

Health Care Homes Certification Assessment Tool

Certification Assessment Form Structure:

Providers, clinics and organizations should use this self-assessment document to prepare for meeting the requirements for Minnesota Department of Health (MDH) [Health Care Homes](#) (HCH) certification/recertification. Applicants will enter a response or method for meeting each of the Assessment's subparts into the [online](#) HCH portal prior to certification/recertification.

- Column one is the standard or criteria as stated in the Minnesota Department of Health HCH Rule Chapter 4764.
- Column two describes the intent of the standard and what must be in place for certification/recertification.
- Column three details required documentation and activities to ensure a successful certification/recertification site visit/team meeting.

Instructions:

The MDH HCH standards are designed to support progressive implementation of the HCH model over time. Rule eligibility subparts (0030 1A, 1B and 2) and odd numbered HCH standards subparts (0040 1,3,5,7 and 9) must be met at initial certification, while remaining standards subparts (0040 2, 4, 6, 8, 10, and 11) must be met at the first recertification (which is three years from the initial certification date).

The HCH clinic/organization recertification cycle is every three years. MDH HCH regional nurse planners are available to conduct optional annual check-ins between certification and recertification to assist with progression on standards over time. The recertification process at year three will focus on progress made on all subparts.

Documentation and data sources:

Clinics are to provide a brief narrative or document verifying that processes, policies and activities are in place to address requirements in the standards (detailed in column three). It is the intent of MDH HCH to limit administrative burden; there are **ten required documents** at initial certification, identified in column three under "Submit as attachment in portal" (policies/protocols/procedures specifically required in subparts 1B, 7A, 9 B & E). The clinic should 'blind' patient level data while still enabling reviewers to see how the clinic uses a document in practice. The initial certification site visit will validate that the processes, policies and workflows are in place. The recertification process uses a team-meeting format, providing the applicant an opportunity to share their story of progression.

Questions: Please submit questions regarding the application process to health.healthcarehomes@state.mn.us
03-19-2018

Minnesota Administrative Rules HEALTH CARE HOME STANDARDS	Certification Assessment	Documentation required; preparation for site visit
<p>4764.0030 Subp. 1</p> <p>Certification and recertification procedures.</p> <p>Eligibility for certification.</p> <p>1 A. An eligible provider, supported by a care team and systems according to the requirements in part 4764.0040, may apply for certification as a health care home.</p> <p>1 B. A clinic will be certified only if all of the clinic's personal clinicians and local trade area clinicians meet the requirements for participation in the health care home. It is the clinic's responsibility to notify the department when a new clinician joins a certified clinic and intends to become a certified clinician. The clinic has 90 days from the date of hiring the new clinician or until its next annual anniversary date to apply for recertification, whichever is sooner. A clinic may operate as a certified clinic with the new clinician acting as though certified until the new clinician is certified. If the clinician chooses not to be certified, the clinic will no longer be certified, but the clinicians who were previously certified as part of the clinic will automatically hold an individual certification only.</p>	<p>Purpose (statute): To specify who is eligible to apply for certification as a Health Care Home (HCH).</p> <p>Explanation (intent): To be eligible for certification, the clinic must deliver patient centered primary care services using a team of staff (clinician, care coordinator and other staff as defined by the patient's needs and clinic's resources).</p> <p>Each patient has an ongoing personal relationship with a personal clinician trained to provide first point of contact, continuous and comprehensive care, including preventive, acute and chronic care.</p> <p>What needs to be in place:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 1A. Documentation of the clinic organizational structure that shows the HCH team structure (i.e. an organizational chart that depicts how the patients are involved in the HCH). <input type="checkbox"/> 1A. Description of services provided by the clinic. <input type="checkbox"/> 1A. Evidence that clinicians are supported by a team care delivery system. (working in the HCH model of care) <input type="checkbox"/> 1A. Evidence that team members, patients and families understand how the team functions. <input type="checkbox"/> 1A. Verification that clinician applicants provide the full range of primary care services, i.e. <ul style="list-style-type: none"> 1. Documentation of board certification and / or licensure in primary care specialties for physicians, nurse practitioners and physician assistants. (contained in letter of intent) 2. Documentation of organizational commitment to primary care services such as a mission or aim statement that demonstrates commitment to HCH model, care coordination and other components of the HCH criteria. <input type="checkbox"/> 1A. A mission or aim statement that includes patient- and family- centered principles. 	<p>Complete in HCH portal - as outlined in the HCH certification/recertification guide.</p> <p>Below are website links to printable versions for preparation purposes:</p> <ul style="list-style-type: none"> <input type="checkbox"/> HCH Letter of intent <input type="checkbox"/> HCH Application form <input type="checkbox"/> HCH Certification Assessment form <p>Submit as attachments in portal when completing assessment form:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 1A. Organizational structure <input type="checkbox"/> 1B. Primary Care mission, vision or aim statement. <p>Describe in Portal: As outlined in the certification/recertification guide, you will describe specified systems and processes when you submit your assessment in the portal.</p>

4764.0020 Definitions:

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

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. 26. Participant. *“Participant” means the patient and, where applicable, the patient’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 participant perspectives and choices. It also incorporates the participant’s knowledge, values, beliefs and cultural background into care planning and delivery. Patient and family-centered care applies to patients of all ages.*

1A. For Specialists Only:

- Provide evidence in the form of a chart audit that they are providing comprehensive primary care services including first point of contact acute care, preventive and chronic care themselves and not referring out primary care services.
- Provide evidence of communicating to their patients that they provide primary care services.
- Provide evidence that patients understand they provide primary care services.

At site visit:

Site visit evaluation team will:

- 1A. Conduct clinic team and patient interviews regarding team based, patient centered care.

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<p>4764.0040 Subp. 1</p> <p>Certification Requirements</p> <p>Access and communication standard The applicant for certification must have a system in place to support effective communication among the members of the health care home team, the participant, and other providers. The applicant must do the following:</p> <p>1 A. Offer the applicant's health care home services to all of the applicant's patients who:</p> <ul style="list-style-type: none"> (1) have or are at risk of developing complex or chronic conditions; and (2) are interested in participation; <p>1 B. Establish a system designed to ensure that:</p> <ul style="list-style-type: none"> (1) participants are informed that they have continuous access to designated clinic staff, an on-call provider, or a phone triage system; (2) 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: <p>(a) 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;</p>	<p>Purpose (statute): To require HCHs to deliver services that facilitate consistent and ongoing communication among the HCH and the patient and family, and provide the patient with continuous access to the patient's HCH;</p> <p>Explanation (intent): The HCH population is the clinic population. The HCH is responsible for management of the clinic's population. The organization establishes a process to screen patients for medical and non-medical complexity to identify those who may benefit from care coordination services. The screening process provides the foundation for determining patient participation based on risk level.</p> <p>Patient participation in HCH care coordination is voluntary. The process includes asking the patient if they are interested in participation, and documenting the patient's decision in the medical record (agreed or declined).</p> <p>The HCH meets patient care needs and prevents unnecessary ER visits and hospitalizations by providing continuous 24-hour access to a designated member of the HCH team and by making sure the patient and family know who to contact after hours.</p> <p>Collecting the patient's racial or ethnic background, primary language, and preferred means of communication helps the HCH team provide culturally appropriate, patient and family centered care that supports patient activation and engagement.</p> <p>Providing information about optimal treatment and care options shows support of patients' decisions, even when they choose care outside of the HCH delivery system.</p> <p>HCHs are required to comply with existing applicable laws on information privacy and security.</p> <p>What needs to be in place:</p> <p><input type="checkbox"/> 1A. A screening process to identify patients who would benefit from care coordination services. The screening process used to identify patients may include a combination of the following:</p>	<p>Submit as attachment in portal when completing assessment form:</p> <p><input type="checkbox"/> 1A. Systematic screening and communication process or protocol to identify which patients would most benefit from care coordination services.</p> <p><input type="checkbox"/> 1B. Communication process or protocol for providing 24-hour access and for informing patients of how to access after-hours care. This should include triage and scheduling process for daytime and after hours.</p> <p><input type="checkbox"/> 1B. Triage and scheduling protocol for during the day and after hours.</p> <p>Describe in Portal: As outlined in the certification/recertification guide, you will describe specified systems and processes when you submit your assessment in the portal.</p> <p>At site visit:</p> <p>Site visit evaluation team will:</p>

<p>(b) the participant's racial or ethnic background, primary language, and preferred means of communication;</p> <p>(c) the participant's consents and restrictions for releasing medical information; and</p> <p>(d) the participant's diagnoses, allergies, medications related to chronic and complex conditions, and whether a care plan has been created for the participant; and</p> <p>(3) the designated clinic staff, on-call provider, or phone triage system representative who has continuous access to the participant's medical record information will determine when scheduling an appointment for the participant is appropriate based on:</p> <p>(a) the acuity of the participant's condition; and</p> <p>(b) application of a protocol that addresses whether to schedule an appointment within one business day to avoid unnecessary emergency room visits and hospitalizations;</p> <p>1 C. Collect information about participants' cultural background, racial heritage, and primary language and describe how the applicant will apply this information to improve care;</p> <p>1 D. Document that the applicant is using participants' preferred means of communication, if that means of communication is available within the</p>	<ul style="list-style-type: none"> • Registry • Population based screening method • Panel management method <p><input type="checkbox"/> 1A. A process to communicate the role of the HCH with patients in both a verbal and a written format (paper or electronic, an MDH template for a HCH brochure is available).</p> <p>Communication includes:</p> <ul style="list-style-type: none"> • purpose and services of the HCH • name of the patient's primary clinician • responsibilities of the patient and of the clinic's team members • role of the care coordinator • clinic's office hours • how to access the clinic after hours • information about referral coordination services • referral options and how to access referrals • explanation of what is new and different from the coordination the patient previously received • payment method for HCH <p><input type="checkbox"/> 1B. A process to provide every patient / family with continuous 24-hour access to an on-call provider or phone triage system.</p> <ul style="list-style-type: none"> • Patient/family knows how to contact the HCH team • Clinic staff, on-call staff and phone triage representative have continuous access to the patient's medical record and are able to identify patient's contact information, personal clinician's name and contact information, care coordination enrollment status, racial or ethnic background, primary language, preferred means of communication, and the patient's consents and restrictions for releasing medical information. • Based on the use of a protocol to determine the acuity of the patient's condition, clinic staff communicate to patient /family when an appointment can be scheduled or whether the patient should seek immediate care <p><input type="checkbox"/> 1C. A process to collect and document race, ethnicity, and language in the medical record for every clinic patient. There is a process to train staff to collect, document and use this information to identify and address barriers to communication. I.e. If primary language is Arabic, staff may need to contact and use interpreter services.</p>	<p>1A. /1B. Review the screening/ communication process.</p> <p>1B. Evaluate the results of the audit regarding continuous access (MDH audit tool available).</p> <p>1C. Review the process to collect and document the cultural background, racial heritage, and primary language of all patients and how the applicant is using this information to improve care.</p> <p>1D. Review the process to collect and document the preferred method of communication of all patients.</p> <p>1E. Review the process to inform patients that they may choose specialty care resources outside of the HCH network</p> <p>1F. Review privacy and security practices</p> <p>Resources: Patient experience surveys Internal chart audits</p>
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health care home's technological capability;

1 E. Inform participants that the participant may choose a specialty care resource without regard to whether a specialist is a member of the same provider group or network as the participant's health care home, and that the participant is then responsible for determining whether specialty care resources are covered by the participant's insurance; and

1 F. Establish adequate information and privacy security measures to comply with applicable privacy and confidentiality laws, including the requirements of the Health Insurance Portability and Accountability Act, Code of Federal Regulations, title 45, parts 160.101 to 164.534, and the Minnesota Government Data Practices Act, Minnesota Statutes, chapter 13

1D. A process to collect and document the patient's preferred method of communication

1E. A process to inform the patient that they may choose specialty care regardless of whether the specialist is a member of the health care home delivery network.

1F. A data security policy that complies with existing applicable law on information privacy and security.

1F. A process for information management and release of information protocols.

1A.-1F. The HCH measures patient's satisfaction with access and communication processes.

Minnesota Administrative Rules HEALTH CARE HOME STANDARDS	Certification Assessment	Documentation required; preparation for site visit
<p>4764.0040 Subp. 3</p> <p>Certification Requirements</p> <p>Participant registry and tracking standard; Participant care activity standard</p> <p>The applicant for certification must use a searchable, electronic registry to record participant information and track participant care.</p> <p>3 A. 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.</p> <p>3 B. The registry must contain: (1) For each participant, the name, age, gender, contact information, and identification number assigned by the health care provider, if any; and (2) Sufficient data elements to issue a report that shows any gaps in care for groups of participants with a chronic or complex condition.</p>	<p>Purpose (statute): To require HCH to deliver services that use an electronic, searchable patient registry that enables the HCH to manage health care services, provide appropriate follow-up, and identify gaps in patient care.</p> <p>Explanation (intent): Maintaining a current registry enables the HCH to readily access clinically useful information on patients that can be used to treat all clinic patients comprehensively, to manage population health, and to support care coordination.</p> <p>What needs to be in place:</p> <p><input type="checkbox"/> 3A. The registry / registries identifies patients, gaps in care, manages health care services and enables appropriate follow-up.</p> <p><input type="checkbox"/> 3B. The registry/s contains required elements</p> <ul style="list-style-type: none"> • name • age • gender • contact information • identification number, if any is assigned • Sufficient data elements to issue a report that shows any gaps in care for groups of patients with a chronic or complex condition. 	<p>Submit as attachment in portal when completing assessment form:</p> <p><input type="checkbox"/> 3A. Procedure or workflow that demonstrates the systematic use of the registry.</p> <p>Describe in Portal: As outlined in the certification/recertification guide, you will describe specified systems and processes when you submit your assessment in the portal.</p> <p>At site visit: Site visit evaluation team will:</p> <p>3A. Conduct interviews with the clinic team to gather information regarding how the registry is used to support quality goals.</p> <p>3B. Provide copy/screenshot of registry report (blinded patient information) with required elements – if not previously submitted.</p> <p>3A, B. Ask clinic team to demonstrate how the registry / registries is used for panel management and care coordination.</p>

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<p>4764.0040 Subp. 5 Certification Requirements Care Coordination Standard</p> <p>The applicant for certification must adopt a system of care coordination that promotes patient and family-centered care through the following steps:</p> <p>5 A. collaboration within the health care home, including the participant, care coordinator, and personal clinician or local trade area clinician as follows:</p> <p>(1) one or more members of the health care home team, usually including the care coordinator, and the participant set goals and identify resources to achieve the goals;</p> <p>(2) the personal clinician or local trade area clinician and the care coordinator ensure consistency and continuity of care;</p> <p>(3) the health care home team and participant determine whether and how often the participant will have contact with the care team, other providers involved in the participant's care, or other community resources involved in the participant's care;</p> <p>5 B. uses health care home teams to provide and coordinate participant care, including communication and collaboration with specialists. If a health care home team includes more than one personal clinician or local trade area clinician, or more than one care</p>	<p>Purpose (statute): To require HCH to deliver services that include care coordination that focuses on patient and family-centered care</p> <p>Explanation (intent): Relationships between the primary care provider (PCP), the care coordinator, and the patient facilitate effective information sharing, goal setting, care planning and follow-up support. These are basic principles in patient- and family-centered care and care coordination.</p> <p>All patients have a designated PCP, and, if applicable, a designated care coordinator. The care coordinator and the clinician have direct communication with some face-to-face time. "Direct communication" means an exchange of information by telephone, electronic mail, video conferencing, or face-to-face contact without the use of an intermediary. Effective communication benefits coordinated patient care and enhances cohesiveness of care team.</p> <p>Protected time ensures the care coordinator can perform the care coordination functions required to make improvements in population health outcomes.</p> <p>For the entire clinic population, follow up support must be provided and includes closed loop referrals for specialty care; follow up of tests ordered, test results and communication of results and plan of care to the patient; follow up of admissions to facilities; post-discharge planning; communication with the pharmacy; and links to external care plans.</p> <p>What needs to be in place:</p> <p><input type="checkbox"/> 5A. A system of care coordination that promotes patient and family-centered care.</p> <p><input type="checkbox"/> 5A. One or more HCH team members engage the patient in setting goals and identifying resources needed to achieve the goals.</p> <p><input type="checkbox"/> 5A. The HCH team works with the patient to determine whether and how often the patient will need contact with the care team, other care providers, and community resources.</p>	<p>Submit as attachment in portal when completing assessment form:</p> <p><input type="checkbox"/> 5B. Systematic process for identifying the patient's primary care provider (PCP) and documentation in the medical record of the PCP and care coordinator (if applicable).</p> <p><input type="checkbox"/> 5D. A document with the role and requirements of the care coordinator, such as a job description and protected hours for care coordination.</p> <p>Describe in Portal: As outlined in the certification/recertification guide, you will describe specified systems and processes when you submit your assessment in the portal.</p> <p>At site visit:</p> <p>Site visit evaluation team will:</p> <p>5A & E. Review completed care coordination audit (an MDH HCH self-audit tool is</p>

<p>coordinator, the applicant must identify one personal clinician or local trade area clinician and one care coordinator as the primary contact for each participant and inform the participant of this designation;</p> <p>5 C. provides for direct communication in which routine, face-to-face discussions take place between the personal clinician or local trade area clinician and the care coordinator;</p> <p>5 D. provides the care coordinator with dedicated time to perform care coordination responsibilities; and</p> <p>5 E. documents the following elements of care coordination in the participant's chart or care plan:</p> <p>(1) referrals for specialty care, whether and when the participant has been seen by a provider to whom a referral was made, and the result of the referral;</p> <p>(2) tests ordered, when test results have been received and communicated to the participant;</p> <p>(3) admissions to hospitals or skilled nursing facilities, and the result of the admission;</p> <p>(4) timely post discharge planning according to a protocol for participants discharged from hospitals, skilled nursing facilities, or other health care institutions;</p> <p>(5) communication with participant's pharmacy regarding use of medication and medication reconciliation; and</p> <p>(6) other information, such as links to external care plans, as determined by the care team to be beneficial to coordination of the participant's care.</p>	<p><input type="checkbox"/> 5A. The HCH measures patient's satisfaction with the care planning process.</p> <p><input type="checkbox"/> 5B. The HCH team designates a personal clinician (primary care provider - PCP) for each patient in the clinic population and designates a care coordinator to every patient enrolled in care coordination. When the HCH team includes more than one clinician or care coordinator, the HCH team identifies a primary PCP and care coordinator for the patient. The HCH team informs the patient of their designated PCP and care coordinator and ensures specialists have access to this designation.</p> <p><input type="checkbox"/> 5C. The PCP and care coordinator have direct communication and work together to ensure consistency and continuity of care.</p> <p><input type="checkbox"/> 5D. Protected time, job training and care coordinator tools are provided to the care coordinator to support care coordination work.</p> <p><input type="checkbox"/> 5E. For the entire clinic population, there are procedures for documentation of care that include:</p> <p>(1) referral tracking and follow up</p> <p>(2) tests ordered, results tracked and timely notification to patients</p> <p>(3) post admissions to facilities are tracked</p> <p>(4) timely post discharge planning</p> <p>(5) communication with participant's pharmacy and medication reconciliation</p> <p>(6) links to external team members and care plans, if applicable</p>	<p>available upon request for use if desired)</p> <p>5A. Review patient experience data.</p> <p>5B. Assess whether patients can identify their designated PCP and care coordinator</p> <p>5C. Review the communication mechanism between the PCP and care coordinator.</p> <p>5D. Interview the care coordinator regarding role; observe care coordinator work area; identify tools available to support care coordination.</p> <p>Ask the clinic team to describe/show process for documenting elements in:</p> <p>5E: referrals, tests, facility admission, post discharge planning, pharmacy communication and links to external care plans</p>
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Minnesota Administrative Rules HEALTH CARE HOME STANDARDS	Certification Assessment	Documentation required; preparation for site visit
<p>4764.0040 Subp. 7</p> <p>Certification Requirements Care plan standard</p> <p>The applicant for certification must meet the following requirements:</p> <p>7 A. Establish and implement policies and procedures to guide the health care home in assessing whether a care plan will benefit participants with complex or chronic conditions.</p> <p>The applicant must do the following in creating and developing a care plan:</p> <p>(1) actively engage the participant and verify joint understanding of the care plan;</p> <p>(2) engage all appropriate members of the health care team, such as nurses, pharmacists, dieticians, and social workers;</p> <p>(3) incorporate pertinent elements of the assessment that a qualified member of the care team performed about the patient's health risks and chronic conditions;</p> <p>(4) review, evaluate, and, if appropriate, amend the care plan, jointly with the participant, at specified intervals appropriate to manage the participant's health and measure progress toward goals;</p>	<p>Purpose (statute): To require HCH to deliver services that include a care plan for selected patients with a chronic or complex condition, involve the patient and, if appropriate, the patient's family in the care planning process.</p> <p>Explanation (intent):</p> <p>Care Plan Policy Not every patient with chronic or complex conditions will require a care plan. The care plan policy guides the development of the care plan, defines which patients would most benefit, identifies required elements of the care plan, and defines how and when the care plan will be updated. The care plan includes the pertinent elements of the assessment performed by a qualified member of the clinical team of the patient's health risks and chronic conditions.</p> <p>Care Plan document An effective care plan is an active document that is updated based on changes in the patient's condition. The care plan includes the patient's goals, action plans for preventive care, chronic care, and exacerbation of a chronic condition, and planning for end-of-life care as appropriate. Goals are patient specific and measurable.</p> <p>What needs to be in place:</p> <p><input type="checkbox"/> 7A.-7.C Care plan policy that:</p> <ul style="list-style-type: none"> • Defines how HCH team will engage patients in the development their care plan and verify joint understanding of the care plan. • Defines how you will engage the broad care team, such as nurses, pharmacists, dieticians and social workers within and outside the clinic. • Defines how the HCH team will document the pertinent elements of the of the patient's health risks and chronic conditions, as assessed by a qualified member of the clinical team. • Defines who will review, evaluate, and, if appropriate, amend the care plan, including patient goals, jointly with the participant; how often this will occur. • Has a process to provide a copy of the care plan to the patient upon completing or amending the plan. 	<p>Submit as attachment in portal when completing assessment form:</p> <p><input type="checkbox"/> 7A. The written care plan policy that references each of the criteria.</p> <p>Describe in Portal: As outlined in the certification/recertification guide, you will describe specified systems and processes when you submit your assessment in the portal.</p> <p>At site visit:</p> <p>Site visit evaluation team will:</p> <p>7A. Interview the care coordinator and preselected patients regarding the development of the care plan.</p> <p>7B. Review randomly selected care plans developed in collaboration between the patient and care team; verify the care plans are complete, current, include all required elements and reflect the care plan template.</p> <p>7B. Interview the HCH team regarding the use of evidence-based guidelines</p>

(5) provide a copy of the care plan to the participant upon completion of creating or amending the plan; and (6) use and document the use of evidence-based guidelines for medical services and procedures, if those guidelines and methods are available;

7 B. A participant's care plan must include goals and an action plan for the following:

- (1) preventive care, including reasons for deviating from standard protocols;
- (2) care of chronic illnesses;
- (3) exacerbation of a known chronic condition, including plans for the participant's early contact with the health care home team during an acute episode; and
- (4) end-of-life care and health care directives, when appropriate; and

7 C. the applicant must update the goals in the care plan with the participant as frequently as is warranted by the participant's condition.

- Defines which and how evidence based guidelines will be used to guide medical services and procedures.

7A.-7.C Care plan design or template that includes:

- Primary care provider (PCP) and care team members such as the care coordinator.
- Preventive care
- Care of chronic conditions
- Management plan for exacerbations of chronic conditions, including steps for early intervention, including when and how to contact the care team
- End of life planning as appropriate
- Patient identified, patient centered goals and resources to achieve those goals.

Other potential care plan elements:

- Current medication list in patient friendly language
- Active problem list
- Pertinent past medical history
- Emergency Contacts
- Cultural considerations
- Preferred method of communication
- Patient centered goals that are SMART (specific, measurable, achievable, reasonable, and time bound) goals.
- After visit summary
- Specialty providers, and community services/programs contact information
- Pertinent information from the specialty provider's plan and other community services/programs

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<p>4764.0040 Subp. 9 Certification Requirements Performance reporting and quality improvement standard</p> <p>The applicant for certification must measure the applicant's performance and engage in a quality improvement process, focusing on patient experience, patient health, and measuring the cost-effectiveness of services, by doing the following:</p> <p>9 A. Establishing a health care home quality improvement team that reflects the structure of the clinic and includes, at a minimum, the following persons at the clinic level:</p> <p>(1) one or more personal clinicians or local trade area clinicians who deliver services within the health care home;</p> <p>(2) one or more care coordinators;</p> <p>(3) two or more participant (patient) representatives who were provided the opportunity and encouraged to participate; and</p> <p>4) if the health care home is a clinic, one or more representatives from clinic administration or management;</p> <p>9 B. Establishing procedures for the health care home quality improvement</p>	<p>Purpose (statute): To require HCH to deliver services that reflect continuous improvement in the quality of the patient's experience, the patient's health outcomes, and the cost-effectiveness of services.</p> <p>Explanation (intent): Quality improvement planning is critical to the success of the HCH and essential to improving health outcomes. The quality team includes patients and clinic staff involved in direct care delivery. A patient- and family-centered HCH relies on patients to provide input to the clinic's quality activities.</p> <p>Implementation of major change is hard work for a team. The supportive environment of the learning collaborative supports successful change.</p> <p>Members of the quality team and learning collaborative share information with the rest of the HCH team and elicit feedback on the information. This process helps the entire HCH team remain up to date and engaged in the quality improvement process.</p> <p>What needs to be in place:</p> <p><input type="checkbox"/> 9A. The HCH has a quality team that includes patients and clinic staff involved in direct patient care</p> <p><input type="checkbox"/> 9A. The clinic keeps a membership list with identified roles of the quality team and records attendance and minutes from quality team meetings. Meeting minutes show clinic team members and patients actively involved and represented in the discussions. The clinic maintains six months of records of meeting attendance and minutes.</p> <p><input type="checkbox"/> 9B. The HCH has a procedure for sharing the HCH's quality plan with HCH team members and for eliciting feedback from team members. (including patients/families is also suggested)</p> <p><input type="checkbox"/> 9B, D. Patients/families are encouraged to participate in the quality team and learning collaborative</p> <p><input type="checkbox"/> 9C. The HCH has a quality plan where at least one quality indicator is selected based on opportunity for improvement. The HCH defines, measures</p>	<p>Submit as attachments in portal when completing assessment form:</p> <p><input type="checkbox"/> 9A, 9D. Membership of HCH quality team and learning collaborative for each unit (i.e. department or clinic)</p> <p><input type="checkbox"/> 9B, 9E. A procedure for sharing information and giving input to and from the quality team and the learning collaborative team.</p> <p>Describe in Portal: As outlined in the certification/recertification guide, you will describe specified systems and processes when you submit your assessment in the portal.</p> <p>At site visit:</p> <p>Site visit evaluation team will:</p> <p>9A. Review HCH quality meeting minutes and discuss key points at quality interview with HCH team members.</p>

team to share their work and elicit feedback from health care home team members and other staff regarding quality improvement activities;

9 C. Demonstrating capability in performance measurement by showing that the applicant has measured, analyzed, and tracked changes in at least one quality indicator selected by the applicant based upon the opportunity for improvement;

9 D. Participating in a health care home learning collaborative through representatives that reflect the structure of the clinic and includes the following persons at the clinic level:

(1) one or more personal clinicians or local trade area clinicians who deliver services in the health care home;

(2) one or more care coordinators;

(3) if the health care home is a clinic, one or more representatives from clinic administration or management; and

(4) two or more participant representatives who were provided the opportunity and encouraged to participate with the goal of having two participants of the health care home take part; and

9 E. Establishing procedures for representatives of the health care home to share information learned through the collaborative and elicit feedback from health care home team members and other staff regarding information.

and analyzes the quality gap; trials interventions; and tracks changes in the indicator.

9D. Members of the HCH participate in the learning collaborative and maintain records of dates of attendance at HCH learning collaborative meetings and workshops.

9E. The HCH has a procedure for sharing information and ideas between the learning collaborative and the HCH team (sharing information with patients/families is also suggested)

9B. Interview HCH team members regarding quality team's approach to eliciting feedback.

9C. Review quality plan, one data element, and results. Review tracking and plan. Discuss the rationale for picking the quality indicator.

AT RECERTIFICATION the following subparts must be met

Minnesota Administrative Rules HEALTH CARE HOME STANDARDS	Certification Assessment	Documentation required; preparation for site visit
<p>4764.0040 Subp. 2.</p> <p>Recertification Requirements * Access and communication standard;</p> <p>By the end of the first year of health care home certification, the applicant for recertification At the time of* health care home recertification, the applicant must demonstrate that they encourage participants to take an active role in managing the participant's health care, and that the applicant has demonstrated participant involvement and communication by identifying and responding to one of the following: participants' readiness for change, literacy level, or other barriers to learning.</p> <p>*Note: On 8-1-2016, a legislative change to the HCH certification cycle now requires the HCH applicant to renew recertification every three years instead of annually. Please refer to Appendix 1.</p>	<p>Purpose (statute): To require HCHs to deliver services that facilitate consistent and ongoing communication among the HCH and the patient and family, and provide the patient with continuous access to the patient's HCH;</p> <p>Explanation (intent): The HCH promotes patient engagement and communication by identifying and addressing one area for improvement: the patient's readiness for change, literacy level or other barriers to learning.</p> <p>Services are designed to respond to the unique barriers experienced by the patient. By addressing these barriers, patients are more likely to understand health instructions, education documents and teaching methods; and therefore actively participate in their care. For example, the HCH may adopt a process to identify a patient's literacy level and use that information to engage the patient in their care. In another example, during care planning or other encounters, HCH staff may assess the patient's readiness for change, and connect the patient to self-management support, education or other resources.</p> <p>What needs to be in place:</p> <ul style="list-style-type: none"> <input type="checkbox"/> The HCH promotes patient engagement and communication by identifying and addressing one area for improvement: the patient's readiness for change, literacy level or other barriers to learning. <input type="checkbox"/> The HCH actively engages patients to help them overcome the identified barrier to care. <input type="checkbox"/> The HCH encourages active participation by patients in their care. 	<p>Describe in Portal: As outlined in the certification/recertification guide, you will describe specified systems and processes when you submit your assessment in the portal.</p> <p>At Site Visit:</p> <p>Site visit evaluation team will:</p> <p>Review and discuss submitted documentation and work processes.</p>

Minnesota Administrative Rules HEALTH CARE HOME STANDARDS	Certification Assessment	Documentation required; preparation for site visit
<p>4764.0040 Subp. 4.</p> <p>Recertification Requirements*</p> <p>Participant registry and tracking participant care activity standard;</p> <p>By the end of the first year of health care home certification *The applicant for recertification must use the registry to identify gaps in care and implement remedies to prevent gaps in care such as appointment reminders and pre-visit planning.</p> <p>*Note: On 8-1-2016, a legislative change to the HCH certification cycle now requires the HCH applicant to renew certification every three years instead of annually. Please refer to Appendix 1.</p>	<p>Purpose (statute): To require HCH to deliver services that use an electronic, searchable patient registry that enables the HCH to manage health care services, provide appropriate follow-up, and identify gaps in patient care.</p> <p>Explanation (intent): The registry is the most useful tool to systematically identify gaps in services such as missed appointments, whether referrals are being tracked and test results followed up.</p> <p>What needs to be in place:</p> <ul style="list-style-type: none"> <input type="checkbox"/> A process that includes dedicated staff time to complete pre-visit planning, make call reminders for preventive care, specific tests or procedures, ensure follow-up visits for chronic conditions, and ensure planned return to clinic appointments. <input type="checkbox"/> A process to identify patients that may have gaps in services. <input type="checkbox"/> Evidence that the HCH team actively uses the registry <input type="checkbox"/> Evidence the HCH team has a process for follow up procedures to address identified gaps <input type="checkbox"/> A self-audit process that is regularly completed and assesses use of the registry. 	<p>Submit as attachment in portal when completing assessment form:</p> <p><input type="checkbox"/> The workflow that demonstrates the systematic use of the HCH registry and follows-up services such as call reminders or pre-visit planning.</p> <p>Describe in Portal: As outlined in the certification/recertification guide, you will describe specified systems and processes when you submit your assessment in the portal.</p> <p>At Site Visit:</p> <p>Site visit evaluation team will:</p> <p>Review and discuss submitted documentation and work processes.</p>

Minnesota Administrative Rules HEALTH CARE HOME STANDARDS	Certification Assessment	Documentation required; preparation for site visit
<p>4764.0040 Subp. 6. Recertification Requirements* Care coordination standard; By the end of the first year of health care home certification,* The applicant for recertification must enhance the applicant's care coordination system by adopting and implementing the following additional patient and family-centered principles:</p> <p>6 A. Ensure that participants are given the opportunity to fully engage in care planning and shared decision-making regarding the participant's care, and that the health care home solicits and documents the participant's feedback regarding the participant's role in the participant's care;</p> <p>6 B. Identify and work with community-based organizations and public health resources such as disability and aging services, social services, transportation services, school-based services, and home health care services to facilitate the availability of appropriate resources for participants;</p> <p>6 C. Permit and encourage professionals within the health care home team to practice at a level that fully uses the professionals' training and skills; and</p> <p>6 D. Engage participants in planning for transitions among providers, and between life stages such as the transition from childhood to adulthood.</p>	<p>Purpose (statute): To require HCH to deliver services that Include care coordination that focuses on patient and family-centered care.</p> <p>Explanation (intent): Relationships between HCH and community partners make it easy to connect patients with needed resources. Referrals to community partners improve health and wellbeing for the patient.</p> <p>-Obtaining and documenting feedback from patients about their care ensures that patients have the opportunity to share in decisions and engage in planning of their health care.</p> <p>-When each member of the HCH team works at the “top of his/her license,” the HCH works more efficiently and team members have improved work satisfaction.</p> <p>-The HCH has an important role in planning for transitions between providers when the HCH coordinates services across specialties to support patient care across all ages and stages of life.</p> <p>What needs to be in place:</p> <p><input type="checkbox"/> 6A. The clinic would demonstrate that shared decision-making and care planning in care delivery is in place through: processes, activities, policies and/or workflows.</p> <p><input type="checkbox"/> 6A. Documentation such as a job description that reflects patient- and family-centered care principles are incorporated into the work scope of members of the HCH team.</p> <p><input type="checkbox"/> 6A. A process to obtain and document feedback from patients regarding their care.</p> <p><input type="checkbox"/> 6B. The HCH sends referrals to at least one community partner as part of an ongoing relationship.</p> <p><input type="checkbox"/> 6B. A process to include non-HCH resources and providers that the patient works with (i.e. pharmacist, specialist) into care planning.</p> <p><input type="checkbox"/> 6C. Each team member has roles and accountabilities that allow full use their education and licensure. This can be demonstrated with a responsibility matrix or workflows that defines team member roles.</p> <p><input type="checkbox"/> 6D. A plan for managing health care related transitions and/or providing information about transitions across the care continuum. Examples include: pediatric to adult, end of life planning, chronic to acute or specialty care, provider to provider.</p>	<p>Submit as attachment in portal when completing assessment form:</p> <p><input type="checkbox"/> 6A. A document that reflects that patient and family centered care principles are included in the work scope of members of the HCH team, such as a job description or workflows/protocols</p> <p>Describe in Portal: As outlined in the certification/recertification guide, you will describe specified systems and processes when you submit your assessment in the portal.</p> <p>At Site Visit: Site visit evaluation team will request:</p> <p>6A. Interviews and/or demonstration that shared decision-making is in place.</p> <p>6B. How the HCH ensures ongoing partnership with one community resource.</p> <p>6C Examples of team members working at the top of their licensure such as swim lane or job descriptions.</p> <p>6D How the HCH addresses transition planning. (There may be a process, policy, workgroup).</p>

Minnesota Administrative Rules HEALTH CARE HOME STANDARDS	Certification Assessment	Documentation required; preparation for site visit
<p>4764.0040 Subp. 8.</p> <p>Recertification Requirements* Care plan standard; Recertification at the end of year one. By the end of the first year of health care home certification,* The applicant <i>for recertification</i> must ask each participant with a care plan whether the participant has any external care plans and, if so, create a comprehensive care plan by consolidating appropriate information from the external plans into the participant's care plan.</p> <p>*Note: On 8-1-2016, a legislative change to the HCH certification cycle now requires the HCH applicant to renew certification every three years instead of annually. Please refer to Appendix 1.</p>	<p>Purpose (statute): To require HCH to incorporate external care plans into the HCH comprehensive care plan.</p> <p>Explanation (intent): Professionals who prepare external care plans often have specific areas of expertise outside those in the HCH. The use of those care plans draws on that expertise and reduces confusion for the patient, who may have two different sets of care plans, and improves planning efficiency by promoting communication.</p> <p>The HCH comprehensive care plan should contain enough information from external care plans or services to coordinate care. This should also facilitate continuity of care.</p> <p>What needs to be in place:</p> <ul style="list-style-type: none"> <input type="checkbox"/> For care coordinated patients who identify external care providers and community partners, there is a process in place to include those members of the patient care team into care planning. <input type="checkbox"/> The care plan policy is updated, if not initially included, to reflect the process for collaborating with patient's external services and providers. <input type="checkbox"/> Care coordinator and the patient determine whether the patient has any external care plans. Together they create a comprehensive care plan incorporating other care plans from the community team (example: public health, social services, mental health, home health, aging services, school services and many others). <input type="checkbox"/> The external provider is identified with the condition they manage or support and contact information for that provider is available in the patient's comprehensive care plan. 	<p>Submit as attachments in portal when completing assessment form:</p> <ul style="list-style-type: none"> <input type="checkbox"/> An updated care planning policy, if not initially included, that includes the procedure for coordinating with community partners for patients with external care plans. <input type="checkbox"/> Submit evidence/documentation demonstrating integration of external care plans. <input type="checkbox"/> Results of a care plan audit. (MDH self-audit tool available) <p>Describe in Portal: As outlined in the certification/recertification guide, you will describe specified systems and processes when you submit your assessment in the portal.</p> <p>At Site Visit: Site visit evaluation team will: Review submitted documents with team members. May ask patient partners about their personal care plan. Ask how is an external care plan identified by clinic staff?</p>

Minnesota Administrative Rules HEALTH CARE HOME STANDARDS	Certification Assessment	Documentation required; preparation for site visit
<p>4764.0040 Subp. 10.</p> <p>Recertification Requirements* Performance reporting and quality improvement standard;</p> <p>10 A. By the end of year one of health care home certification,* The applicant for recertification must: Participate in the statewide quality reporting system by submitting outcomes for the quality indicators identified and in the manner prescribed by the commissioner;</p> <p>Submit health care homes data in the manner prescribed by the commissioner to fulfill the health care homes evaluation requirements in Minnesota Statutes section 256B.0752, subdivision 2</p> <p>10 B. Show that the applicant has selected at least one quality indicator from each of the following categories and has measured, analyzed, and tracked those indicators during the previous year:</p> <p>(1) improvement in patient health; (2) quality of patient experience; and (3) measures related to cost-effectiveness of services.</p> <p>*Note: On 8-1-2016, a legislative change to the HCH certification cycle now requires the HCH applicant to renew certification every three years instead of annually. Please refer to Appendix 1.</p>	<p>Purpose (statute): To require HCH to deliver services that reflect continuous improvement in the quality of the patient's experience, the patient's health outcomes, and the cost-effectiveness of services.</p> <p>Explanation (intent):</p> <p>The focus for measuring performance outcomes is on the certified clinic's primary care population served, not just the outcomes for HCH care coordination patients. Progress will be based on the IHI "triple aim" outcomes measured simultaneously. This results in comprehensive measurement and avoids focus on only one measurement area.</p> <p>The HCH attests to participate in the statewide quality reporting system and registers with the vendor selected by the state (Minnesota Community Measurement (MNCM)) for data submission and submits the data in the manner prescribed by the Commissioner.</p> <p>HCH submits its annual quality plan and report with data that has been measured, analyzed and tracked for the previous year.</p> <p>The HCH may select measures that the HCH has determined are relevant to the direct improvement of HCH's services in each of the measurement areas or they may report quality data from the measures that are announced annually by the Commissioner.</p> <p>What needs to be in place:</p> <p><input type="checkbox"/> 10A Outcomes data submitted through the statewide quality reporting system. HCHs need to register with the state's vendor, MNCM, for submission of statewide quality reporting and measurement data (SQRMS) as per MNCM's annual clinic and provider registration instructions.</p> <p>* Data submission requirements and timelines are outlined through MNCM's data collection guides.</p> <p><input type="checkbox"/> 10 B Quality plan and report with data that has been measured, analyzed and tracked with at least one quality indicator for the previous year in each of the three triple aim categories:</p> <p>(1) improvement in patient health (2) quality of patient experience (3) measures related to cost-effectiveness of services.</p>	<p>Submit as attachment in portal when completing assessment form:</p> <p><input type="checkbox"/> A quality plan and quality report with data that has been measured, analyzed and tracked in each of the triple aim categories. Any format is acceptable. A HCH Quality Plan template is available for use if desired.</p> <p>Describe in Portal: As outlined in the certification/recertification guide, you will describe specified systems and processes when you submit your assessment in the portal.</p> <p>At site visit: Site visit evaluation team will:</p> <p>10 A., B. Review and discuss the submitted documents with the quality team members.</p> <p>* HCHs are not required to utilize a specific patient survey instrument, but are required to measure patient experience. Please contact the HCH program at Health.healthcarehomes@state.mn.us or your nurse planner for further information.</p>

Minnesota Administrative Rules HEALTH CARE HOME STANDARDS	Certification Assessment	Documentation required; preparation for site visit
<p>4764.0040 Subp. 11.</p> <p>Recertification Requirements*</p> <p>Performance reporting and quality improvement standard;</p> <p>11 A. By* recertification as a health care home, and each year thereafter, the applicant must continue to participate in the statewide quality reporting system by submitting outcomes for the additional quality indicators identified by the commissioner and in the manner prescribed by the commissioner.</p> <p>11 B. To qualify for recertification, the applicant's outcomes in primary care services patient population must achieve the benchmarks for patient health, patient experience, and cost-effectiveness established under part 4764.0030, subpart 6.</p> <p>*Note: On 8-1-2016, a legislative change to the HCH certification cycle now requires the HCH applicant to renew certification every three years instead of annually. Please refer to Appendix 1.</p>	<p>Purpose (statute): To require HCH to deliver services that reflect continuous improvement in the quality of the patient's experience, the patient's health outcomes, and the cost-effectiveness of services.</p> <p>Explanation (intent): The HCH continues to be recertified based on annually and bi-annual reported outcomes.</p> <p>What needs to be in place:</p> <p><input type="checkbox"/> 11A. Outcomes data that can be submitted in the manner prescribed by the Commissioner annually.</p>	<p>Submit as attachment in portal when completing assessment form:</p> <p><input type="checkbox"/> Outcomes data in the manner prescribed by the commissioner annually.</p> <p>Describe in Portal: As outlined in the certification/recertification guide, you will describe specified systems and processes when you submit your assessment in the portal.</p> <p>At site visit:</p> <p>Site visit evaluation team will:</p> <p>Review and discuss benchmark achievements and opportunities for improvement with quality team members.</p>

Recertification Timeline

Goal: Maintain relationship, provide ongoing technical assistance and facilitate forward movement of implementation of standards.

Initial Certification	Recertification: 3 years from initial certification date (HCH portal will generate a 180 and 90 day notice)	Subsequent years: Repeat process of every 3 year recertification
<p>The Organization submits letter of intent, application/s, and assessment containing the odd numbered standards 1-9 only.</p> <p>The MDH Nurse Planner will then schedule a Health Care Home site visit evaluating the implementation of the odd numbered standards, 1-9 only.</p>	<p>The Organization submits letter of intent, application/s, and assessment containing all standards.</p> <p>The MDH Nurse Planner schedules a team meeting to review all standards in the following manner;</p> <ul style="list-style-type: none"> • Changes with any odd numbered standards 1-9 • Review of the even numbered standards • Review of standard 11 • Review any variances 	<p>The Organization submits letter of intent, application/s, and assessment containing all standards.</p> <p>The MDH Nurse Planner schedules a team meeting to review all standards.</p> <ul style="list-style-type: none"> • Review any changes in standards • Review any variances • Analyze benchmarks

*MDH Nurse Planner will contact the certified Health Care Home organization and offer optional check-ins during the 3-year certification cycle.