4764.0020 DEFINITIONS.

Subpart 1. **Scope.** The terms used in this chapter have the meanings given them in this part.

Subp. 2. [Repealed, 47 SR 338]

Subp. 3. **Care coordination.** "Care coordination" means a team approach that engages the patient, the personal clinician or local trade area clinician, and other members of the health care home team to enhance the patient's well-being by organizing timely access to resources and necessary care that results in continuity of care and builds trust.

Subp. 4. [Repealed, 47 SR 338]

Subp. 5. **Care coordinator.** "Care coordinator" means a person who has primary responsibility to organize and coordinate care with the patient and family in a health care home.

Subp. 6. **Care plan.** "Care plan" means an individualized written document, including an electronic document, to guide a patient's care.

Subp. 7. [Repealed, 47 SR 338]

Subp. 8. **Clinic.** "Clinic" means an operational entity through which personal clinicians or local trade area clinicians deliver health care services under a common set of operating policies and procedures using shared staff for administration and support. The operational entity may be a department or unit of a larger organization as long as it is a recognizable subgroup.

Subp. 9. **Commissioner.** "Commissioner" means the commissioner of health.

Subp. 10. **Commissioners.** "Commissioners" means the commissioners of health and human services.

Subp. 11. **Complex condition.** "Complex condition" means one or more medical conditions that require treatment or interventions across a broad scope of medical, social, or mental health services.

Subp. 12. [Repealed, 47 SR 338]

Subp. 13. **Continuous.** "Continuous" means 24 hours per day, seven days per week, 365 days per year.

Subp. 14. **Cost-effectiveness.** "Cost-effectiveness" means the measure of a service or medical treatment against a specified health care goal based on quality and cost, including use of resources.

Subp. 15. **Direct communication.** "Direct communication" means an exchange of information through the use of telephone, electronic mail, video conferencing, or face-to-face contact without the use of an intermediary. For purposes of this definition, an interpreter is not an intermediary.

Subp. 16. **Eligible provider.** "Eligible provider" means a personal clinician, local trade area clinician, or clinic that provides primary care services.

Subp. 17. **End-of-life care.** "End-of-life care" means palliative and supportive care and other services provided to terminally ill patients and their families to meet the physical, nutritional, emotional, social, spiritual, cultural, and special needs experienced during the final stages of illness, dying, and bereavement.

Subp. 18. **Evidence-based practice.** "Evidence-based practice " means the integration of best research evidence with clinical expertise and patient values.

Subp. 19. **External care plan.** "External care plan" means a care plan created for a patient by an entity outside of the health care home such as a school-based individualized education program, a case management plan, a behavioral health plan, or a hospice plan.

Subp. 20. **Family.**

A. For a patient who is 18 years of age or older, "family" means:

(1) any person or persons identified by the patient as a family member;

(2) legal guardian according to appointment or acceptance under Minnesota Statutes, sections 524.5-201 to 524.5-317;

(3) a health care agent as defined in Minnesota Statutes, section 145C.01, subdivision 2; and

(4) a spouse.

B. For a patient who is under the age of 18, "family" means:

(1) the natural or adoptive parent or parents or a stepparent who live in the home with the patient;

(2) a legal guardian according to appointment or acceptance under Minnesota Statutes, sections 260C.325 or 524.5-201 to 524.5-317;

(3) any adult who lives with or provides care and support for the patient when the patient's natural or adoptive parents or stepparents do not reside in the same home as the patient; and

(4) a spouse.

Subp. 21. **Health care home.** "Health care home" means a clinic, personal clinician, or local trade area clinician that is certified under this chapter.

Subp. 22. **Health care home learning collaborative or collaborative.** A "health care home learning collaborative" or "collaborative" means an organization established under Minnesota Statutes, section 256B.0751, subdivision 5, in which health care home team members and patients and other organizations that provide health care and community-based services to work together in a structured way to improve the quality of their services by learning and sharing experiences.

Subp. 22a. **Health care home services.** "Health care home services" means accessible, continuous, comprehensive, and coordinated care that is delivered in the context of family and community, and furthers patient-centered care.

Subp. 23. **Health care home team or care team.** "Health care home team" or "care team" means a group of health care professionals who plan and deliver patient care in a coordinated way through a health care home in collaboration with a patient. The care team includes at least a personal clinician or local trade area clinician and the care coordinator and may include other members and health professionals based on the patient's needs.

Subp. 23a. **Health disparities.** "Health disparities" means preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

Subp. 23b. **Health equity.** "Health equity" means achieving the conditions in which all people have the opportunity to attain their highest possible level of health.

Subp. 23c. **Health inequities.** "Health inequities" are avoidable inequalities in health between groups of people within countries and between countries.

Subp. 23d. **Health literacy.** "Health literacy" means the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Subp. 23e. **Integrated care.** "Integrated care" means a team-based model of care, based on the representatives of different disciplines and their expertise, to care for a shared population. The team collaborates with the patient and the patient's family to develop a shared plan of care that reflects patient-centered health outcomes and preferences.

Subp. 24. **Local trade area clinician.** "Local trade area clinician" means a physician, physician assistant, or advanced practice registered nurse who provides primary care services outside of Minnesota in the local trade area of a state health care program recipient and maintains compliance with the licensing and certification requirements of the state where the clinician is located. For purposes of this subpart, "local trade area" has the meaning given in part 9505.0175, subpart 22.

Subp. 24a. **Minnesota statewide quality reporting and measurement system.** "Minnesota statewide quality reporting and measurement system" means a system created through chapter 4654 that requires physician clinics and hospitals to submit data on a set of quality measures and establishes a standardized set of quality measures for health care providers across the state.

Subp. 25. **Outcome.** "Outcome" means a measurement of improvement, maintenance, or decline as it relates to patient health, patient experience, or measures of cost-effectiveness in a health care home.

Subp. 26. **Patient.** "Patient" means a person and, where applicable, the person's family, who has elected to receive care through a health care home.

Subp. 27. **Patient and family-centered care.** "Patient and family-centered care" means planning, delivering, and evaluating health care through patient-driven, shared decision-making that is based on participation, cooperation, trust, and respect of patient perspectives and choices. It also incorporates the patient's knowledge, values, beliefs, and cultural background into care planning and delivery. Patient and family-centered care applies to patients of all ages.

Subp. 27a. **Patient engagement.** "Patient engagement" means a concept that combines a patient's knowledge, skills, ability, and willingness to manage the patient's care with interventions and strategies designed to promote active and competent participation.

Subp. 28. **Personal clinician.** "Personal clinician" means a physician licensed under Minnesota Statutes, chapter 147, a physician assistant licensed and practicing under Minnesota Statutes, chapter 147A, or an advanced practice nurse licensed and registered to practice under Minnesota Statutes, chapter 148.

Subp. 28a. **Population health.** "Population health" means the health outcomes of a group of individuals, including the distribution of health outcomes within the group.

Subp. 28b. **Population health improvement.** "Population health improvement" means efforts to improve health, well-being, and equity for a defined population or a group of people who live in a geographically defined area such as a neighborhood, city, or county.

Subp. 29. **Preventive care.** "Preventive care" means disease prevention and health maintenance. It includes screening, early identification, counseling, treatment, and education to prevent health problems.

Subp. 30. [Repealed, 47 SR 338]

Subp. 31. **Primary care.** "Primary care" means overall and ongoing medical responsibility for a patient's comprehensive care for preventive care and a full range of acute and chronic conditions, including end-of-life care when appropriate.

Subp. 32. **Primary care services patient population.** "Primary care services patient population" means all of the patients who are receiving primary care services from the health care home.

Subp. 33. [Repealed, 47 SR 338]

Subp. 34. **Shared decision making.** "Shared decision making" means the mutual exchange of information between the patient and the provider or delegated care team member to assist with understanding the risks, benefits, and likely outcomes of available health care options so the patient and family or primary caregiver are able to actively participate in decision making.

Subp. 34a. **Social determinants of health.** "Social determinants of health" are the conditions in which people are born, grow, live, work, and age. The distribution of money, power, and resources at global, national, and local levels shapes these circumstances. The social determinants of health are mostly responsible for health inequities, which are the unfair and avoidable differences in health status seen within and between countries.

Subp. 35. **Specialist.** "Specialist" means a health care provider or other person with specialized health training who may be available on-site as part of the health care home care team or outside of the health care home. This includes traditional medical specialties and subspecialties. It also means individuals with special training such as chiropractic, mental health, nutrition, pharmacy, social work, health education, or other community-based services.

Subp. 36. [Repealed, L 2022 c 55 art 1 s 187]

Subp. 37. [Repealed, 47 SR 338]

Subp. 38. **Variance.** "Variance" means a specified alternative or an exemption from compliance to a requirement in this chapter granted by the commissioner according to the requirements of part 4764.0050.

Subp. 39. **Whole person care.** "Whole person care" means primary care focused on the patient's physical, emotional, psychological, and spiritual well-being, as well as cultural, linguistic, and social needs, including needs related to communities in which patients self-identify.

Statutory Authority: *MS s 62U.03; 256B.0751; 256B.0752; 256B.0753*

History: *34 SR 591; L 2011 1Sp11 art 3 s 12; 47 SR 338; 47 SR 557*

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