health reform MINNESOTA

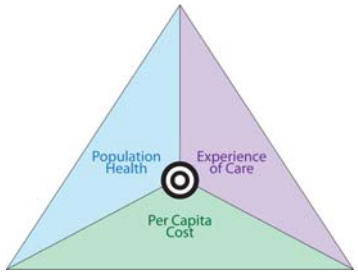
HCH | Health Care Homes

Marie Maes-Voreis RN MA
Director, Health Care Homes

Health Reform in Minnesota

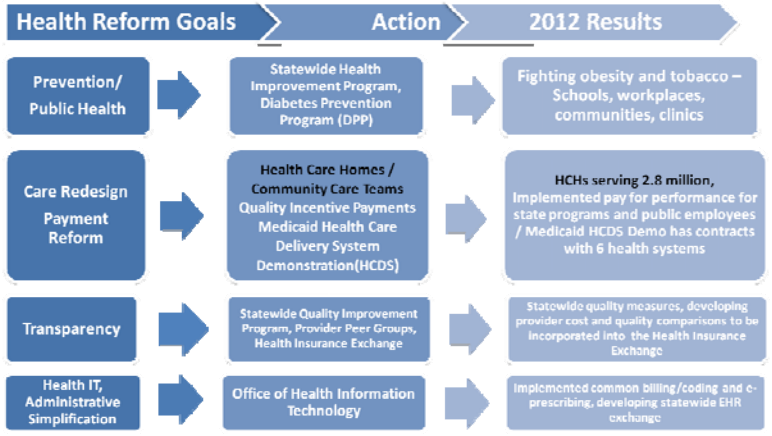
Minnesota's Three Reform Goals

- **Healthier communities**
- **Better health care**
- **Lower costs**



Institute of Medicines Triple Aim

MN Health Reform



Patient Centered Health Care Home (HCH)

Health Care Home is not:

- A nursing home or home health care
- A restrictive network
- A service that only benefits people living with chronic or complex conditions

Health Care Home is:

- Population clinical care redesign
- Transformed services to meet a new set of patient-and family-centered standards to achieve triple aim
- Foundation to new payment models such as ACOs
- Community partnerships that build healthy communities

Patient Centered Health Care Home
Care Delivery Redesign, What is different?

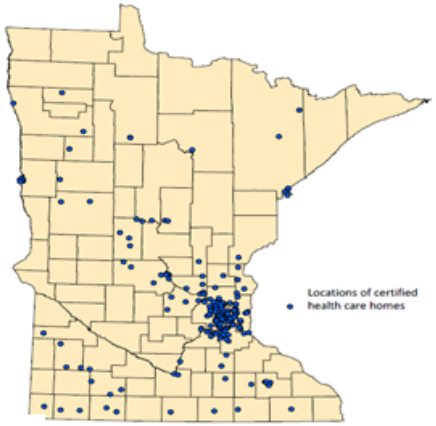
Today's Care	Health Care Homes
Patients are recipients of services by providers and clinics.	Patients and families are partners in the provision and planning of care.
Patients are those who make appointments to see providers.	Patients have agreed to participate and understand how to contact their HCH. There is 24/7 access to the HCH.
Care is determined by today's problem and time available today.	Proactive care planning is done with patients and family's to anticipate patient's needs and set patient centered goals.
Care varies by memory or skill of the provider.	Care is standardized with evidence-based guidelines and planned visits.
Patients are responsible to coordinate their own care.	A team, including the care coordinator, coordinates care with patients and families between clinic visits.
It's up to the patient to tell us what happened to them.	Uses a registry to track visits and tests and does follow-up after referrals to specialists, ED and hospital visits.
Clinical operations center on meeting the doctor's and clinic's needs.	Clinical operations are designed as patient and family centered and focused on patient's preferences and values.
I know I deliver high quality care because I'm well trained.	We measure our quality outcomes and make ongoing changes to improve it. Patients / families are partners in quality work.

What Makes Minnesota's HCH Approach Unique?

- **Statewide approach, public/private partnership**
- Standards for certification all types of clinics can achieve
- Support from a statewide learning collaborative
- Development of a payment methodology
- Integration of community partnerships to the HCH
- Outcomes measurement with accountability
- OHIT EMR & interoperability adoption plan
- Statewide HCH Evaluation supported by legislation.

Focus on patient- and family-centered care concepts

Minnesota's Certified Health Care Homes



health reform MINNESOTA
A Better State of Health

rce: MN Department of Health, February 25, 2013

MDH

23

HCH Certification Updates

Certified Clinics: 242

33% of Primary Care Clinics in Minnesota

Certified Clinicians: 2,800

Approximately 2.8 million patients receiving care in a certified HCH.

- Applicants are from all over the state.
- Variety of practice types such as solo, rural, urban, independent, community, FQHC and large organizations.
- All types of primary care providers are certified, family medicine, pediatrics, internal medicine, med/peds and geriatrics.

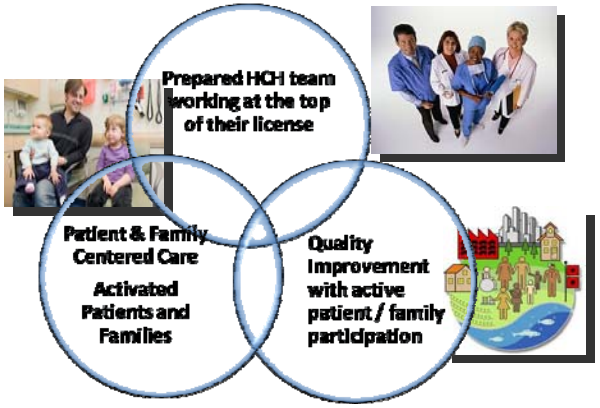
We focused on patient-and family- centered care as one of our core principles!

Improving Healthcare

"Making patients and their families truly the force that drives everything else in health care is perhaps the most revolutionary tool of all. It's importance is evident at the system level, but it comes though even more strongly at the personal level."

Donald Berwick, Former CEO, Institute for Healthcare Improvement

The Patient and Family Centered Health Care Home Foundation



HCH Teams!

MN Patient Center Development Structure

Established Consumer Family Advisory Council to Health Care Homes since 2008.

•Regular ongoing consumer input through surveys.

•Consumers participate in all HCH State level workgroups.

•Patients/families present new learning in all training conferences and learning collaborative activities.

•Mini-grants are awarded for implementation of patient- and family- centered care concepts.

MN Patient Centered Development Structure

- Twelve consumers are contracted to serve as a member of the HCH site evaluation team to conduct site visits at clinics.
- Patients/Families are interviewed as part of HCH certification process.
- Consumer member of the HCH certification committee that advises the Commissioner of Health on certification.
- Development of Consumer-Based Messaging Plan, 2011/2012.
- Pilot activities with Family Voices Patient and Family Centered Care Index and coaching.
- Contracting with a Consumer to coordinate Consumer Activities, 2013

Statewide Consumer Family Council

Purpose: The council will provide consumer/family perspectives and expertise to assist in the development, implementation and evaluation of patient- and family-centered health care homes in Minnesota.

The consumer/family council includes:

- Diverse representation of chronic health and development conditions (including physical and mental health)
- Diverse cultural, linguistic and socioeconomic composition
- Diverse ages of patients being represented

Consumer-Based Messaging Project

We created a consumer/family friendly:

- Message Platform, with clean and succinct messaging to describe the HCH approach to care.
- Descriptor: Compelling and succinct tagline/descriptor.
- Description of HCH that is meaningful to broad audiences.
- Certification emblem/seal to identify HCH's.
- Communication plan to shape public awareness and drive participation in HCH's with value messages and fact-based messages.
- Comprehensive public education communications plan.
- Provider communications tool kit recommendations.

Consumers Perspective, Better Health Made Easy

- **Welcoming** – Anyone can use, and benefit from, a HCH.
- **Relationship-based** – Your providers and specialists are aware of your health history and your care team works closely with you to improve your health.
- **Organized** – A HCH coordinates services and shares information to minimize confusion, prevent duplication and gaps in care.
- **Unrestricted** – A HCH can help you choose the best provider and specialists for your needs and helps you share information with your care team.
- **Comprehensive** – A HCH is designed to help you meet your health care needs, from preventive care and common illnesses, to urgent care and treatment of chronic and complex conditions.
- **Personalized** – A HCH puts you at the center of your health care team.

HCH teams!

Health Care Home Standards

- **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:** coordination of services 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

MN HCH Rule Consumer Focus

- After hours access, requirements include access to MR/ care plan and continuous access.
- Care coordination that focuses on patient- and family-centered care.
- Development of care plan with patient/family participation.
- Development of patient-centered goals and emergency after hours plan in the patient's language with patients and families.
- Collection and use of cultural, race and ethnicity data.

MN HCH Rule Consumer Focus

- Use of registry for consistent patient/family communications. Patient quote “makes you feel like they care about you all the time.”
- Focus on shared-decision making and patient choice for referral providers.
- Families and consumers on HCH clinic advisory committees or QI committees.
- Quality improvement verification patient satisfaction/ experience survey.
- Patient Experience survey results required element for recertification.

MN HCH Rule Community Partnerships

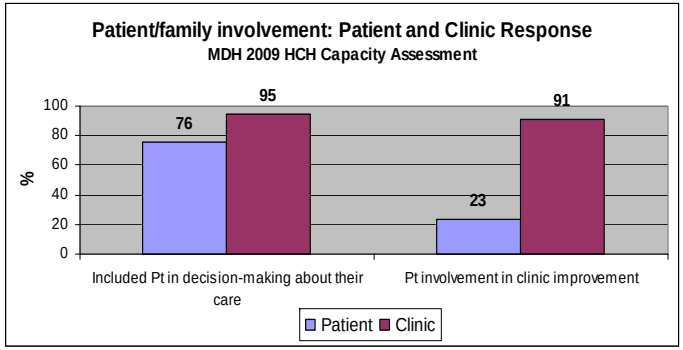
- HCH Rule requires established community partnerships.
- Examples:
  - Work group with 24 community associations representing all ages and diverse organizations.
  - Survey asking families what community resources were important and necessary for them.
  - Day-long community meeting with representatives from diverse groups and all ages to develop new transparent community-based strategies.

We will keep learning together.

Why have Patient/family Partners?

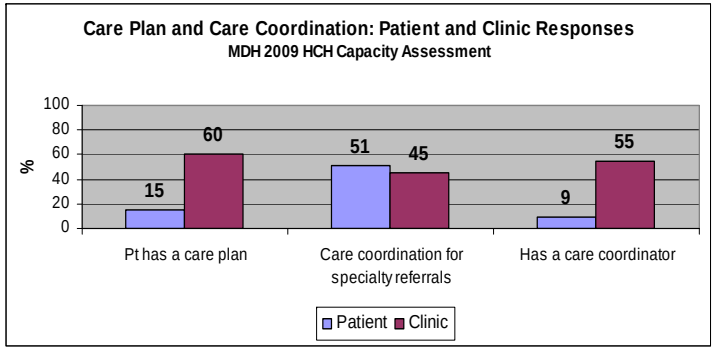
- Patients with chronic health care needs and their families have a unique expertise based on their experiences of being service consumers.
- They bring the perspective that providers and policy-makers do not have the perspective of someone very close to the system but not constrained by the traditions of the system.

Capacity Assessment Survey: Do you feel like a partner in your care?



Minnesota Health Care Home Capacity Assessment, June 2009
N= 560 Consumers / 373 clinics (57% response rate)
http://www.health.state.mn.us/healthreform/homes/capacity/HCHCapacityAssessmentReport.pdf

Capacity Assessment Survey: Care Plan and Care Coordination



Minnesota Health Care Home Capacity Assessment, June 2009
N= 560 Consumers / 373 clinics (57% response rate)
http://www.health.state.mn.us/healthreform/homes/capacity/HCHCapacityAssessmentReport.pdf

Aren't we already providing P&FCC?

Key questions for team to consider:

- What are the team's feelings about the patient / family as "customer" versus "team member"?
- Evaluate clinic process design, "who are processes designed for?"
- What does it mean to be working in partnership with patients and families?
  - Are we sometimes in an adversarial relationship.
  - Do we do "with" not "for"?
- How do we communicate with patients in person and in writing?
- What does the patients "choice" mean for your team?
  - Primary care provider relationship.
  - Referrals to specialty providers.
  - Preferences and values.

- Does your team use the language of shared decision making?

Strategies to Address Patient Centered Care

- Facilitated team discussion.
- Use a structured assessment tool:
  - Institute for Patient & Family Centered Care, IHI /NICHQ, TransforMed, Safety Net Medical Home Program (Qualis Health / Common Wealth) PCMH-A and Family Voices
- Evaluate care delivery model. Consider benefits to patient centered medical home?

Strategies to Address Patient Centered Care

Gather Direct Input:

- Direct dialogue in clinic, do “walk about” with patients.
- Consumers meet with consumers to interview.
- Patient / family participation on quality committees, new facility planning, strategic planning, LEAN or clinical committees.
- Interact with patients / families often such as, lobby talks, question of the day, suggestion boxes, patient surveys.
- Community planning such as community care teams.
- Regularly measure patient experience, “Truth Point”.

The Power of Patient and Team Stories

Patient & Family Centered Care at Work

We spoke with a patient at a large urban clinic system who said, "this is one of the most important things I can do in my life right now, participating in this quality committee in my community gives me the ability to give back to my children.

- Each week I meet with my friends at the local coffee house in order to get input on the things we're improving at the clinic. This is my opportunity to make a real difference."

Patient & Family Centered Care at Work

We spoke with a truck driver from southern Minnesota who described how the HCH had changed his life.

- He described the new access standards that let him schedule appointments when he could come.
- His connection to community resources for weight loss and his HGA1C had come down to nearly his goal.
- His relationship with his primary care provider & care coordinator,
- He was so thrilled about the change in his life!

Patient & Family Centered Care at Work

We spoke with a physician in a large urban clinic who said that health care home was his "miracle in his practice". He had left primary care to work at the hospital and had now come back and his practice was totally different, focused on the patients and their families!

We have focused on improved outcomes for the health of our families, patient experience, cost and value.

AHRQ TransforMN Study

- Patients report better experiences in PCMH
- Patient and family centered care is a driver for transformation.
- Patient participation is a key element.
- Patient partners are part of the change team

2013 HealthPartners Research Foundation, Minnesota Department of Health and Human Services and other partners.

What We Know About Care in a Patient & Family-Centered HCH's

- **Patient and family-centered care is increased**
- **Family worry and burden are reduced**
- **Care coordination** and **chronic condition management lead** to:
  - Reduction in emergency room use
  - Reduction in hospitalizations
  - Reduction in redundancy
  - Efficiency and effectiveness are increased

Center for Medical Home Improvement

Early Evidence Supporting HCH Transformation

- Medica Study: 5% reduction in costs for patients whose care is paid for by Medica, that compares with a 2.6% increase in other clinics.

Dr. Jim Guyn, 2012

- AHRQ TransforMN Study, HealthPartners Research Foundation: Studies show on average HCH clinics have significantly better performance scores for diabetes and cardiovascular disease than other clinics.

Dr. Leif Solberg, 2012

Parting Thought

" …when we looked across the landscape at what we wanted to buy for our patients, we couldn't find it."

- Dr. Paul Grundy, IBM; President, Patient-Centered Primary Care Collaborative (PCPCC)

Minnesota has defined and is recognizing this transformed, high-value model of patient centered-primary care so that consumers and purchasers can find it and buy it.

We will keep learning together.
Thank you to our Consumer Advisors!

Health Care Homes Contacts:

health.healthcarehomes@state.mn.us

http://www.health.state.mn.us/healthreform/homes/index.html

651-201-5421

Marie Maes-Voreis, RN MA
HCH Director
marie.maes-voreis@state.mn.us

MINNESOTA MDH DEPARTMENT OF HEALTH

health reform MINNESOTA
HCH | Health Care Homes