

# Minnesota Health Care Home

## Overview

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 establish 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.

## 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. The health care home is both a redesign of care delivery (patient-centered and team-based) and payment reform. 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 2008 health reform law. Health care homes (HCHs) are one piece of Minnesota's Vision for a Better State of Health. The "Triple Aim" of this vision is to reform our state's health care system – and transform our health – by improving the health of the population, the patient experience of care and the affordability of health care. The practice redesign that comes with the transformation to a health care home can benefit all patients, whether they have chronic or complex conditions or are relatively healthy.



## Minnesota's Vision for HCHs

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

HCH team will make sure that all providers – including specialists – share needed information about patients' health through patient tracking and care plans. Care coordinators help patients set goals and be active partners in managing their care.

In order to continuously improve, a health care home also has a practice-level quality improvement team that includes patients and families as equal team members.

## Health Care Home Standards

The HCH rule that took effect in January 2010 establishes five major standards, each with measurable criteria. These include:

- Access/communication
- Patient tracking and registry functions
- Care Coordination
- Care plans
- Performance reporting and Quality Improvement

## Certification Process:

The certification process started on July 1, 2010. Based on this certification process there have been 393 clinics certified overall.

For a current [list of certified health care homes](http://www.health.state.mn.us/healthreform/homes/hchmap/index.html) <http://www.health.state.mn.us/healthreform/homes/hchmap/index.html>

## Payment Methodology

The payment methodology for per-person care coordination includes adequate risk adjustment for medical and non-medical complexity. A complexity tier assignment tool developed jointly by DHS and MDH is available <http://www.health.state.mn.us/healthreform/homes/payment/index.html>. Care coordination payments began July 1, 2010.

## Outcomes Measurement

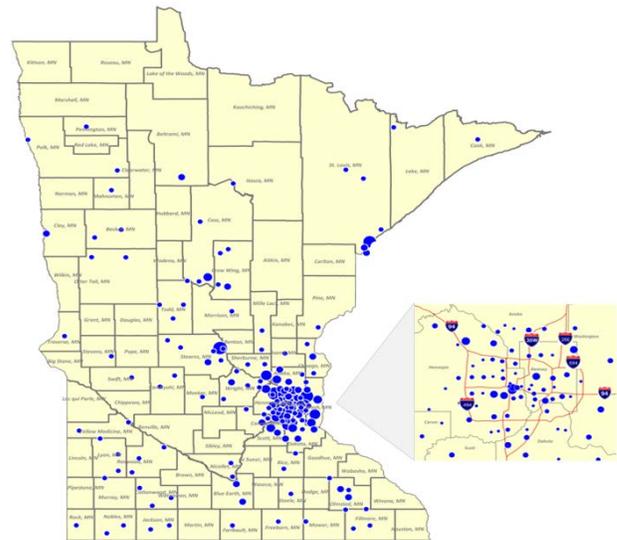
Robust quality measurement is a cornerstone of the health care homes initiative. A public-private stakeholder group provided recommendations for a Health Care Home Outcome Measurement System. Data submitted is used for benchmarking, recertification and overall evaluation of the health care homes program. Approved measures include:

### Patient Health:

- Optimal vascular care (OVC)
- Optimal asthma care (OAC)
- Depression Readmission at 6 months
- Optimal Diabetes Care
- Colorectal Cancer Screening
- Patient experience: The [MN Health Care Homes Patient Experience Survey: Implications of Moving from CG-CAHPS Visit to PCMH](#) was completed July 30, 2013.

### • Resources

- Educational materials, webinars, and general information about health care homes and additional resources are [available at: http://www.health.state.mn.us/healthreform/homes/resources/index.html](http://www.health.state.mn.us/healthreform/homes/resources/index.html)



## Learning Collaborative

The HCH statewide learning collaborative provides opportunities for health care homes and state agencies to exchange information and enhance understanding related to quality improvement and best practices. Certified health care homes are required to participate in the HCH learning collaborative initiatives. Learning collaborative activities are available for both certified and not certified clinics/clinicians. For further information:

<http://www.health.state.mn.us/healthreform/homes/collaborative/lcindex.html>

## HCH Advisory Committee

An advisory group made up of HCH practitioners, stakeholders and consumers was enacted into Legislation in 2014. This group will advise the commissioners of Health and Human Services on future development of the program in Minnesota. The committee will meet quarterly beginning in Spring 2015.