

# An Overview

## Background

A health care home, also known as a medical home, is an approach to health care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life. Coordination of care is a hallmark of health care homes.

The development of and payment for health care homes in Minnesota are part of Minnesota's nation-leading health reform law, passed in 2008. Health care homes (HCHs) are one piece of Minnesota's Vision for a Better State of Health. The aims of this vision are to reform our state's health care system – and transform our health – by improving the health of the population, the patient experience and the affordability of health care.

## Minnesota's vision for HCHs

In a health care home, patients and families are at the center of care. A team of health professionals works in partnership with patients and families to provide the best care.

Seeking opportunities for continuous improvement, a health care home will have a practice-level quality improvement team that will include patients and families as equal team members.

Care coordination is an essential part of health care homes. A care coordinator will make sure that all providers – including specialists – will share needed information about patients' health through patient tracking and care plans. Care coordinators can help patients manage their care.

## Developing HCHs in Minnesota

Minnesota's vision for health care homes includes both flexibility and breadth so that providers can successfully achieve the standards and outcomes. Minnesota's vision also includes public-private partnerships and input from a variety of stakeholders to help craft health care homes in the state.

Minnesota's Department of Health (MDH) and Department of Human Services (DHS) are collaborating to support clinics and clinicians in creating health care homes in the state. The health care home is both a redesign of care delivery and a payment reform.

There are a number of areas where work is being done to establish health care homes in Minnesota:

*Health care home standards and criteria*  
MDH and DHS have established five standards, each with measureable criteria. Major categories include:

- Access/communication
- Patient tracking and registry functions
- Care coordination
- Care plans
- Performance reporting and quality improvement

Criteria were developed through a process that included public meetings, facilitated discussions and input from local and national experts. Patients, families and members of the health care community participated. **The proposed rule for standards has been published for public comment and is in the final stages of development.**

### *Certification Process*

The certification process began in **September 2009**. Information about the process is available at <http://www.health.state.mn.us/healthreform/homes/certification/index.html>.

Applying for certification starts with the submission of a letter of intent. Providers who have or are in the process of meeting the health care home standards may now submit a letter of intent online. Future steps will be available soon, including a full online application and site visits. Certified health care homes will be eligible for care coordination payments.

### *Payment methodology*

The payment methodology for the new per-person care coordination payment will include adequate risk adjustment for medical and non-medical complexity. A steering committee is meeting to develop the payment methodology by **January 1, 2010**. Subgroups include:

- Clinic and health plan processes for health care home payment
- Patient risk stratification and payment architecture
- Consumer/patient payment considerations

Care coordination payments begin **July 1, 2010**.

### *Outcomes measurement*

Minnesota will be moving to an outcomes-based system of recertification. A steering committee is developing health care home measures. Measures will be integrated with Minnesota Community Measurement ([www.mncm.org](http://www.mncm.org)) work on quality transparency through the statewide reporting system.

The framework for outcomes was developed by a collaborative group led by the Institute for Clinical Systems Improvement. Those recommendations are available at <http://www.health.state.mn.us/healthreform/homes/documents>.

### *Learning collaborative*

MDH is developing a statewide learning collaborative to provide an opportunity for health care homes to share information and support each other. Certified health care homes are required to participate in the learning collaborative.

**The learning collaborative is expected to launch in early 2010.** A report evaluating collaborative learning methods is available at <http://www.health.state.mn.us/healthreform/homes/collaborative>.

### *Education and resources*

General information about health care homes and additional resources are available at <http://www.health.state.mn.us/healthreform/homes/education/index.html>.

Educational materials have been developed in part as a response to needs identified during a clinic and consumer readiness assessment performed in summer 2009 by a consortium of primary care associations. A report on that assessment is available at <http://www.health.state.mn.us/healthreform/homes/capacity>.

### *Patient and family consumer council*

To ensure that patients, families and consumers are involved in all aspects of health care home development, MDH has convened a volunteer patient/family/consumer council that advises the department. The council includes members from or advocating for all ages, many disease-specific groups and many cultures.

