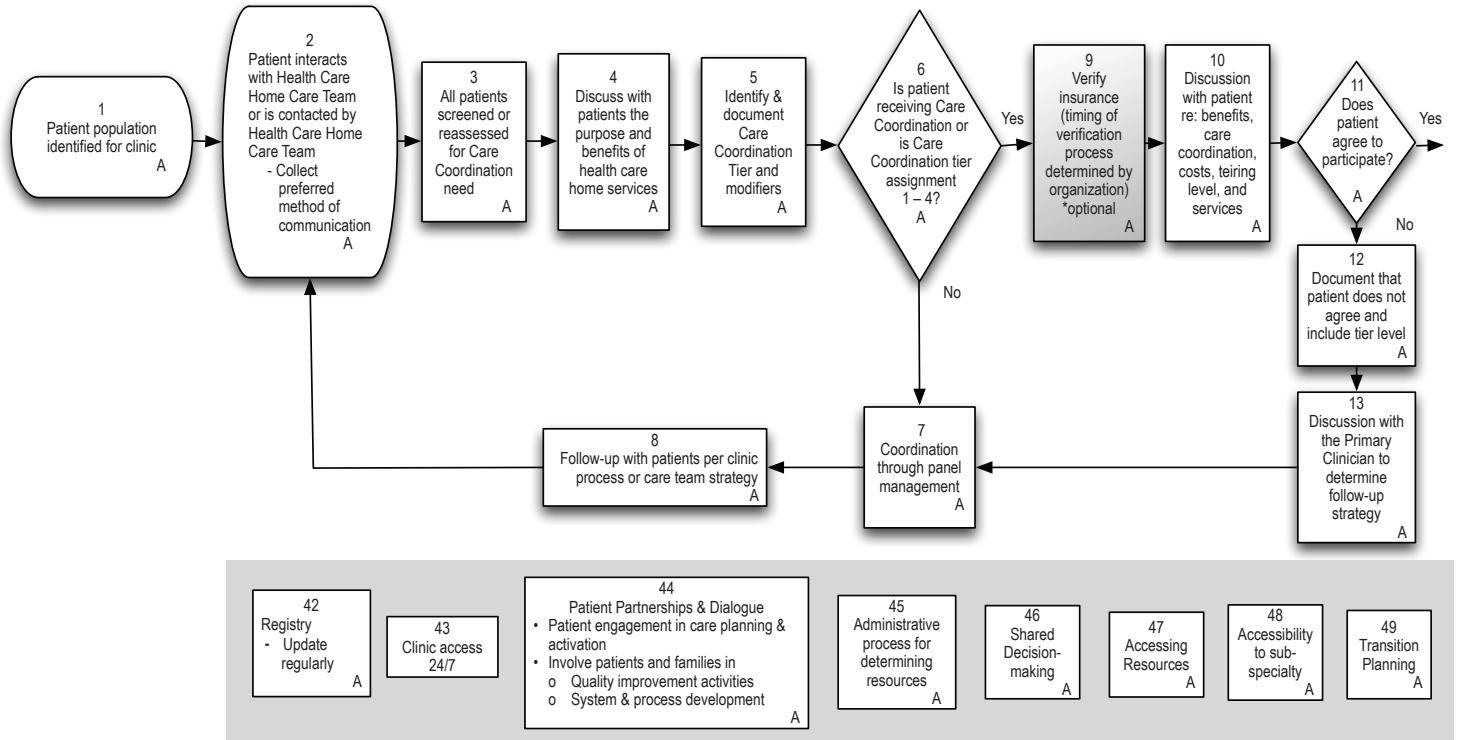
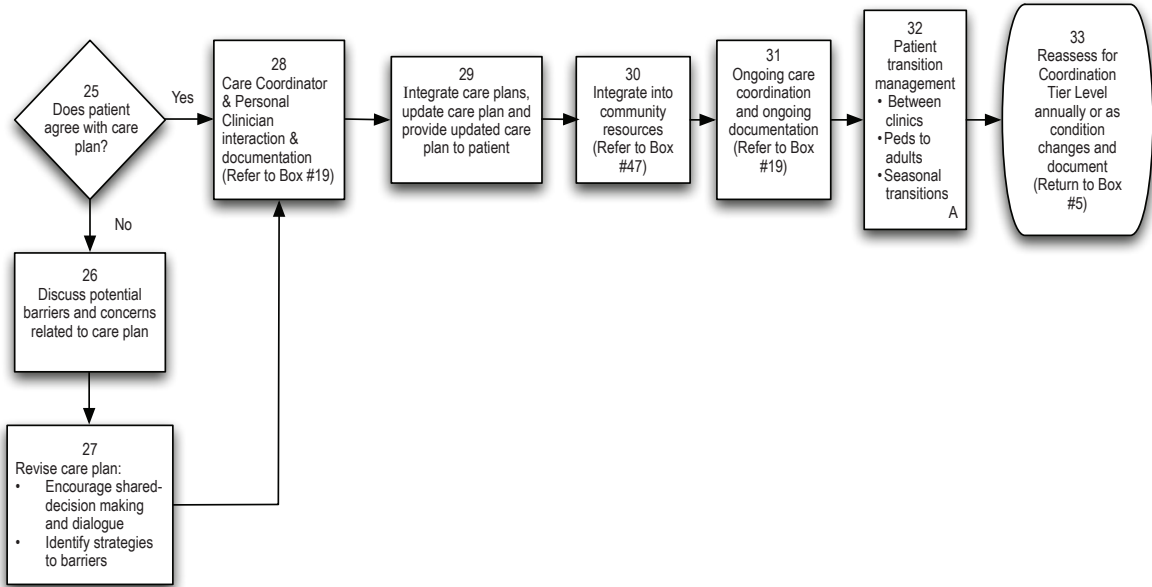
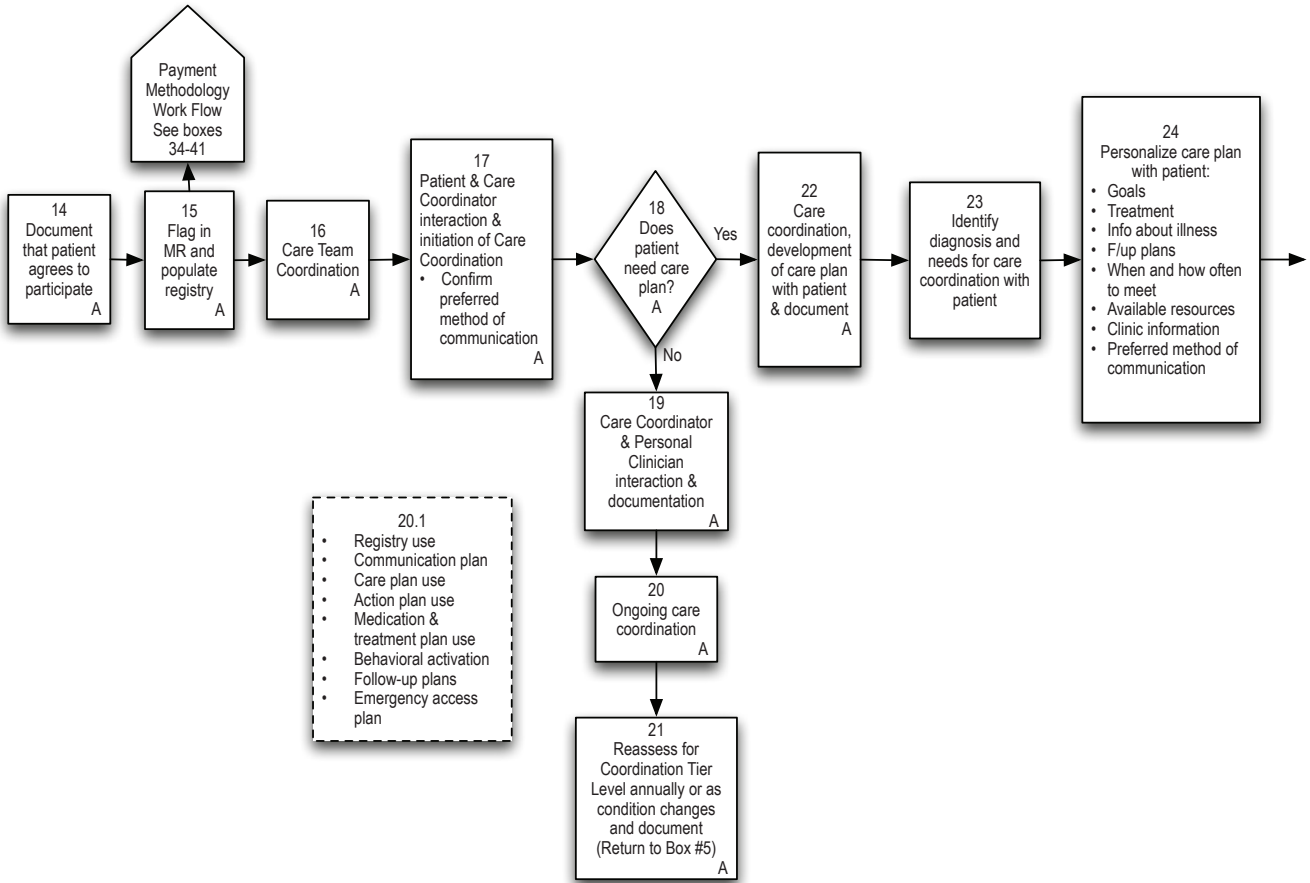
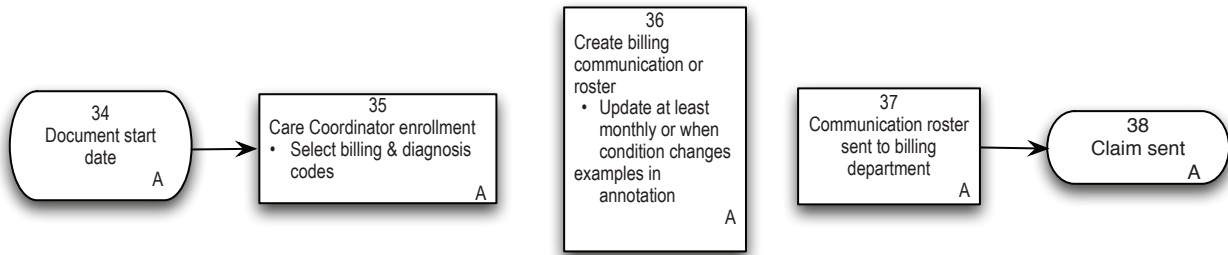


A Health Care Home is an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities.

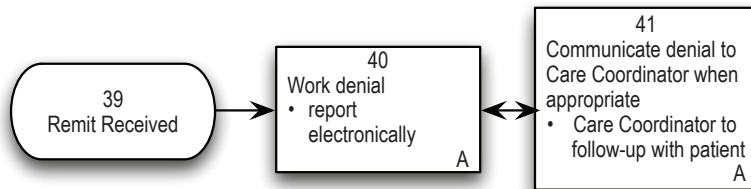




Billing Process



Denial Process



ICSI Health Care Home Clinical Work Flow Work Group

The following members worked together to develop the clinical work flow algorithm and corresponding annotations. An effort was made to include a diverse cross-section of stakeholders representing the health care system.

Role	Work Group Member	Organization
Patient – Adult Representative	Jeff Bangsberg	Patient Representative
Medical Group - Administrator	Paul Berrisford	Family HealthServices Minnesota
Medical Group - Administrator	Kathy Cumming O’Hara	HealthPartners Central Minnesota Clinic
Family Medicine - Physician	Paul Erickson, MD	NorthPoint Health & Wellness Center
Medical Group - Operations	Michele Gustafsson	Family HealthServices Minnesota
Family Medicine - Physician	Julie Johnson, MD	HealthPartners Central Minnesota Clinic
Medical Group - Operations	Tari Lange	Ridgeview Medical Center – Chanhassen Clinic
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Minnesota Department of Health	Marie Maes-Voreis, RN, MA	Minnesota Department of Health
Family Practice – Nurse Practitioner	Valerie Overton, NP	Fairview Health Services – Rosemount Clinic
Medical Group - Operations	Tracy Radtke	Multicare Associates
Patient – Pediatric Representative	Ceci Shapland	Patient Representative
Medical Group - Physician	John Vukelich, MD	Family HealthServices Minnesota
Medical Group – Care Manager	Laura Quigley, DIAMOND Care Manager	Family HealthServices Minnesota
ICSI Staff Facilitator	Janet Jorgenson-Rathke Melissa Marshall Nancy Jaeckels	Institute for Clinical Systems Improvement

ICSI/MDH/DHS Health Care Home Payment Methodology Work Flow Work Group

The following members worked together to develop the clinical work flow algorithm and corresponding annotations. An effort was made to include a diverse cross-section of stakeholders representing the health care system.

Role	Work Group Member	Organization
Payer Relations/Quality Improvement Manager	Karen Amezcua	Lakeview Health - Stillwater
Patient – Adult Representative	Jeff Bangsberg	Patient Representative
Family Medicine - Physician	Paul Erickson, MD	NorthPoint Health & Wellness Center
AUC Representative	Erika Greenlee	Childrens Hospitals and Clinics
Minnesota Department of Health	Marie Maes-Voreis, RN, MA	Minnesota Department of Health
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HCH Clinical Work Flow Guide: Annotations

Introduction

Minnesota Department of Health (MDH) defines a "health care home," or "medical home," as “an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities.” In May of 2008, legislation was passed in Minnesota to develop health care homes that address coordination of care and partnerships between care teams and their patients and families.

A key goal of health care homes is to provide care that is patient- and family-centered. A patient- and family-centered approach includes easy and convenient access into the health care delivery system that is based on individual patient preferences, control of their own health care, and strong patient and care provider partnerships. The patient understands whom to contact on the care team and the team knows the patient’s preferred communication method. The partnerships created support an ongoing relationship with a personal clinician trained to provide first point of contact, continuous and comprehensive care; including preventive, acute, and chronic care.

Health care home standards and criteria have been created to support the 2008 Legislation. The purpose of the standards and criteria is to require health care homes to deliver services that:

- Facilitates consistent and ongoing communication among the health care home and the patient and family,
- Provides the patient with continuous access to the health care home,
- Uses an electronic, searchable patient registry,
- Includes care coordination that focuses on patient and family-centered care,
- Includes a care plan for selected patients with a chronic or complex health condition, and
- Reflects continuous improvement in the quality of (Institute for Healthcare Improvement (IHI)

Triple Aim):

- The patient’s experience,
- The patient’s health outcomes, and
- The cost-effectiveness of services.

The purpose of this document is to provide support to ambulatory care clinics implementing MDH’s health care home standards and criteria. The document incorporates aspects of a health care home; the clinical work flow and the payment work flow.

The clinical work flow addresses the clinic flow for care coordination and parallel processes that should occur in a certified health care home. The payment methodology work flow addresses the work flow associated with billing, denials, and communication. Both areas have annotations to support the steps in the process.

The key components of the State’s health care home standards and criteria are addressed within the document. Clinics implementing this work flow will need to adapt the work flow to their needs. In addition, policies and procedures should be created to support the standards and criteria.

**The italicized information indicates verification requirements for policies, procedures and processes that are to be implemented in order to meet Health Care Home Certification requirements. Please refer to the Adopted Rules and the Health Care Homes Certification Assessment Tool for details.*

Definitions

The following definitions are from The Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS) adopted rule related to health care homes adopted on January 11, 2010 (MDH/DHS, 2010):

- **Care Coordination** –a team approach that engages the participant, the personal clinician or local trade area clinician, and other members of the health care home team to enhance the participant’s well being by organizing timely access to resources and necessary care that results in continuity of care and builds trust.
- **Care Coordinator** –a person who has primary responsibility to organize and coordinate care with the participant in a health care home.
- **Care Plan** – an individualized written document, including an electronic document, to guide a participant’s care.
- **Care Team** – 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 “participant”. The care team includes at least a personal clinician or local trade area clinician, and the care coordinator. The care team may include other health professionals based on the participant’s need.
- **Comprehensive Care plan** – the care plan for a participant plus all available and relevant portions of any external care plans created for that participant.
- **Continuous** – 24 hours per day, seven days per week, 365 days per year.
- **Direct Communication** – 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, and interpreter is not an intermediary.
- **Clinic** – 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.
- **External Care Plan** – a care plan created for a participant by an entity outside of the healthcare home.
- **Health Care Home** – A health care home is an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic or complex health conditions.

Health care homes are driven by the Institute for Healthcare Improvement's Triple Aim, an initiative to simultaneously achieve the following goals:

- Improve the individual experience of care.
 - Improve the health of the population.
 - Improve affordability by containing the per capita cost of providing care.
-
- **Motivational Interviewing** – a client-centered, directive counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Rather than telling a client what changes to make, the interviewer elicits "change talk" from them, taking into account an individual's priorities and values (Dunn, 2001; Resnicow, 2002).
 - **Panel Management** – Baseline coordination that includes appointment management, preventive and routine care utilizing a set of tools and processes for population management applied to a primary care panel with the personal clinicians directing proactive care for their patients.
 - **Patient Activation** – a term used to describe the ability of a patient to understand and implement activities that will improve his or her health care outcomes along the entire life continuum (ICSI Task 1, 2008).
 - **Personal Clinician** – a physician licensed under Minnesota Statutes, a physician assistant, or an advanced practice nurse licensed and registered to practice under Minnesota Statutes.
 - **Pre-visit Planning** – planning for the participant's visit by reviewing the participant's medical record, and if applicable, communicating with the participant before a health care appointment to review changes in the participant's condition and determine a plan for the visit.
 - **Primary Care** – 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.
 - **Shared Decision-Making** – the mutual exchange of information between the patient and the personal clinician [health care home team] to assist with understanding the risks, benefits, and likely outcomes of available healthcare options so the patient and family or primary caregiver are able to actively participate in decision making.
 - **Specialist** – a health care provider or other person with specialized health training not available within 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.
 - **Readiness to Change (RTC)** – a set of standardized questions that have been developed to address the five stages of readiness to change specific to health behaviors. These stages are identified as: pre-contemplation, contemplation, action, maintenance, and termination (Prochaska, 2005; Prochaska, 2008).

Annotations

Patient Activities

1. Patient Population Identified for Clinic

2. Patient interacts with Health Care Home Care Team or is contacted by the Health Care Home Care Team

The patient interaction with the health care home care team encompasses initial and follow-up clinic visits and non-visit scenarios that may include, but is not limited to, electronic communication, telephone interactions, and e-prescribing. The clinic visit, assessment and care delivery by a team of staff (clinician, care coordinator and other staff as defined by the patient's needs and clinic's resources) engages the patient and provides "whole person" care delivery. The assessment, completed by a qualified member of the care team, includes identification of the patient's diagnosis, chronic conditions and health risks.

It is necessary that the clinic systematically collects and documents the following:

- Patient's contact information
- Personal clinician
- Patient's preferred method of communication
- Racial or ethnic background
- Primary language
- Diagnosis
- Allergies
- Medications related to chronic and complex conditions
- Whether or not a care plan is available

The collection of this information can assist with assessing patient barriers and providing information for continuous access to care.

**The clinic has a systematic process for:*

- *Collecting and documenting patient data at new patient registration and confirms data on a specified basis, such as at each visit, monthly, or annually. This information is to be accessible to the health care home team, triage system after-hours care, and scheduling staff.*
- *Discussing the patient's preferred method of communication and assessing barriers to communication.*
- *Training the health care home team members in the collection and application of the information.*
- *Contacting and utilizing interpreter services for communication, care planning, and education.*

(MDH Health Care Home Certification Assessment Tool, 2009).

**In the event that the care team identifies the need for a specialty referral, the clinic has a process in place to:*

- *Communicate with the patient his/her choice of referrals to specialty provider.*
- *Demonstrate support of the patients decision and continues to provide care coordination services and care planning for the patient who chooses to seek specialty services outside of the Health Care Home delivery system (if applicable).*
- *Discuss the patient's responsibility for determining specialty care resources covered by the patient's insurance.*

(MDH Health Care Home Certification Assessment Tool, 2009)

3. All patients screened or reassessed for care coordination need

The health care home has been defined in the legislative rules as the whole clinic population. As such, a health care home is responsible for the management of the clinic's population.

All patients are to be screened for potential health care home eligibility. Screening is to be a systematic process to determine which patients require care coordination. The screening mechanism may include a registry, population-based screening mechanism, panel management, or a combination of methods.

All patients are to be offered health care home services, including care coordination, who:

- Have or are at risk of developing complex or chronic conditions
- Are interested in participation

The screening for care coordination provides the foundation for patient participation, activation into the health care home, the level of care coordination, and billing. The patient's complexity level identified in the screening makes them eligible for care coordination payment.

Reassessment or rescreening for care coordination need is to occur annually, as the patient's condition changes, or based on the plan of care.

**The clinic has a process to systematically:*

- *Screen patients to identify those patients who would benefit from care coordination services based on the patient's medical and non-medical complexity.*
- *Follow-up and reassess the needs of patients who would benefit from health care home services but decline the service or whose complexity tier is zero.*

(MDH Health Care Home Certification Assessment Tool, 2009)

4. Discuss with patients the purpose and benefits of health care home services

Following the screening process, there is a discussion that engages the patient and builds trust in the care team. The discussion addresses the purpose, role and benefits of the health care home and care coordination services. Written educational materials must also be provided.

**The clinic has a process to:*

- *Discuss with the patient the role of the health care home, including the following items:*

- *Purpose and the services of the health care home,*
- *Responsibilities of team members including the patient's and clinic's team members,*
- *Role of the care coordinator,*
- *Clinic office hours,*
- *“Continuous” access to designated staff, an on-call provider or a phone triage system*
- *What is new and different from the coordination services they may have previously received, and*
- *Inform the patient that participation in the health care home is voluntary and is asked if interested in participating.*
- *Provide written education materials (paper or electronic) to the patient that further explains the health care home concept.*

(MDH Health Care Home Certification Assessment Tool, 2009)

See Appendix A: Health Care Home Script

5. Identify and document care coordination tier with modifiers

The patient's complexity and level of care coordination is to be identified and noted in the patient's medical record.

The Minnesota Department of Health and Human Services have set criteria that identifies the “complexity tier” and the care coordination tier level. Care Coordination Tier Levels are zero through four. The “complexity tier” is based on the patient's number of major chronic condition categories, the use of “non-English primary language to communicate (includes deaf and hearing impaired), and a diagnosis of serious or persistent mental illness. The Minnesota Department of Health and Human Services Care Coordination Tier Assignment tool can be applied to assess and identify the overall complexity and care coordination tier levels of a patient.

The identified tier level provides the foundation for patient participation and engagement in the appropriate level of care coordination services. The level of care coordination with the care team will be dependent on the stability of the patient's condition. For example, a patient who has a severe chronic condition that is stable will not need as intensive care coordination services as a patient whose condition is unstable. An example of a stable patient is someone with hyperthyroidism, who is taking medications consistently, following their clinical plan and potentially seeing a specialist

A qualified member (Physician/DO, Physician Assistant, Registered Nurse, Nurse Practitioner) of the clinical team completes the clinical assessment and determines the patient's diagnosis, identifies chronic conditions and condition severity. The qualified member documents or updates this on the patient problem list or medical record.

Additional members of the care team complete the tool and identify the patient's complexity tier. The complexity tier, including modifiers are to be documented in the patient's medical record.

Modifiers are included to address the patients complexity level, and whether the patient has a primary language that is non-english and/or has a severe and persistent mental illness.

The patient's complexity tier is noted in the medical record in a location where the health care team and specialty providers can see the patient's health care home status and complexity tier. The complexity tier should also be documented in the billing system.

(MDH Health Care Home Certification Assessment Tool, 2009; MDH/DHS Care Coordination Tier Assignment Tool, 2010)

The Care Coordination Tier Assignment Tool can be found on the Minnesota Department of Health Website: <http://www.health.state.mn.us/healthreform/homes/certification/index.html>

6. Is patient receiving care coordination or is care coordination tier assignment 1 – 4?

The purpose of care coordination at the various tiers is to attain and maintain the patient's stability or to reach the patient's optimal goals. Patients who are receiving care coordination services or who have been assigned a care coordination tier level of one through four require coordination of services by a *care team* (see definitions) with varying levels of care coordination services.

7. Coordination through panel management

Panel management is baseline coordination for those patients that do not meet criteria for more intensive care coordination services, for inactive patients, for patients who choose not to participate in health care home, and for patients who have met personal health goals. Baseline coordination includes:

- Preventive services, routine care, and chronic disease management
- Post-visit follow-up (i.e. lab results, procedures)
- Routine reminders from orders and labs

Panel Management is a type of approach to population care. Neuwirth (2007), et.al. defined panel management as a set of tools and processes for population care that is applied at the level of the [personal clinician] care panel, with the [personal clinician] directing proactive care for their panel of patients. Panel management may optimize clinic efficiencies by utilizing non-physician staff in proactive population care through outreach, potentially offloading tasks of the personal clinician. (Neuwirth, 2007; Bodenheimer, 2007).

Panel management process steps may included:

- Identification of patients with unmet care by a panel manager
- Preparation for review of patient status
- Patient status reviewed and treatment decisions made between [the care team] and panel manager
- Follow-up on [the care team] instructions (communication with patient)
- Unmet preventive service needs

It is important when implementing panel management that (Neuwirth, 2007):

- Roles and scope of practice are clarified for non-physician and physician staff
 - Non-physician staff roles and responsibilities may include, but is not limited to:
 - Follow-up on PCP orders
 - Communication with patients by their preferred mode of communication
- Allotment of dedicated [personal clinician] time for directing clinical decisions
- Allotment of dedicated staff time to support physicians and conduct outreach
- Information technology tools to identify care gaps
- Standardized work flows and processes are created
- Training and scripts are provided to support safe and reliable communication and coordination of care.

8. Follow-up with patients per clinic process or care team strategy

Patients who would benefit from health care home services but decline or whose complexity tier is zero are to have consistent follow-up to ensure care coordination services are provided. Strategies may need to be identified by the care team to ensure those patients who are in need of care coordination services receive regular or consistent follow-up ensuring eventual participation in health care home services.

**The clinic is to have a process to follow-up and reassess for care coordination services. (MDH Health Care Home Certification Assessment Tool, 2009)*

9. Verify insurance(timing of verification process determined by organization)

***optional**

Identify the patient's payment source (and determine whether their insurance coverage includes a health care home care coordination payment). The health care home can determine whether or not they want to check insurance eligibility prior to claim submission for care coordination payments*. Timing of verification process is established by the health care home.

Insurance eligibility is documented in the clinic's usual manner. The AUC is investigating best practices for updating patient portals

*The payers' eligibility portals should include a health care benefits designation for efficient and reliable eligibility checking by Health Care Homes.

10. Discussion with patient about benefits, care coordination, costs, tier level and services provided and document

Participation in the health care home is voluntary. Therefore, it is the patient's choice to be a participant in a health care home. A discussion should occur with the patient that explains to them

about the health care home, the potential benefits, tier level and what that means, what is different, recommendations from the clinician, and the patient's payment eligibility. This conversation with the patient includes shared decision making about the patient's engagement and participation in care coordination. After the explanation of the health care home program has been completed, the patient is asked if they are interested in participating. If the patient does not express an interest in participating, they have the option to decline. If they receive usual care and their care coordination tier assignment remains the same or worsens, the option of this program is to be offered again following re-assessment.

The work group recommends that the clinic check the language provided in health plan contracts regarding requirements for completion of patient waivers.

Documentation that the discussion occurred is required. This can occur in a simple statement "HCH discussion patient agrees/disagrees to participate in care coordination. Tools can be used for this documentation .

This discussion can occur through phone, email, or face-to-face contact.

**The clinic has a process to discuss with the patient the role of the health care home, including the following items:*

- *The purpose and services of the health care home,*
- *Payment method for health care home*
- *Inform the patient that participation in the health care home is voluntary and is asked if interested in participating.*
- *Provide written education materials (paper or electronic) to the patient that further explains the health care home concept and member liability.*

(MDH Health Care Home Certification Assessment Tool, 2009)

See Appendix A: Health Care Home Script

11. Does patient agree to participate?

The discussion and whether or not the patient agrees to participate in care coordination is the trigger to start the care coordination and payment process.

12. Document that patient does not agree and include tier level

The health care home standards and criteria require that the patient's decision not to participate in the health care home and care coordination services is documented (MDH Health Care Home Certification Assessment Tool, 2009). Documentation that the patient does not agree is required. This can occur in a simple statement "HCH discussion, patient disagrees to participate in care coordination. Tools can be used for this documentation.

It is important to include the care coordination tier level for future follow-up and reassessment purposes.

13. Discussion with the primary clinician to determine follow-up strategy

In the event that a patient does not agree to participate, a discussion should occur to gain an understanding of the patient's reasoning for not participating. If after further discussion, the patient decides not to agree to participate, it is important that there is communication between the care team and the primary clinician to determine future follow-up strategies for patient participation in the health care home. The care team may continue care planning even if the patient does not agree.

14. Document that patient agrees to participate

The health care home standards and criteria require that the patient's decision to participate in the health care home and care coordination services is documented in their medical record. This can occur in a simple statement "HCH discussion patient agrees/disagrees to participate in care coordination. Tools can be used for this documentation (MDH Health Care Home Certification Assessment Tool, 2009; Health Care Home Payment Methodology: Structure and Design, 2010).

Documentation of the agreement and discussion is the action that activates/engages payment. The start date for billing begins with the patient's agreement to participate in care coordination and identification of the complexity tier.

15. Flag medical record and populate registry

The patient's chart is flagged and the registry is populated after the patient has agreed to participate in the health care home.

16. Care team coordination

Fundamental to the health care home are the relationships that are established between the care team (personal clinician, coordinator, and other health care professionals) and the patient. The established relationships are essential to effective information sharing, goal setting, care coordination, care planning and follow-up support that are basic principles in patient- and family-centered care and care coordination.

The Minnesota health care home standards and criteria state that collaboration between the patient, care coordinator, and personal clinician is as follows:

- One or more members of the health care home team, usually including the care coordinator, and the patient set goals and identify resources to achieve the goals;
- The personal clinician and the care coordinator ensure consistency and continuity of care,
- The health care home team and patient determine whether and how often to have contact with the care team, other providers involved in the participant's care, or other community resources involved in the participant's care.

Finally, to be a successful health care home, each member of the care team should be permitted and encouraged to practice at a level that fully uses the professionals' training and skills. When each member works at the "top of their licensure", the health care home functions more efficiently and the flow of patient within and between provider settings is more streamlined. This model will improve clinic efficiencies and streamline the flow of patients within and between provider settings.

(MDH Health Care Home Certification Assessment Tool, 2009; ICSI Task 1, 2008)

**The health care home standards and criteria indicate that the clinic has the following:*

- *Defined roles and accountabilities consistent with patient- and family-centered care principles and demonstrates full use of care team member's education and licensure, such as responsibility matrix or workflows where roles are defined for team members.*
 - *These roles and accountabilities are defined in a summary document such as job descriptions.*

(MDH Health Care Home Certification Assessment Tool, 2009; ICSI Task 1, 2008)

17. Patient and Care Coordinator interaction and initiation of care coordination

The interaction between the care coordinator and the patient to initiate care coordination services can be done via a face-to-face meeting, phone conversation, or e-mail. It is important to confirm the patients preferred method of communication for future interaction at this time.

Care coordination helps with linking the patient with the appropriate resources and services to achieving their personal health goals and good health. Care coordination calls for interconnectivity among care providers that acknowledge the patient's transition among various types of services ranging from acute care and rehab settings into community-based programs, nursing homes, or home care. Care coordinators must have knowledge of and be able to provide health care coaching within a variety of different health care systems. Care coordination should also coordinate mental and physical health needs of the patient. Finally, the care coordinator should provide patients the opportunity to be involved in shared-decision making, patient activation, motivational interviewing, and readiness for change discussions. *(ICSI Task 1, 2008)*

The Minnesota health care home standards and criteria identify the following elements of care coordination be documented in the patient's chart or care plan:

- Referral for specialty care, tracking of whether and when the participant has been seen by a provider to whom a referral was made, results of the referral.
- Referral tracking and follow-up
- Tests ordered, and test result tracking, including processes to manage normal and abnormal test results with timely notification of test results to patient
- Admissions to hospitals or skilled nursing facilities, and the result of the admission
- Timely post-discharge planning including review of information from discharging facilities (hospitals, skilled nursing facilities, or other health care institutions) and coordination of discharged patient information
- Communication with patient's pharmacy; medication refill protocols, medication reconciliation, post-discharge planning and communication with the pharmacy
- Other information, such as links to external care plans, as determined by the care team to benefit the coordination of the patient's care.

If the health care home team includes more than one personal clinician or more than one care coordinator, the patient must identify one personal clinician and one care coordinator as the primary contact and is documented in the patient's medical record.

(MDH Health Care Home Certification Assessment Tool, 2009)

The health care home must encourage patients to take an active role in managing their health care. The clinic must identify one area of readiness for change annually, literacy level, or other barriers to learning. Services are then designed to respond to the unique barrier experience by the patient, to work with the patient to overcome the barrier and actively participate.

Imperative to the success of the coordinator, is designated protected time for performing care coordination tasks and focusing improvements in population outcome measurements. The care coordination process should reflect a plan for communication between the team and the patient with the shared understanding from the patient of the elements below. This includes written procedures for documentation of elements of care.

(MDH Health Care Home Certification Assessment Tool, 2009; ICSI Task 1, 2008)

**The health care home standards and criteria indicate that the clinic has the following:*

- *A systematic process for selection of the patient's personal clinician and care coordinator, which is documented in medical record of each HCH patient receiving care coordination services.*
 - *The documentation includes that the patient has been informed of the identified personal clinician.*
- *A system of care planning in place that includes goal setting with a consistent member of the care team, usually the care coordinator, which includes the patient's involvement.*
- *Patient and care coordinator determine how often the patient should come for planned clinic visits.*
- *Evaluation of the effectiveness of care coordination documentation.*
- *Patient experience / patient satisfaction survey measuring the patient's experience with care planning process.*
- *Training, designated scheduled hours for the care coordinator to complete functions of care coordination in a work schedule, tools to support the work of the care coordinator, documented care coordinator functions (i.e. care coordinator job description).*
- *Written procedures for documentation of elements of care.*
- *Documentation showing evidence of closing the loop on referrals, such as tracking status of referrals, obtaining reports from specialist for personal clinician and notifying patients of referral results, and establishing a follow-up plan.*
- *Evidence in patient's medical record that workflow is being followed.*
- *A process to routinely identify a patient's literacy level or barriers to literacy level and how the care team uses that information in actively involving the patient in their care.*

(MDH Health Care Home Certification Assessment Tool, 2009)

See Appendix A: Health Care Home Script

18. Does patient need care plan?

Not every patient with a chronic or complex condition will require a care plan. Factors such as risk levels, patient type, and patient interest in a care plan may be taken into consideration in the development of a care plan. For example, those patients who have the highest risk level, those patients whom the clinic may not typically provide care, or those patients who choose to have a care plan.

**The health care home standards and criteria indicate that the clinic has the following:*

- *The clinic must have a policy in place that sets criteria to guide which patients with complex or chronic conditions should have a care plan and how elements that should be included in a care plan are addressed by the health care home in care planning. (The above factors may be taken into account in the development of such clinic policies and procedures for care planning).*

19. Care Coordinator and Personal Clinician interaction and documentation

Relationships evolve differently when face-to-face contact is made, so that one person can see and respond to the physical demeanor and nonverbal cues of the other. The requirement that the care coordinator and the clinician have some face-to-face contact enhances the communication and cohesiveness of the care team. With a dedicated care coordinator who is more engaged in the care team based on personal relationships, the clinician has a greater ability and confidence to rely on the coordinator to meet the needs of the participant, therefore freeing the clinician to practice to the fullest extent of his/her license.

The Care Coordinator and Personal Clinician should review the treatment plan, determine follow-up intervals, and discuss their communication plan with the patient. The depth and details of this step will vary based on the team's strengths and internal processes. For example, the skill level of the care coordinator may warrant more or less discussion of medication issues, or an organization's charting and sign off procedures may warrant specific check-in points.

The communication between the care coordinator and the personal physician is to be documented in the patient's medical record or electronic health record.

**The health care home standards and criteria indicate that the clinic has the following:*

- *An infrastructure that supports confidential personal clinician and care coordinator face-to-face interaction.*
- *Ongoing communication between the personal clinician and the care coordinator regarding the patient's goals and progress in the clinic's procedures.*
- *Documentation of communication between the care coordinator and personal clinician such as regular meeting minutes, inbox messaging, and notes of personal clinician approval or orders for care delivery showing ongoing routine direct communication*

(MDH Health Care Home Certification Assessment Tool, 2009)

See Appendix H: Personal Clinician and Care Coordinator Communication Form

20. Ongoing care coordination and documentation

Care Coordination services continue until the patient elects to discontinue the services or their condition stabilizes and care coordination services are no longer required. Ongoing care coordination also includes the principles of panel management (refer to Annotation #6) and the use of a registry (Annotation #28).

Ongoing care coordination includes the following:

- Registry use
- Communication plan with the patient and with the care team
- Care plan use
- Action plan use
- Medication and treatment plan use
- Behavioral activation
- Follow-up plan
- Emergency access plan

Care coordination requires a reasonable level of documentation that provides evidence that the patient is being actively managed based on the HCH certification requirements. The level of documentation is based on the patient's complexity tier consistent with the HCH standards.

Ongoing documentation related to care coordination is required by those managing care coordination, it is not required by the personal clinician. The personal clinician must document if clinical consult provided regarding a change in the patient's plan of care or if the personal clinician reviewed the care plan.

Documentation for all HCH participants includes:

- Standard preventive maintenance and the patient's preferred mechanism of communication
- Basic medication reconciliation to avoid interactions or duplications
- Ongoing support, oversight and guidance by a primary clinician and team
- Patient understanding of access to the clinic and after hours plan
- Routine clinic panel or registry management and tracking of hospital and other admissions or transitions
- Evidence-based guidelines are implemented. Staff monitoring to ensure use of evidence-based guidelines and clinical decision making to facilitate diagnostic test tracking, pre-visit planning and after visit test / set follow-up

21. Reassess for Coordination Tier Level annually or as condition changes and document

Reassessment of the patients Coordination Tier Level is assessed annually or as the patient's condition changes. A qualified member (Physician/DO, Physician Assistant, Registered Nurse, Nurse Practitioner) of the clinical team completes the clinical risk assessment and determines the patient's diagnosis and documents the diagnoses on the problem list. This information is documented in the patient's medical record and the chart is flagged.

Refer to Box #5

22. Care coordination, development of Care Plan with patient, and document

A key component to care coordination is the development of an individualized plan of care with the patient. The care plan not only identifies the patient's health history, desired goals, and an action plan, but also facilitates coordination of consistent, appropriate, and non-duplicative care across the patient's community and other health care providers. The care plan is an active document that is updated based on the changing condition of the patient. Care plan information should flow with or precede the patient to all appropriate care settings. (*ICSI Task 1, 2008*)

The health care home ensures that the patients are given the opportunity to fully engage in care planning and shared decision-making regarding their care. The health care home is required to obtain and document feedback from patients regarding their care. The Minnesota health care home standards and criteria identify the following content of the care plan:

- Goals and an action plan
- Preventive care, including reasons for deviating from standard protocols
- Care of chronic illnesses
- Exacerbation of a known chronic condition, including plans for the patient's early contact with the health care home team during an acute episode
- End-of-life care and health care directives, when appropriate
- The goals must be updated in the care plan with the patient as frequently as is warranted by the patient's condition

The Minnesota health care home standards and criteria identify the following elements of creating and developing care plans:

- Actively engage the patient and verify joint understanding of the care plan
- Engage all appropriate members of the health care team, such as nurses, pharmacists, dietitians, and social workers
- Incorporate pertinent elements of the assessment that a qualified member of the care team performed about the patient's health risks and chronic conditions
- Review, evaluate, and if appropriate, amend the care plan jointly with the participant, at specified intervals appropriate to manage the patient's health and to measure progress towards goals
- Provide a copy of the care plan to the patient upon completion of creating or amending the plan
- Use and document the use of evidence-based guidelines for medical services and procedures if available.

The health care home is responsible for identifying external care plans of those patients with a care plan created by the clinic. If so, the health care home care team is to create a comprehensive care plan by consolidating the appropriate information from the external plans with the health care home care plan.

(*MDH Health Care Home Certification Assessment Tool, 2009*)

**The health care home standards and criteria indicate that the clinic has the following:*

- *Workflows to solicit patient participation and shared decision-making in care planning and other aspects of care delivery and there is documentation of the patient's participation in the process.*
- *A written format for a care plan in the medical record or electronic health record developed collaboratively between the health care home team members and patient.*
- *The care plan policy reflects the following:*
 - *a plan for communication between the team and the patient, and there is a shared understanding with the patient of each of the elements*
 - *a process for completing the risk assessment and documenting patient risks and diagnosis on the problem list.*
 - *Procedural elements on how patient goals will be documented and updated, including a procedure on how often the care plans are updated and include all of the care plan elements.*
- *An audit is completed to determine whether care plans are complete, patient goals are updated and the care plan includes the required elements.*
- *A schedule of encounters for care planning visits between the care coordinator and patients is completed.*
- *The health care home adopts and implements evidence-based guidelines for medical services and procedures.*
- *The health care home demonstrates use of evidence based-guidelines for one important condition. This includes the source of the guideline, training for clinicians, auditing process, screen shot of template and how it is used by clinicians, and documentation.*
- *A process to identify external resources/care plans for those patients with a care plan in order to include external members as part of the care team for planning.*
- *During care planning or other encounters the care coordinator discusses with and encourages the patient to develop an awareness of their responsibilities for their health, assesses with the patient their readiness for change, and connects the patient with self-management support programs, education classes, or other resources.*

Appendix B: Adult Medical Plan

Appendix C: Pediatric Care Plan

Appendix D: Personal Self-care Action Plan

Appendix E: Your Medication Treatment Plan

Appendix F: Behavioral Activation Tool

Appendix G: Follow up Contact Sheet

32. Patient transition management

Management of patient transitions between clinics and care coordination services must occur to support continuity of care.

Transitions include:

- Between clinics
- Pediatric care to adult care
- Seasonal transitions

Transition processes are to be determined by the clinic and include, but is not limited to, contacting the transition clinic, sending records and care plan.

34. Document Start date

The discussion and agreement by the patient to participate in care coordination is the trigger to starting the payment process. There is an activation / engagement action in place with documentation of the event. This could occur through phone, email or face-to-face contact. The start date for billing starts with the patient’s agreement to participate in care coordination and identification of the complexity tier. The claim can be submitted to the payer at any time during the month for the full month's payment, and monthly payments will not be prorated by the number of days in the month.

35. Care Coordinator enrollment: Select billing and diagnosis codes

The HCH will use the procedure codes and modifiers recommended by the Administrative Uniformity Committee (AUC). The recommendations of the AUC⁷ include the use of two new HCPCS codes for medical home services, and a series of modifiers to indicate the patient’s complexity tier level and the presence of the two supplemental complexity factors.

Using these codes and modifiers, the HCH submits a claim for one unit per month per patient. Care coordination services can be billed on a claim with other services. Billing is done based on the statewide claim transaction standards as defined by MN Statutes, 62J.

HCPCS Codes:

S0280: medical home program, comprehensive care coordination and planning, initial plan

S0281: medical home program, comprehensive care coordination and planning, maintenance

Tier			Primary Language Non English	Severe and Persistent Mental Illness
0	Low	No modifier	U3	U4
1	Basic	U1	U3	U4
2	Intermediate	TF	U3	U4
3	Extended	U2	U3	U4
4	Complex	TG	U3	U4

Because of the need for payers to verify that only certified HCH clinicians receive this payment, the rendering or treating provider listed on the claim line for care coordination must be a certified HCH clinician.

An ICD-9 code is not required for health care home, however, in order to submit a claim to a health plan clinics may use the most appropriate code for that patient. A suggested code is V65.49- other specified counseling.

36. Create Billing Communication or Roster: update at least monthly or when condition changes

The HCH will develop an internal process for communication between the clinical staff and the finance staff to stop the monthly claim process when the patient is no longer receiving care coordination services.

Example of an EMR that doesn't talk to billing system.

1. Run EMR report (includes name, MRN, tier level in the problem list, PCP)
2. Add the appropriate HCPCS code, modifiers, and diagnosis to the EMR report.
3. Send completed report to charge entry.

37. Communication/Roster sent to billing department

38. Claim Sent

It is recommended that clinics establish a policy around the date the claim is to be submitted. Billing is done based on the statewide claim transaction standards as defined by MN Statutes, 62J.

39. Remit Received

- The HCH will develop a remittance process based on MN 835 and 62J for Claim Adjustment Reason Code (CARC) or Remittance Advice Remark Code (RARC).
- When a claim is denied because another HCH is already providing care coordination services to a patient, the following remark codes should be used per AUC recommendations: **B20** (CARC) or **N472** (RARC).

40. Work Denial

The HCH will establish a communication process whereby, in the case of a care coordination claim denial, billing staff notify clinical staff (such as the care coordinator) of the denial and a HCH team member discusses the issue with the patient.

41. Communicate denial to care coordinator when appropriate Care coordinator to follow-up with patient

Concurrent Activities

42. Registry-update regularly

It is important that the health care home designs and implements a registry that systematically manages patient information and uses the information for population management to support care coordination. The registry must enable the health care home team to conduct systematic reviews of the health care home's participant population to manage health care services, provide appropriate follow-up, and identify any gaps in care.

The registry must be readily accessible and contain clinically useful information on patients thus allowing for the comprehensive treatment of patients. Minnesota health care home standards and criteria indicates that the registry must contain:

- The name, age, gender, contact information, and identification number assigned by the health care provider, if any, for each participant; and

- Sufficient data elements to issue a report that shows any gaps in care for groups of participants with a chronic or complex condition.
(MDH Health Care Home Certification Assessment Tool, 2009)

A registry is a useful tool for appointment reminders, pre-visit planning, and post-visit follow-up. Refer to Annotation #5 for panel management.

The care coordinator should document on a regular basis that the registry was reviewed and action steps taken. Additionally, the registry should indicate the patient's diagnosis and tier level with modifiers.

**The health care home standards and criteria indicate that the clinic has the following:*

- *A work flow that describes the use of a registry and*
- *A process on use of the registry and how patients are identified for health care services, follow-up and gaps in care are managed.*
- *Registry reports and data elements that demonstrate how the registry is used for panel management and care coordination.*
- *A documented process in place with identified staff time to complete pre-visit planning, call reminders for preventive care, specific tests or procedures, follow-up visits for chronic conditions planned return to clinic appointments and developed guidelines to identify those patients that may have gaps in services.*
- *Evidence that the registry is worked by members of the care team and a process is in place for follow-up procedures.*
- *An audit process that is completed routinely on the use of the registry.*

43. Clinic Access 24/7

Access means the patient has meaningful contact with a primary clinician capable of responding to the patient's needs. Access to care needs to encompass visit and non-visit scenarios. Allowing patients to use e-mail or discuss their care by phone with a caregiver are examples of non-visit outcomes that take into account the patient's preferences and lifestyle. Additionally, extended hours by the health care home offers more patient convenience. Equitable access for groups and individuals most likely to experience a disparity in health care needs to be addressed, such as barriers to race, ethnicity or age, low literacy, geographic isolation, socioeconomic or physical disability. Access can be enhanced through electronic communications and the widening use of electronic medical records and e-prescribing. (ICSI Task 1, 2008)

Based on the Minnesota standards and criteria, the health care home is to design a system where patients have continuous access to the care team during and after regular clinic hours and effective communication with patients and families.

Minnesota health care home standards and criteria identify the following items to be designed within the clinic system as follows:

- Patients are informed that they have continuous access to designated clinic staff, an on-call provider or a phone triage system

- The designated clinic staff, on-call provider or phone triage system representative has continuous access to participants' medical record information, which must include the following for each participant:
 - o The participant's contact information, personal clinician's or local trade area clinician's name and contact information, and designated enrollment in a health care home;
 - o The participant's racial or ethnic background, primary language and preferred means of communication;
 - o The participant's consents and restrictions for releasing medical information;
 - o The participant's diagnoses, allergies, medications related to chronic and complex conditions, and whether a care plan has been created for the participant; and
- The designated clinic staff, on-call provider, or phone triage system representative who has continuous access to the patient's medical record information will determine when scheduling an appointment for the patient is appropriate based on:
 - o Acuity of the patient's condition
 - o Application of a protocol that addresses whether to schedule an appointment within one business day to avoid unnecessary emergency room visits and hospitalizations.

(MDH Health Care Home Certification Assessment Tool, 2009)

**The health care home standards and criteria indicate that the clinic has the following:*

- *A process for how and when the care team, an on-call provider or phone triage system is contacted by the patient 24 hours per day, seven days per week, 365 days per year.*
- *A protocol for the designated clinic staff, on-call providers, or phone triage staff that has continuous access to the patients medical record that establishes scheduling decision-making criteria, telephone response time and response to urgent calls within a specified time.*
 - o *The protocol includes scheduling standards based on patient's risk level and the acuity of the patient's condition and the emergency plan in the patient's care plan to include determining whether to schedule an appointment within one business day to avoid unnecessary emergency room visits and hospitalizations (see Certification Assessment Tool or rules for specific language)*
- *A communication system that informs clinic staff, on-call staff and the triage system of the patient health care home status and risk level for care coordination.*
- *A process for documentation of telephone triage and advice outlined in protocol.*
- *An audit process to collect data that demonstrates continuous access to health care home services and time response to patients.*
- *Patient satisfaction or experience surveys addressing aspects of the patient's experience with access to care.*

44. Patient partnerships and dialogue

The health care home is to provide an environment that supports patient partnerships and dialogue consistent with patient- and family-centered care principles. 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 incorporates the patient's knowledge, values, beliefs, and cultural background that is incorporated

with patient activation, care planning and care delivery. Patient and family-centered care applies to patients of all ages.

A patient- and family-centered health care home relies on patient's to support and provide input on the clinic's quality improvement activities, to include system and process development.

45. Administrative process for determining resources

It is the administrative decision of the individual health care home to establish a policy for care coordination services to those patient's whom elect to participate in the health care home services, but do not have insurance coverage for care coordination services

46. Shared Decision-Making

Shared decision-making is the mutual exchange of information between the patient and the personal clinician 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.

Shared decision-making utilizes patient decision aids that are standardized, evidence-based tools intended to facilitate the shared decision-making process and provide information about the variety of options and their relevant outcomes (*O'Connor, 2004*). They are meant to supplement rather than replace the patient-practitioner interaction. Patient decision aids may be leaflets, interactive media, video, or audio-tapes (*Elwyn, 2006*).

**The health care home standards and criteria indicate that the clinic has the following:*

- *Patients are to be given the opportunity to fully engage and share in the decisions regarding their care.*
- *Workflows are to be established to solicit patient participation and shared decision-making in care planning and other aspects of care delivery.*
- *There is documentation of the patient's participation in the process.*

(MDH Health Care Home Certification Assessment Tool, 2009)

47. Accessing Resources

It is important that the health care home identify partnerships and work with community-based organizations and public health resources such as social services, transportation services, school-based services, disability and aging services, in addition to health care home services. These are resources for patients to access in the event the patient is in need of additional community support. Referrals to community resources enhances the patient's quality of life and journey to optimal health.

**The health care home standards and criteria indicate that the clinic has the following:*

- *The health care home demonstrates ongoing partnership with at least one community resource that the health care home typically provides referrals.*

- *A communication plan for care team members to learn about community resources, such as training about resources, “lunch and learns”, the health care home collaborative, or other ongoing training about community resources or community meetings.*

(MDH Health Care Home Certification Assessment Tool, 2009)

48. Accessibility to Subspecialty

Collaboration between the patient, personal clinician and specialty provider is an essential element of the health care home. This collaboration involves direct, personal interaction between the patient and the personal clinician, care coordinator, or appropriately trained staff and the specialty provider.

It is essential that all specialists providing care to the patient have access to the patient’s information. Therefore, the care team and the care coordinator work together to provide and coordinate patient care, including communication and collaboration with specialists.

With regards to sub-specialty consults, the work group recommends that consultative relationships and processes be developed that support brief telephone interactions between the clinic and sub-specialty clinics when warranted.

49. Transition Planning

The health care home has a vital role in planning for transitions between providers when the health care home coordinates services across specialties and all ages and stages of health. Additionally, the patient must engage in the planning for transitions among providers, health care facilities, and between life stages.

Health care transition interventions were designed to address potential threats to quality and safety during a care transition by providing patients and their caregivers with the tools and support necessary to encourage more active patient participation in care transitions. Findings from a randomized control trial of a care transition intervention identified that coaching chronically ill older patients and their caregivers to ensure that their needs are met during care transitions may reduce the rates of subsequent re-hospitalization (Coleman, 2006).

Coleman’s (2006) care transition intervention was built on four pillars derived from patient and caregiver feedback identifying factors that would be most valuable to them during care transitions. The four factors are:

- Assistance with medication self-management
- A patient-centered record owned and maintained by the patient to facilitate cross-site information transfer
- Timely follow-up with primary or specialty care, and
- A list of “red flags” indicative of a worsening condition and instructions on how to respond to them.

It is therefore important that the health care home has processes in place to engage the patient in preparing and planning for health care related transitions.

**The health care home standards and criteria indicate that the clinic has the following:*

- *A process for anticipatory planning for health care related transitions, such as:*
 - *Planning for referrals of children to adult providers*
 - *Discussion with patients at key transitions*
 - *Transition care planning when the patient transfers to a new personal clinician*
 - *Resources that are in place that provides information about transitions.*

(MDH Health Care Home Certification Assessment Tool, 2009)

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Resources Available

* Author/Organization	Title/Description	Audience	Web Site
American Academy of Family Physicians	The AAFP provides information, tools, and resources related to Patient-Centered Medical Home (PCMH)	Health care professionals	http://www.aafp.org/online/en/home/membership/initiatives/pcmh.html
Center for Children with Special Needs	The Center for Children with Special Needs provides information to families and professionals focusing on children who have chronic physical, developmental, behavioral or emotional conditions. The Web site provides resources on care planning and care coordination for pediatrics	Health care professionals; Patients and families	http://cshcn.org/ http://cshcn.org/planning-record-keeping
* Institute for Clinical Systems Improvement	Tool Kit Contains the following: <ul style="list-style-type: none"> • Care plans <ul style="list-style-type: none"> • Adult • Pediatric • Communication Form • Self-care Action Plan • Your Medication Treatment Plan 	Health care professionals	http://www.icsi.org/health_care_redesign_/health_care_home/
Institute for Clinical	ICSI/MDH Recommendations of Health care		http://www.icsi.org/health_care_redesign_/

Systems Improvement Health Care Home and Patient professionals health_care_home_
Outcomes

*Author/Organization	Title/Description	Audience	Web Site
Minnesota Department of Health (MDH)	The Minnesota Department of Health's Web site provides tools and resources pertinent to the implementation of the adopted Health Care Home Standards and Criteria.	Health care professionals; Patients and families	http://www.health.state.mn.us/healthreform/homes/index.html

- Health Care Home Certification Assessment Tool

National Center for Medical Home Implementation	The mission of the National Center for Medical Home Implementation is to work in cooperation with federal agencies, particularly the Maternal and Child Health Bureau (MCHB), and other partners and stakeholders to ensure that all children, including children with special needs, have access to a medical home.	Health care professionals; Patients and families	http://www.medicalhomeinfo.org/
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The National Center provides medical home resources, technical assistance and support to physicians, families, and other medical and non-medical providers who care for children.

* Author/Organization	Title/Description	Audience	Web Site
National Institute for Children's Healthcare Quality	The National Initiative for Children's Healthcare Quality (NICHQ) is an independent, action-oriented organization dedicated to achieving a world in which all children receive the high quality healthcare they need.	Health care professionals; Patients and families	http://www.nichq.org/
Ottawa Health Research Institute	The Web site provides information, tools, and resources regarding medical home. An inventory of decision aids and the Cochrane review	Health care professionals	http://decisionaid.ohri.ca/AZinvent.php
	<ul style="list-style-type: none"> • A-Z Inventory of Decision Aids 		