Health Care Homes: A Minnesota Perspective*

In 2004, the Minnesota Department of Health (MDH) received a grant from the federal Maternal and Child Health Bureau to implement the Medical Home Initiative for children with special health care needs. The Medical Home Initiative involved the coordination of a Leadership team comprised of representatives from healthcare, state government agencies, research, and family consumers.

The project sought to promote a community-based system of services for all children with special healthcare needs and focused on six core outcomes.

1. Families of children with special health care needs partner in decision making at all levels and are satisfied with the services they receive.

2. Children with special health care needs receive coordinated ongoing comprehensive care within a Medical Home.

3. Families of children with special health care needs have adequate private and/or public insurance to pay for the services they need.

4. Children are screened early and continuously for special health care needs.

5. Community-based services for children and youth with special health care needs are organized so families can use them easily.

6. Youth with special health care needs receive the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence.

* Flyer information adapted from material at: www.health.state.mn

The Minnesota Medical Home Learning Collaborative was modeled after the national medical home learning collaborative conducted by the National Initiative for Child Health Quality (NICHQ). An evaluation of the Medical Home Initiative showed that from 2005-2008:

- 15 Learning Collaborative sessions took place with 30 visits from expert faculty and 150 breakout and plenary sessions
- Over 7,500 children with special health needs were identified by teams who had implemented Medical Home changes in their physician practices
- 1,200 care plans were written
- The top three areas of focus for Quality Improvement efforts by practice teams were: delivery system design, care partnership support, and clinical information systems
- At least 177 presentations were made by Medical Home team members to other clinicians
- Medical Home team members provided an estimated 69 hours of Continuing Medical Education hours to other clinicians related to Medical Homes
- Three-quarters of providers reported that Medical Home is “better than other quality improvement programs”
- Parents, even those not involved directly in the Medical Home team, noticed improvements at their clinics that benefited children with special health care needs
- All participating providers surveyed agreed that care coordination has improved the health and well-being of their patients.
- This perception was reinforced by a health service utilization study conducted by the Minnesota Departments of Health and Human Services which examined claims data for 500 children involved in nine of the participating Medical Home practices. Data showed over the course of three years:
  - ER visits and inpatient admissions decreased
  - Dental and well child visits increased

2008 Health Care Reform Legislation

In 2008 Minnesota passed significant health care reform legislation. A large component of this legislation was to expand the health care home concept to adults with complex or chronic conditions. Savings from treating chronic diseases in a health care home were projected and key to the passage of the legislation.

The Legislation required development and implementation of standards for certification by July 1, 2009 and established payment for care coordination from public and private payers for certified providers (an all-payor approach).

Standards for Health Care Home Certification

1. Emphasize, enhance and encourage the use of primary care, and include use of primary care physicians, advanced practice nurses, and physician assistants as personal clinicians.

2. Focus on delivering high-quality, efficient and effective health care services

3. Encourage patient-centered care, including active participation by family, legal guardian or agent in decision making and care plan development.

4. Provide patients with consistent, ongoing contact with personal clinician or team, available 24/7 to reduce emergency room care use.

5. Maintain comprehensive care plans for patients with complex or chronic conditions with extensive plans for evaluation of results.

6. Enable and encourage utilization of range of qualified health care professionals, including dedicated care coordinators, in a manner that enables providers to practice to the fullest extent of their license.

7. Focus initially on patient with chronic conditions or at risk for developing.

8. Measure quality, resource use, cost of care, and patient experience.

9. Ensure use of health information technology and systematic follow-up, including use of patient registries.

10. Encourage use of scientifically-based health care and patient decision-making aids to assist them in choosing treatment options and associated benefits, risks, costs, comparative outcomes, and other clinical decision support tools.

Additional Information on Minnesota’s Health Care Homes: http://www.health.state.mn.us/divs/fh/mcsbn/medhm/