

MINNESOTA'S VISION

A Better State of Health

*Health Care
Homes* | HCH



Defining Medical Home

- The American Academy of Pediatrics introduced the medical home concept in 1967.
- Further describing it in 2002 as a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

Patient-and family- centered care as one of our core principles!



2007 Medical Home Consensus Statement by ACP, AAFP, AOA, & AAP

The Patient-Centered Medical Home is an approach to providing comprehensive primary care for children, youth and adults... that facilitates *partnerships* between individual patients, their personal physicians and when appropriate the patient's family ... and includes patients and families participating in quality improvement at the practice level ...

Working together to develop new *partnerships* as a new team with patients and families as members

Medical Home, Is satisfying for patients, families, providers and clinic staff!



Minnesota's History of Medical Home Development

- 1995: Title V/Part C Funded MN-AAP effort to increase awareness of medical home among pediatricians
- 1996: Universal children's Benefit Set-State Health Care reform
- 1999: Safe at Home *Partnership* grant-MCHB
- 2001-AAP National Medical Conference, Hawaii (promise to the state)

Our *partners* listened to each other and are committed to building trust



Minnesota's History of Medical Home Development

- 2002-Minnesota Medical Home Development Project Grant-MCHB
- 2005-building Community Systems of Care for CYSHCN in Minnesota-MCHB. Goal to integrate the six core components of MCHB 2010 plan into medical home learning collaborative structure.
- 2005 – 2009 Pediatric Medical Home (title V program).

Minnesota's History of Medical Home Development

- 2007 state legislative appropriation of one million dollars to expand medical home
- 2008-state landmark legislation creates concept of health care home (HCH) for Minnesota citizens (except those insured by Medicare and ERISA plans)
- 2010-HCH rule is approved by the governor and published for certification of HCH's.

Our *partners* agreed to collaborate and work towards transformation, even when we disagreed.



New Vision and Framework for HCH Implementation *Partners*

Create meaningful, transformative health reform based on the IHI's Triple Aim.

The goals of the Triple Aim are to simultaneously:

- Improve population health;
- Improve patient/consumer experience; and
- Improve affordability of health care.



In Minnesota its a Health Care Home

- **Access: facilitates** consistent **communication** among the HCH and the patient and family, and provides the patient with **continuous access** to the patient's HCH
- **Registry: uses** an electronic, searchable **registry** that enables the HCH to identify gaps in patient care and manage health care services
- **Care coordination:** that focuses on **patient and family-centered care**
- **Care plan:** for selected patients with a **chronic or complex** condition, that involves the patient and the patient's family in care planning
- **Continuous improvement:** in the **quality** of the patient's experience, health **outcomes**, cost-effectiveness of services

Together *our partners*, patients and families, providers, payers, agencies, designed new standards for HCH's.



Lessons Learned

- Do visioning and set the plan with ***partners***, community, patients, clinicians, payers, legislators and other agencies such as Medicaid and “dream big and long term”.
- Utilize existing programs and ***partnerships*** to build towards new goals, such as Title V objectives, state and federal grant programs.
- Build transparency and earn engagement and support of ***partners***.

Our *partners* gave us their time to improve care delivery for Minnesotans!



Lesson's Learned

- Engage patient, community, payers and clinician ***partners*** to support legislation.
- Identify early challenges and strategize with ***partners***, in key areas development of payment methodology, standards and criteria, outcomes measures.
- Bring patients and families (consumers) to the table right away as ***partners***.

**We have benefited from the expertise of
our best thinkers; consumers,
researchers, consultants, our *partners!***



Lessons learned

- Learning collaborative models where teams ***partner*** with other teams that include patients and families is an effective way to make changes.
- Learn from community, state and federal ***partners*** and implement best practices.
- Metrics and measurement are essential for ***partners*** feedback. “Small is Beautiful” (cut it in half, cut it in half and cut it in half again)...

Our *partners* agreed to population outcomes measurement with accountability!



Lesson's learned

- Utilize existing resources to ***partner***, such as MSCHN nurses in the community to support HCH implementation.
- Establish new leadership ***partnerships*** with Medicaid, Title V and Public Health in project implementation.
- Check assumptions all along the way with ***partners***, if you believe you're doing medical home confirm that.

Minnesota's Vision for Health Care Homes: *Partnerships with challenges & opportunities!*



Transformational change in care delivery

- Changes in clinic / community infrastructure and culture
- Creation of a patient- and family-centered care system

Measurement focused on “IHI Triple Aim”

Payment for coordination of care

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