

Health Care Homes Model Progression

PROPOSED FRAMEWORK AND RULE CHANGE

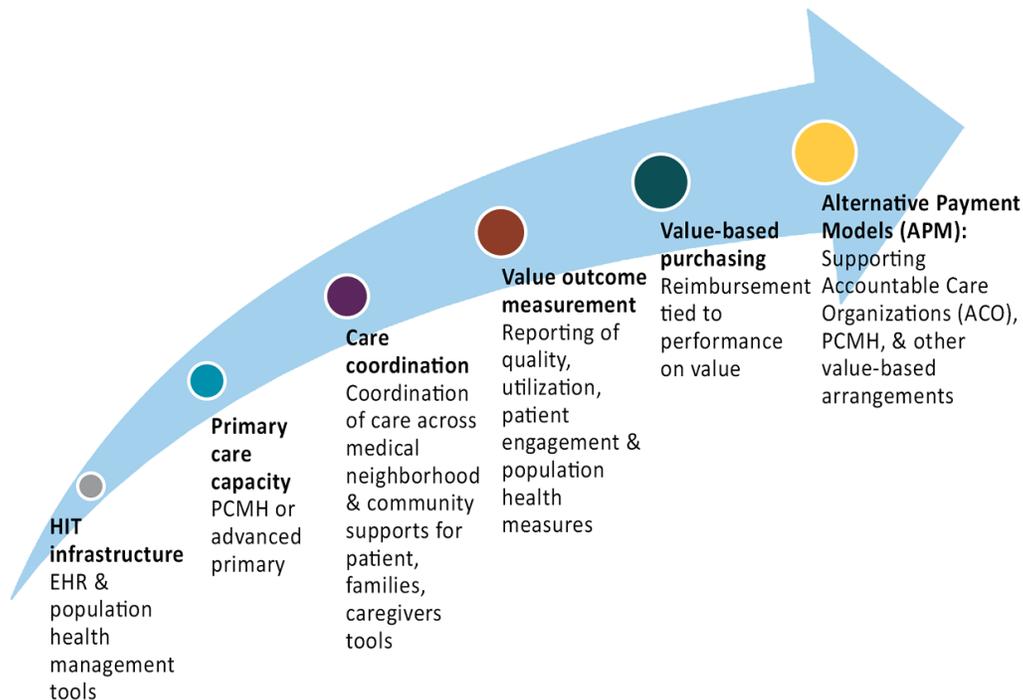
Background

The Health Care Homes (HCH) program began in 2008 as a part of a broader health reform initiative to transform patient clinical care through team-based, patient-centered care and innovative payment models. HCH uses voluntary certification, combined with learning and support, to drive quality and transformation in a majority of Minnesota’s primary care clinics. The HCH model has succeeded in transforming patient care¹ while delivering significant cost savings to the system².

Why action is needed now

Value-based Care. The landscape for health care payment and delivery is changing rapidly and HCH must keep pace with changes to continue momentum in health reform and primary care transformation. Payment models are becoming increasingly value based. A foundational infrastructure that provides accessible, effective, team-based coordinated care within a health care system is essential to successful participation in these models.

Trajectory to Value-based Purchasing: Patient-centered medical home (PCMH) part of a larger framework³



¹ State Health Access Data Assistance Center (SHADAC), September 2017. Evaluation of the Minnesota Accountable Health Model. University of Minnesota School of Public Health.

² Wholey DR, Finch M, et. al., December 2015. Evaluation of the State of Minnesota’s Health Care Homes Initiative Evaluation Report for Years 2010-2014. University of Minnesota School of Public Health.

³ THINC – Taconic Health Information Network and Community. Accessed 11/16/2017
http://www.ehcca.com/presentations/macrasummit/nielsen_ms2.pdf

Community & Population Health. A broader focus that includes community and regional partnerships in the HCH standards is an important strategy for advancing population health and improving the quality of whole person care.

Social Determinants of Health. Medical care alone affects only about 20 percent of what creates health. Social determinants of health such as education, income, housing, and transportation have a larger influence. The rule needs updating to acknowledge broader trends in health care delivery that include management of social determinants of health.

Health Equity. Disparities based on race, geography, and economic status have a negative effect on health. Health equity is a systems-level issue, with policies and processes designed in such a way that certain groups in Minnesota are disadvantaged with regards to factors such as access to care and health literacy, to name just a few. Changes to the HCH rule offer an opportunity for a more explicit focus on health equity.

Stakeholder support. This plan has broad community support and builds on key stakeholder input. HCH will support Minnesota primary care clinicians and community partners in transforming the health care delivery system with clear standards, tools, and resources that align with other initiatives at the state and federal levels.

Progression Goals

1. Strengthen clinic-community linkages and population health efforts
 - a. Integration of care with local public health, social services, behavioral health, oral health, specialists
 - b. Address social determinants of health and health equity
 - c. Strengthen clinic role in community health
 - d. Expand care team
2. Assist clinics in preparing for value-based care
 - a. Enhance measurement of HCH outcomes
 - b. Work with payers to advise on best payment models for clinics
 - c. Align with MACRA (Medicare Access and CHIP Reauthorization Act of 2015), other payment models
3. Support health information exchange (HIE) to improve data sharing and alignment with state goals
 - a. Use lessons learned from MN Accountable Health Model – State Innovation Model grant (SIM)
 - b. Support clinics in sharing and using data
 - c. Collaborate with MDH Office of Health Information Technology
4. Align with existing and emerging models of care delivery
 - a. Examine other models for progression criteria
 - b. Clarify and strengthen standards on social determinants of health, health equity
 - c. Support clinic alignment with other models
5. Primary care clinics achieve and maintain certification at one of three levels
 - a. Seek input from non-certified clinics on barriers
 - b. Evaluate requirements for needed change and flexibility
 - c. Provide technical assistance and learning opportunities

Proposed Framework

The Health Care Homes proposed new framework builds on the current HCH certification and adds levels of progression. Certified clinics could choose to remain in their current level if they continued to meet required criteria, and would not have to advance beyond the foundational standards and certification structure. A certified health care home could elect to change levels within the 3-year recertification period if they met requirements.

Participation in the Health Care Homes program would remain voluntary and free. Clinics have identified this feature of a state-sponsored program as an important incentive for embarking on a certification process, in addition to HCH Learning Collaborative support and technical assistance provided by program staff.

Progressing levels of certification recognize an organization's increasing capacity to take on value based care and successfully participate in those payment arrangements. Clinics choosing to seek certification as a Health Care Home cite the benefits of certified status as a "seal of approval" in marketing their services. Additional levels could add to a perception of higher distinction.

HCH Level 1 (Current Standards)

The foundational level of certification focuses on building team-based patient-centered care that helps individuals achieve coordinated care within the clinic and among specialty providers.

HCH Level 2

Broadens the focus for individuals and attributed clinic populations to improve processes that affect whole person care such as addressing social determinants of health, wellness, and early prevention; and strengthening partnerships across the medical neighborhood and community support system.

HCH Level 3

Further broadens the focus to include population health with emphasis on integrating community health efforts, developing shared responsibility for health, using data, and sharing care management.

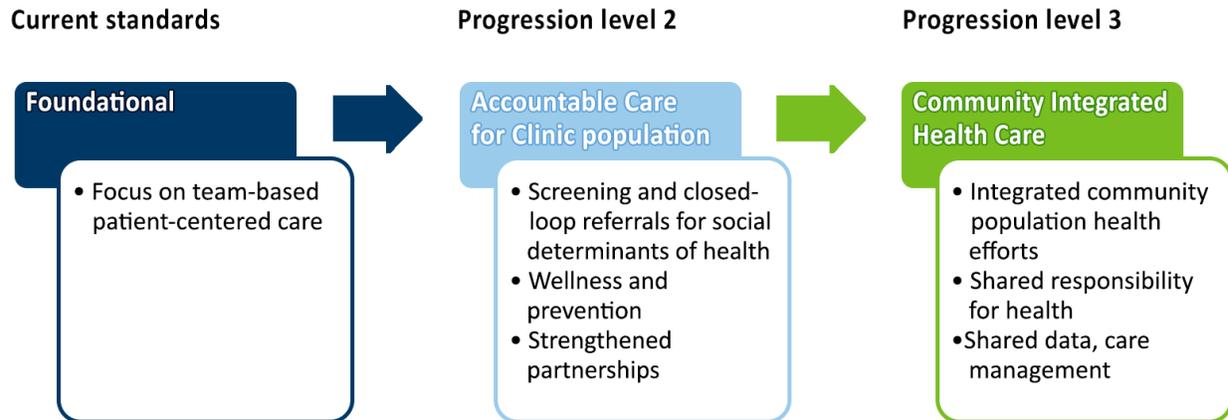
Framework Features

- Certification remains voluntary and free
- Multiple levels of certification
 - Current certification is foundational
 - Two additional levels build on current standards
- Clinics enter at level appropriate for them
- No requirement to advance
- Can choose to change within 3-year recertification period

"Like to see gradient levels of health care home certification. ... System should demo comprehensiveness and choose level they want to achieve. Doesn't need to have points or complexity – just recognition for achievement / recognition of the progression of the foundational standards."

Program Innovation Workgroup Member

HCH Progression Framework



What has HCH done to date to advance the model?

- Conducted stakeholder outreach
 - Request For Information
 - Community meetings
 - Clinic/stakeholder meetings
- Consulted with HCH Advisory Committee and Workgroups
- Researched state and national patient-centered medical home, accountable communities for health models
- Incorporated learnings from the Minnesota Accountable Health Model – State Innovation Model grant
- Solicited input from state partners
- Convened Rule Advisory Committee and started rulemaking process

Next Steps

Public and stakeholder input through the rulemaking process
HCH Advisory Committee and Workgroups input
Continued meetings with stakeholders

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<https://www.health.state.mn.us/facilities/hchomes/rulerevision/index.html>

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