. A goal of the program is to maximize clinic flexibility to achieve all of the outcomes.

### Steps in health care home program development

#### Foundational components

- Outcomes recommendations
- Capacity assessment – clinic and consumer
- Patient/family/consumer council

#### Program components

- Certification criteria
- Certification and recertification process
- Payment methodology
- Learning collaborative
- Outcome measurement

### Progress to date and upcoming activities

#### Foundational components

Building on local and national experiences, work is collaboratively organized by state government between the state departments of health and human services, with a strong emphasis on public-private collaboration. Work is being completed through a combination of grant contracts and state-organized processes.

- **Outcomes recommendations.** Outcomes were developed by a collaborative group led by the Institute for Clinical Systems Improvement. Developed at the start of the program, these outcomes will guide the development of specific measures. More information is available at <http://www.health.state.mn.us/healthreform/homes/documents/index.html>.
- **Capacity assessment.** A consortium of Minnesota primary care associations received a contract to do a capacity and readiness assessment. The final report from this assessment is available online at <http://www.health.state.mn.us/healthreform/homes/capacity/index.html>.
- **Patient/family/consumer council.** The council will support involvement by patients, families and consumers in all aspects of health care home development. The council includes members from or advocating for all ages, many disease-specific groups and many cultures. The council meets independently and participates in other health care home groups.



## Program components

### Health care home criteria

- Criteria were developed through a process that included open public meetings, facilitated discussions and expert input, involving patients, families and all sectors of the health care community. Minnesota collaborated with leading national criteria/standards organizations. Standards from this process have been developed into the health care home rule.
- There are five standards with measureable criteria that support each standard. The major categories for standards include:
  - Access/communication
  - Patient tracking and registry functions
  - Care coordination
  - Care plans
  - Performance reporting and quality improvement
- The proposed rule has been published for public comment and is currently in the final stages of development. It is available for review at <http://www.health.state.mn.us/healthreform/homes/standards/proposedrule.html>.

### Certification and recertification process

- Clinics can now submit a letter of intent to notify MDH of their intention to seek certification. Certification site visits will start when the health care home rule becomes final later this year. Recertification requires the demonstration of progress towards health care home outcomes. A certification process checklist with details to guide clinics through the certification process and the letter of intent is available at <http://www.health.state.mn.us/healthreform/homes/certification/index.html>

### Payment methodology

- A payment methodology steering committee has been created. Payment methodology is due to be completed by January 1, 2010. Primary care coordination payment methodology, approved by the Centers for Medicare and Medicaid Services, will be used as one of the starting points for health care home payment discussion. The statute requires stratification of care coordination payments by medical and non-medical complexity. More information is online at [www.dhs.state.mn.us/primarycarecoordination](http://www.dhs.state.mn.us/primarycarecoordination).
- A payment methodology technical development contract has been granted to the University of Minnesota School of Public Health.
- Payment methodology subgroups include:
  - Clinic and health plan processes for health care home payment
  - Patient risk stratification and payment architecture
  - Consumer/patient payment considerations.



### Learning collaborative

- Minnesota successfully completed a five-year Maternal Child Health Bureau/Minnesota Legislature-funded Medical Home Learning Collaborative in 2009 that included 24 practices and more than 7,000 patients and families. A report is currently online at <http://www.health.state.mn.us/healthreform/homes/collaborative/index.html>. Many of the lessons from this program have been incorporated into the current health care home program development.
- Wilder research has prepared a report on learning collaborative research and implementation models. A health care home learning collaborative kick-off education event is planned for later in October. Registration details are at <http://www.health.state.mn.us/healthreform/homes/events/index.html>.

### Outcome measures

- A measurement steering committee has been created. Measures will be structured within the framework of the outcomes recommendations and used for recertification.
- Measures will be integrated with Minnesota Community Measurement ([www.mncm.org](http://www.mncm.org)) work on quality transparency through the statewide reporting system.

### Resources

- A health care home resource committee comprised of professional and clinical groups from across the state is meeting to develop and recommend resource tools to support clinics throughout the implementation process. This group aims to provide widespread communication and linkages to clinics and clinicians across the state who are interested in implementing health care homes.

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