DEPARTMENT OF HEALTH

Health Care Homes Model Progression

PROPOSED FRAMEWORK AND RULE CHANGE 2018

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. A collaboration between the MN Department of Human Services and the MN Department of Health, HCH has used voluntary certification, combined with technical assistance and structured learning opportunities, to drive quality and transformation in a majority of Minnesota's primary care clinics. The HCH model has succeeded on transforming patient care[1] while delivering significant cost savings to the system[2]

As part of the recent four-year State Innovation Model (SIM) grant program funded through the Centers for Medicare and Medicaid Innovation to improve health in communities, provide better care, and lower costs, HCH clinics have gained additional tools and resources necessary to become integrated into a community model of health care that includes behavioral, public health, social services, and other community partners sharing responsibility to keep people and communities healthy. As the SIM project draws to a close, the community partnerships developed and lessons learned provide a foundation for continuing to improve upon a successful model of community-centered care and to align with the goals of Minnesota's Integrated Health Partnership model and national quality improvement initiatives such as MACRA[3].

This document outlines program and rule changes (Ch. 4764) to the Health Care Homes program to reflect the evolution of the program and the health care reform environment since 2009.

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[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] Centers for Medicare and Medicaid Services. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html Accessed 11/14/2017.

Why action is needed now

Value-based care

In Minnesota and nationally, the landscape for health care payment and delivery is changing very rapidly, and it is important that the HCH program keep pace with these changes in order to continue momentum in health reform and HCH primary care transformation. Payment models are becoming increasingly value based. A foundational infrastructure that provides accessible, effective, team-based integrated care within a health care system is essential to successful participation in these models. The Joint Principles of ACOs[4] states that primary care should be the foundation of any ACO and the recognized patient and/or family-centered medical home (i.e. HCHs in Minnesota) is the model that all ACOs should adopt for building their primary care base. The Vermont Blueprint for Health[5] initiative has medical homes at the foundation of regional community health teams across the state.

Community and population health

Incorporating a broader focus on social determinants, community/regional partnerships, and ACHs in the current HCH standards are important strategies for advancing population health, achieving health equity, and improving the quality of whole person care. Strengthening care coordination and use of secure health information exchange enhances a provider's ability to deliver safe and efficient care based on timely and accurate information. Enhanced HCH standards have the potential to influence how care is delivered throughout the state by primary care, local public health, DHS, payers, social services, and community organizations. Current HCH certification standards do not adequately address the need for improving community partnership and population health. Current HCH certification standards do not adequately address the need for improving community partnership and population health.

Health equity

MDH is committed to addressing health disparities and improving health equity. As is widely understood, disparities and inequity are more common among populations of color and the disability community. Patient-centered, culturally responsive care is a foundational requirement of the HCH program, as is patient engagement. HCH certified clinics include Federally Qualified Health Centers, independent medical groups, hospital based clinics, and large integrated groups serving diverse clinic populations and patients with social and physical complexity. These providers have been and will continue to be significant in shaping the evolution of the HCH program, and are supportive of finding ways to support clinics and their partners in addressing health equity and social determinants of health.

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[4] https://www.acponline.org/acp_policy/policies/joint_principles_accountable_care_organizations_2010.pdf
[5] http://blueprintforhealth.vermont.gov/

Stakeholder support

This plan has broad community support and builds on key stakeholder input. Minnesota primary care clinicians and community partners will be supported in transforming the health care delivery system with clear standards, tools, and resources that align with other initiatives at the state and federal levels. All Minnesotans will benefit from health care and community integration through improved care coordination to meet whole person needs. Through a shared responsibility around community health, Minnesotans will be cared for in the context of where they live. Communities can address identified needs, build capacity, and make improvements to health that individual sectors of the health care system cannot achieve alone.

Health Care Homes Model Progression: Program Goals

Strengthen clinic-community linkages, population health, and health equity

Program enhancements are needed to support HCHs in "expanding our understanding of what creates health" and "strengthening the capacity of communities to create their own healthy futures", two of the three elements of the Triple Aim of health equity. Changes to the current standards are intended to encourage care beyond clinic walls and promote integration of care with local public health, social service organizations, and other health care providers such as mental health and specialists, to improve efficacy and coordination in the system and the ability to address social determinants and whole person care, and to strengthen the role of clinics in sharing responsibility for community health. Further, standards to integrate emerging health professions, including community health workers and community paramedics, into the HCH and community care team are missing from the current HCH framework and are critical to a successful community health model that addresses clinician burnout and workforce shortage issues.

Assist clinics in preparing for value-based care

In Minnesota and nationally, the landscape for health care payment and delivery is changing very rapidly and increasingly value-based. The HCH program must keep pace with these changes to sustain a statewide infrastructure of primary care and prepare Minnesota clinicians for entering into value-based payment arrangements. Enhancements to the HCH standards will recognize the advancing work and increasing capacity of clinics to do this work.

Support health information exchange to improve data sharing and align with state goals

With a growing emphasis on community-centered/integrated care, there has been significant recognition of the importance of exchanging clinical data between providers. SIM has identified opportunities and strategies for better data sharing and analysis among community providers. Supporting HCH clinics in sharing and effectively utilizing data is a critical piece of both patient-

and population- health strategies to improve the safety and efficacy of care and reduce fragmentation.

Align with existing and emerging models of care delivery

Other patient centered medical home (PCMH) programs (NCQA, etc.) are changing their recognition process to keep up with evolving system changes including behavioral and oral health integration, social determinants of health screening and referral, coordination with community supports and services, and equitable access. The HCH standards framework must be updated to align with other programs and standards.

Primary care clinics achieve and maintain certification at one of three levels

While Minnesota clinics have provided positive feedback on the benefits of HCH certification and the provision of team-based, innovative care for patients, some have also reported the current process for obtaining Health Care Home certification or recertification has at times placed unnecessary burden on staff and clinic resources. Certification and recertification requirements need to be evaluated to ensure that they are not unnecessarily burdensome, including identifying opportunities to streamline administrative processes and areas of potential alignment/duplication with other requirements (i.e. SQRMS, IHPs, Quality Payment Program). Requirements also need to be reviewed for adequate flexibility to ensure clinics of varying resources can successfully achieve certification/recertification while balancing accountability of care delivery within the HCH model. Learning and technical assistance will continue to be essential to supporting HCHs and will need to be considered in program enhancements.

Health Care Homes 2.0: Proposed progression framework

Certification remains voluntary and free

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 the HCH Learning Collaborative support and technical assistance provided by the Health Care Homes program staff. Clinics that have already achieved certification have cited the many benefits of participating with a network of peers and availability of technical assistance and resources.

Multiple levels of certification

The new Health Care Homes proposed framework builds on the current HCH certification and added levels of progression. Two additional levels of progression described in the table would be added to the current HCH certification, with clinics/organizations choosing to enter at the level appropriate for their organization.

Certified clinics could choose to remain in their current level if they continued to meet required criteria, and would not be required to advance beyond the foundational standards/structure. A certified health care home could elect to change levels within the certification period (three years) if they met the requirements.

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. The opportunity for recognition at additional levels is seen as adding to a perception of higher distinction.

Health Care Home Level 1 (Current Standards)

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

Health Care Home Level 2

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

Health Care Home Level 3

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

See Table below for detail.

Health Care Home Level 1 Foundational	Health Care Home Level 2 Accountable Care for Populations	Health Care Home Level 3 Community Integrated Health Care
Current Standards	Builds upon Foundational Level	Builds upon Foundational and Level 2

• Clarify definitions and language
• Update recertification timeline to match legislative change
	• Strengthen care coordination systems and partnerships across the medical neighborhood and community support system
	• Enhance whole person integrated care models (behavioral/mental health, oral health, public health)
	• Promote wellness, early intervention, and prevention
	• Strengthen patient and caregiver engagement
	• Screen, identify and address social determinants
	• Expand registry work to include identification of health inequities and social needs, chronic conditions, and those with emerging risk for chronic conditions
	• Augment cultural competency
	• Enhance access
	• Enhance referral network to include traditional and non-traditional resources
	• Identify patient education opportunities
	• Strengthen follow-up with referrals, admissions, discharges, transfers
		• Integrate into a community health network
		• Focus on population and community health
		• High and continuously improving quality through a learning health system
		• Focus on community health improvement;
		  o Healthy community investment
		  o Community health capacity development through multi-sector collaboration
		  o Community and health resource integration
		  o Community engagement and shared responsibility
		• Use data analytics to collaborate on community health data
		• Expand care coordination team to community
		• Secure exchange of information with clinical and community partners
		• Develop shared care management processes

Stakeholder input and development

Community meetings and outreach

The process for vetting the future path for HCH began in 2016 with a request for information and a series of community meetings that generated input from individuals and organizations across the state. Work has been further informed by input from the HCH Advisory Committee and workgroups, DHS partners, certified and non-certified clinics, state and federal policymakers, health care, and public health stakeholders, as well as by lessons learned from the 15 Accountable Communities for Health, recommendations from the Governor's Health Care Financing Task Force (HCFTF), and the Minnesota Olmstead Plan. Overall, providers, professional associations, and community partners have expressed support for the proposed path forward and provided input on the types of support needed for success.

Health Care Homes Advisory Committee

The statewide HCH Advisory Committee, created under legislative authority in 2014, advises MDH and DHS overseeing the development of the HCH program, participating in and learning from the State Innovation Model grant initiative, and developing strategic goals for the future. Members of the Advisory Committee include consumers, health care professionals, employers, researchers, health plan representatives, HCH clinics, a quality improvement organization, and a state agency. Over the past year, five Advisory Committee workgroups addressed key priority areas:

- Program Innovation
- Financial Sustainability
- Learning and Technical Assistance
- Partnerships and Communication
- Measurement and Evaluation

The **Program Innovation (PI) workgroup** of the advisory committee has focused on ways to improve the standards and to recognize advanced levels of clinic and organization performance as patient centered medical homes. The PI workgroup's 23-person membership represents DHS, independent, safety net, medium and large clinics, community organizations, consumers, researchers, and quality organizations.

Research of other state and national models

In addition to stakeholder input, HCH staff performed an extensive search of other state and national patient centered medical home and accountable communities for health models to identify best and emerging practices. HCH staff also completed a literature search to inform advancement of the standards on the following topic areas:

- Practice transformation
- Health equity
- Population health
- Community partnerships
- Care coordination

Input from state partners

The quality delivery of primary care is a component to successfully achieving the work of other state programs, including MDH's Statewide Health Improvement, Community Wellness Grant, Office of Health Information Technology, Public Health Practice, and Office of Rural Health and Primary Care and DHS's Integrated Health Partnerships and Behavioral Health Homes. The framework to advance the HCH standards was further informed and vetted through coordinated work across these areas.

Next steps

Opportunities for further input on this work as it develops include:

- Public and stakeholder input through the rulemaking process
- HCH Advisory Committee and workgroup meetings
- Continued meetings with stakeholders
- DHS input and involvement

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