

Health Care Homes

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Health Care Homes

Background

- **Centerpieces of Minnesota's 2008 health reform initiative.**
- **Focus is on redesign of care delivery and meaningful engagement of patients in their care.**
- **The name "Health Care Home" acknowledges a shift from a purely medical model of health care to a focus on linking primary care with wellness, prevention, self-management and community services.**

Health Care Homes

2016 Goals

- **Continue building a strong primary care foundation to ensure all Minnesotans have the opportunity to receive team-based, coordinated, patient-centered care.**
- **Increase care coordination and collaboration between primary care providers and community resources to facilitate the broader goals of improving population health and health equity.**
- **Improve the quality and the individual experience of care, while lowering health care costs.**

Health Care Homes

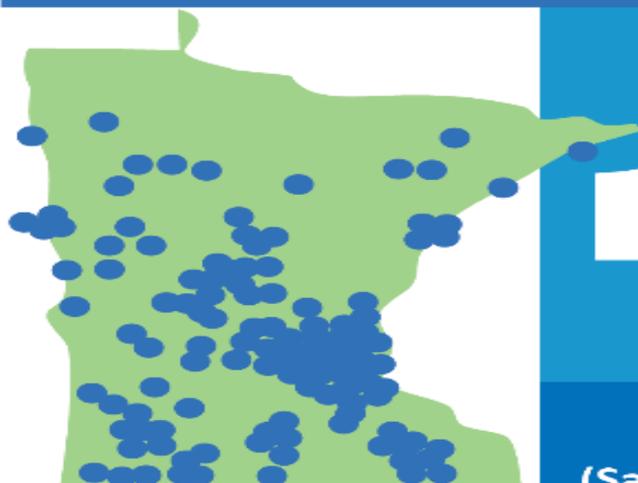
Key Elements of Model

- **Access and Communication**
- **Patient Tracking & Registry Functions**
- **Care Coordination**
- **Care Plans**
- **Performance Reporting & Quality Reporting**

Health Care Homes Transform Care and Lives of 3.6 Million Minnesotans



PATIENT-CENTERED PRIMARY CARE TEAM MINNESOTA'S HEALTH CARE HOMES



**3.6 MILLION
SERVED**



(Savings to Medicaid and Medicare from 2010 to 2014)

Source: University of Minnesota,
Health Care Homes, Five Year Program Evaluation 2016



ACCESS

Receive continuous access to your primary care team



REGISTRY

Provider keeps track of your health goals and history



COORDINATION

Team of doctors, nurses and community partners prevent gaps in your care



CARE PLAN

Team helps you plan for your best health



QUALITY

IMPROVEMENT
Providers use benchmarks to improve care and reduce costs

 **HealthCareHomes**
H E A L T H R E F O R M

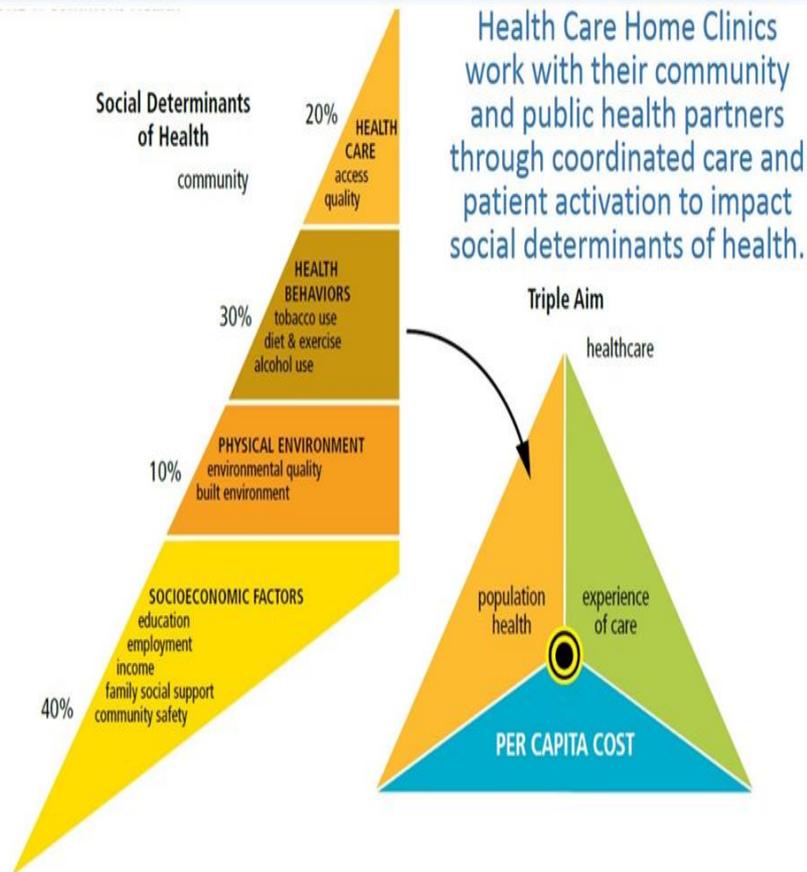


Clinics voluntarily apply to be health care homes and certified by the Minnesota Department of Health

Health Care Home Model Best Practices

- **Proving structure through certification requirements pushes clinics to continually assess their care coordination systems while developing partnerships outside of the traditional health care system.**
- **Transforming to a Health Care Home prepares primary care clinics for alternative payment models, which is at the forefront of CMS's goal to change to payment based on value vs. volume.**

Health Care Homes and Accountable Communities for Health



- **The HCH model builds a strong primary care foundation for building Accountable Communities for Health.**
- **Certification standards that aid in transforming systems to support better care coordination that is patient centric**
- **Developing community partnerships**
- **Improving patient outcomes**

HCH Evaluation

Mark Caldwell

Health Care Home

Research Analyst

An Overview of Health
Care Homes 5 Year
Evaluation Conducted by
the University of
Minnesota

Costs and utilization

- Medicare, Medicaid, and Dual using Medicare and Medicaid data
- Reimbursements: total PMPY and by type of care
- Utilization (ED visits, inpatient stays, primary care visits, etc.).
- Counter-factual (i.e., if non-HCH clinic patients had been seen in HCH clinics), using adjusted differences in costs.

Figure 9: regression adjusted reimbursement by type of insurance, 2010-2014

	Non Certified Clinics		Certified Clinics		PMPY		Program wide
	# of enrollees	Avg Reimbursement	# of enrollees	Average Reimbursement	% savings	\$ savings	\$ savings (in millions)
Medicare	543,637	\$4,989	275,088	\$4,896	1.9%	\$93.20	\$26
Medicaid	1,096,930	\$6,578	1,197,949	\$5,821	11.5%	\$756.86	\$907
Dual	117,424	\$34,434	87,597	\$33,581	2.5%	\$853.45	\$75
Total	1,757,991	\$7,946	1,560,634	\$7,216	9.2%	\$729.64	\$1,139

Quality Measures

- Full-year certified HCH clinics and partial-year certified (first year) HCH clinics versus non-HCH clinics
- SQRMs (“MNCM”) quality of care measures:
 1. Diabetes (control of A1c, LDL, BP; not smoking; on aspirin if needed)
 2. Vascular (same as diabetes but w/o A1c)
 3. Colorectal cancer screening
 4. Asthma (AAP in place, asthma under control, no risk of exacerbations)
 5. Depression (follow-up at 6 months, remission at six months)
- Asthma for Adults and Peds has greatest difference.

Quality Measures

	Non-HCH clinics	HCH-Transforming clinics (1 st year of certification)		HCH-Certified clinics	
	% meeting goals	% meeting goals	Difference from non-HCH clinic	% meeting goals	Difference from non-HCH clinic
Vascular care	46.6%	53.2%	6.6%	53.3%	6.7%
Diabetes care	36.6%	40.1%	3.5%	40.6%	4.0%
Asthma care (adults)	16.7%	29.8%	13.1%	34.5%	17.8%
Asthma care (children)	19.2%	30.2%	11.0%	39.2%	20.0%
Depression follow-up	19.5%	23.6%	4.1%	26.7%	7.2%
Depression remission	22.6%	24.3%	1.7%	25.0%	2.4%
Colorectal Cancer screening	58.8%	60.7%	1.9%	63.3%	4.5%

Quality Measures – Patient Experience

- The CG-CAHPS survey measures patient experience in terms of whether patients were:
 - Getting care when needed
 - Being listened to and receiving understandable information and instructions
 - Experiencing courteous and helpful office staff
 - Satisfied with their provider
- 1. Over half of all HCH clinics had at least *60 percent* of their patients who reported a positive score in relation to shared decision making.
- 2. Over half of all HCH clinics had at least *50 percent* of their patients who reported a positive score in relation to attention to mental health.

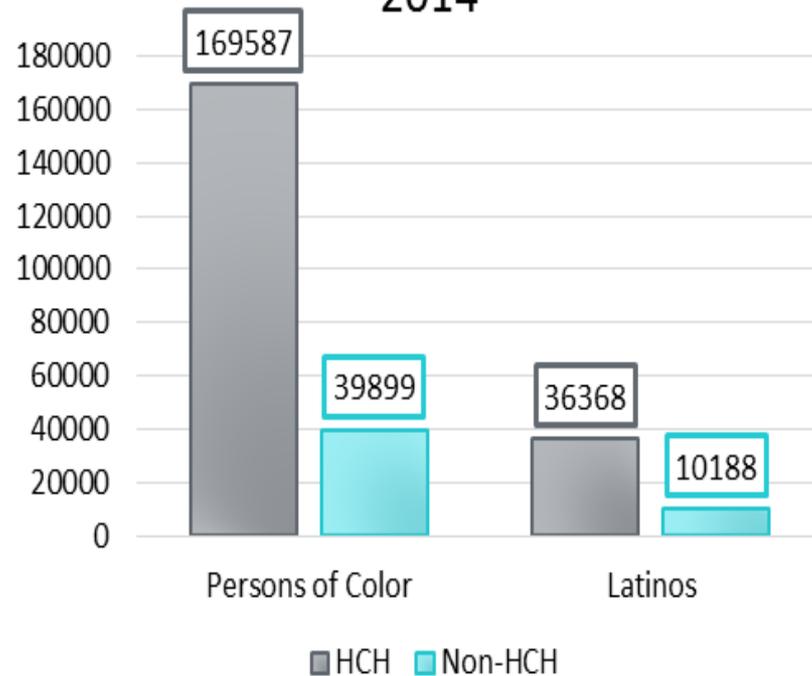
Disparities

- **Among: Medicare, Medicaid, and Duals using Medicare and Medicaid data**
- **Differences in:**
 - ED visits
 - inpatient stays
 - unplanned hospitalizations
 - And gaps in medications by prescription fill days (Medicaid only)
 - adjusted for patient and clinic factors
- **Disparities groupings**
 - race/ethnicity (all grps versus white)
 - disabled v non-disabled
 - rural v urban
 - serious mental illness (major depressive, bipolar, and/or schizophrenic disorders versus those without)
 - morbidity (sickness) level (all levels of morbidity versus lowest level)

Disparities

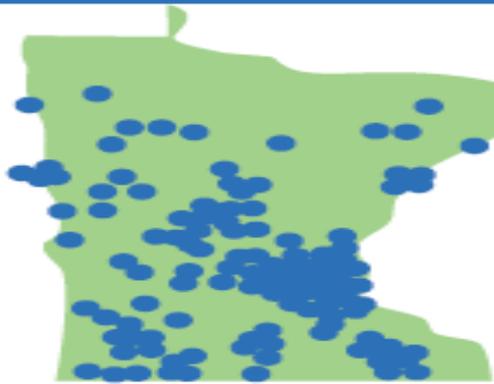
- Racial disparities were significantly smaller for Medicare, Medicaid and Dual-Eligible patients served by HCHs compared to non-HCHs for most measures.
- Children (0 to 18) were most likely to be in HCHs, followed by adults (18 to 65), followed by Seniors (> 65).
- Persons of color and Hispanics were more likely to be in HCHs.
- Non-English speakers and those who had completed high school were more likely to be in HCHs.

Comparison of Populations Served in HCHs vs. Non-HCHs for 2014



Questions

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