

Information for Providers

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.

For more information about Minnesota's Vision and the health reform initiative, please go to www.health.state.mn.us/healthreform.

Minnesota's Department of Health (MDH) and Department of Human Services (DHS) are collaborating to help clinics and clinicians develop HCHs in the state. Both departments are also working with other private and public partners.

What will HCHs mean for providers?

HCHs are a change in the way care is delivered and accessed, building on primary care and the importance of your relationship with your patients. HCHs focus on care coordination, team care, evidence-based medicine and patient- and family-centered care. You may already be incorporating some of these HCH features in your practice.

Certification standards help define ways for clinics to deliver care that is more coordinated and offer better access. Standards also outline ways to track patients and report outcomes. In a HCH:

- You and the other clinicians and staff at your clinic will work as a team, and each of you will be able to do the work you do best.
- Your focus can be on meeting your patients' health care needs in the best possible way. The HCH team is both coordinated and integrated, so that you can more effectively communicate and coordinate with other clinicians, specialists, patients and families.
- You can work in partnership with your patients and their families. The HCH team develops a proactive care plan with patients and families when appropriate.

Is certification as a HCH required?

Certification as a HCH is voluntary, but only certified HCHs are eligible to receive the care coordination payment. Recertification will be done annually. Specific requirements must be met at certification and annually thereafter. Variances may be granted for good cause.

The proposed rule with the standards for certification is available for review at <http://www.health.state.mn.us/healthreform/homes/standards/proposedrule.html>.

Who can apply for HCH certification?

Individual providers or the clinic can be certified. To be eligible, a provider must be a physician, nurse practitioner or physician assistant who works as part of a team that takes responsibility for coordinating the whole spectrum of the patient's care. Eligible providers must offer or coordinate a full range of primary care services:

- First point of contact acute care
- Preventive care
- Chronic care

An entire clinic can be certified when all of its providers meet the certification requirements.

How does the certification process work?

When you have met the HCH standards and feel you are ready to apply, you can begin the certification process.

- A certification process checklist with details to guide you through the process is available at <http://www.health.state.mn.us/healthreform/homes/certification>.
- You can use the tools there to assess your readiness to become certified as a HCH. You can find out what elements of the HCH model you are already doing well – and where you might need some improvement in order to be certified.
- When you are ready to begin the certification process, you can submit an online letter of intent. Instructions and additional information about this first step are available on the certification Web page.
- Additional steps will be available soon, including a full online application. Site visits will be scheduled at a mutually convenient time and will offer an opportunity to provide the certification team with additional information about your clinic or practice.

How will the care coordination payment work?

Certified HCHs will receive a per member per month care coordination payment. The payment methodology is currently being developed by a steering committee and must be completed by January 1, 2010. Payments will begin on July 1, 2010. The payment methodology will include risk adjustment for medical and non-medical complexity.

Are there quality improvement guidelines for HCHs?

Certified HCHs must submit outcomes data to the statewide reporting system for HCH outcomes measures that are announced annually by the Commissioners of Health and Human Services. Those measures are being identified by a community advisory group. Over time, HCHs must meet the benchmarks for improvements of outcome in order to be recertified.

A HCH will also have an active clinic-based quality improvement team that includes patients and families as team members.

What support is there for teams seeking certification?

MDH is developing the learning collaborative for HCHs, which is expected to launch in early 2010. The learning collaborative is an opportunity for health care homes to share information and support each other.

Certified HCHs will be required to participate in the learning collaborative. Providers or clinics can join the learning collaborative at any time while they are preparing to become certified. A report evaluating collaborative learning methods is available at <http://www.health.state.mn.us/healthreform/homes/collaborative>.

Where can I find additional information and resources?

Resources and information about HCHs are available at <http://www.health.state.mn.us/healthreform/homes/education/index.html>.