DEPARTMENT OF HEALTH

Health Care Homes (HCH) COMPASS:

Certification/recertification Operations Manual Providing Application Submission Support

Introduction

Thank you for your interest in Health Care Homes (HCH) certification. HCH certification is a free and voluntary program that the Minnesota Department of Health (MDH) provides to primary care clinicians, clinics, and organizations committed to providing high quality, **patient and family centered care**. Health Care Homes is not a prescriptive framework. Each practice implements the standards based on its own unique characteristics, such as the size of the practice, location, and the patient population it serves.

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

What is a Health Care Home?

A primary care clinic or clinician certified by the Minnesota Department of Health to coordinate care among the primary care team, specialists, and community partners to ensure patient-centered, **whole person care** and improve total health and well-being. The idea is that a clinician/clinic provides its patients a home base for health care and helps them navigate the health care system, they are a patient's "health care home".

Whole person care: primary care focused on the patient's physical, emotional, psychological, and spiritual well-being, as well as cultural, linguistic, and social needs.

This guide is designed to assist applicants with the Health Care Homes certification and recertification process. It helps assess which required components of the program are already in place and functioning effectively, while identifying areas needing more attention to achieve results. The HCH application can be found at the Health Care Homes on-line portal: Public Portal (mn.gov).

If you would like to sign up for access to the portal, or need assistance with your user name or password, please email Health.HealthCareHomes@state.mn.us.

Additional information can be found at the Health Care Homes website.

Why seek Health Care Homes certification?

- Health Care Homes certification is a free and voluntary program that benefits all Minnesotans.
- Certification is achievable. Most uncertified clinics are meeting many of the requirements for certification already.
- Certification recognizes a flexible primary care delivery model based on continuous improvement and evidence-based practice supported by accessible learning, technical assistance, and peer-based interaction.
- Health Care Homes clinics are recognized for high standards of excellence, commitment to continuous quality improvement, and quality patient-centered care.
- Many clinicians can receive board maintenance of certification credits for practicing in a certified Health Care Home:
  - American Board of Family Medicine: refer to the Recognitions/Certifications section of the Performance Improvement At-A-Glance (PDF)
  - Patient-Centered Medical Home (PCMH) | The American Board of Pediatrics
- Minnesota's certified Health Care Homes receive full credit from The Centers for Medicare and Medicaid Services (CMS) for the Improvement Activities performance category under the Merit-based Incentive Payment System (MIPS).
- The Health Care Homes model puts patients at the forefront of care by building better relationships between people and their clinical care teams.
- Health Care Homes clinicians and staff report higher job satisfaction.
- Research confirms that Health Care Homes improve all elements of the quadruple aim: quality, patient experience, staff satisfaction, and cost-effectiveness.
- Certification as a HCH provides accessible, effective, team-based coordinated care within a health care system. This foundational infrastructure is essential to successful participation in alternative payment models, such as Accountable Care Organizations (ACO) or other value-based arrangements.
- Additional levels of certification further support clinics in their efforts to participate in the growing field of value-based purchasing by recognizing achievements in addressing needs

beyond the current foundational requirements. This includes identifying and addressing social determinants of health, advancing health equity, meeting whole person care needs, expanding community partnerships, and working with their communities on population health improvement.

Background

The HCH program began in 2008 as part of a broad health reform initiative to transform clinical care to coordinated, team-based, patient and family-centered care and innovative payment models. The MDH certified the first Health Care Home in 2010 using the foundational standards. A list and map of certified HCH is on the program's webpage, Find Certified Health Care Homes.

The team-based care delivery approach in a HCH clinic is a partnership with primary care providers and patients and families. Goals of the model are to:

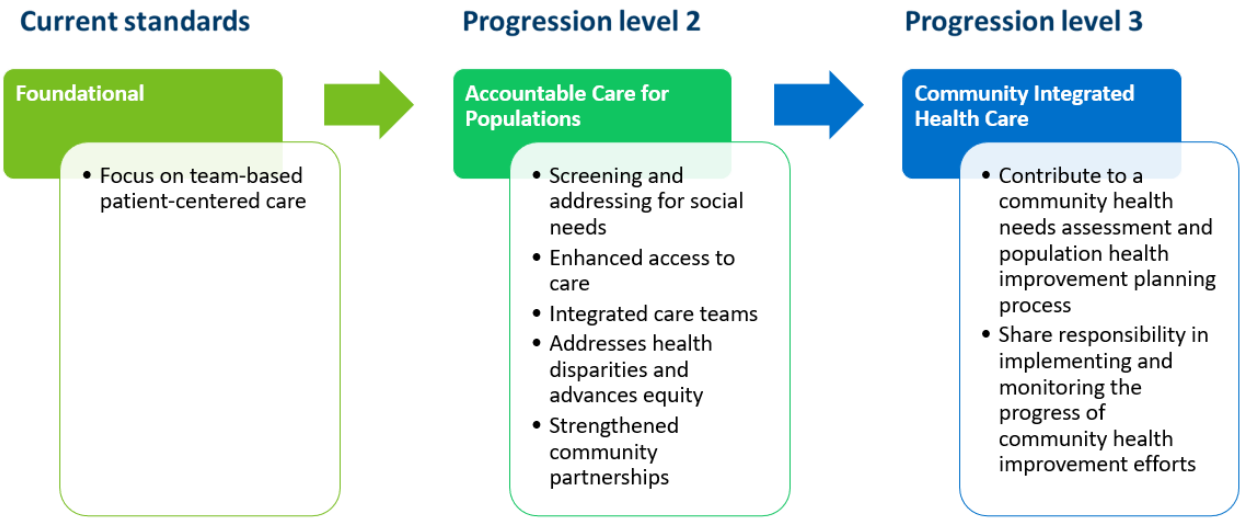
- Build a strong primary care foundation for all Minnesotans to access team-based, coordinated, patient and family-centered care.
- Increase care coordination and collaboration between primary care and community resources to support whole person care, population health, and health equity.
- Improve the quality, experience, and value of care.

Health Care Homes are known nationally as the patient-centered medical home (PCMH). PCMH is a widely accepted model for how primary care should be organized and delivered throughout the health care system. Additional information and resources can be found at the Primary Care Collaborative website.

Additional background information about HCH can be found at the Health Care Homes website.

Model progression

In 2016, the Health Care Home program began the process of proposing a new framework for its care delivery model, building on foundational Health Care Home standards to add two additional levels of certification. The purpose of the HCH progression model framework is to recognize clinics that are advancing primary care models to reduce disparities, improve value, and address population health. The Health Care Homes rule was amended October 2022 to update the rule and reflect this work. HCH statutes and rule links can be found on our MDH HCH website.



Beginning the HCH transformation

The HCH care delivery model is grounded in continuous improvement. All staff members play an important role in team-based care; everyone can impact care. Encourage your team to brainstorm ways to serve patients better, test those techniques and report back. Everyone is empowered to become experts in their area, resulting in increased employee satisfaction.

Set your entire team on the proper path from the beginning. It is about creating a new culture among staff, to enhance working as a team and collaborating – everyone understanding and having ownership in their piece of the Health Care Home model of care. Additional resources on HCH implementation can be found at the Health Care Homes website.

How to use this guide

Please reference this guide when preparing for HCH certification and recertification and when completing the HCH application which can be found online at the Public Portal (mn.gov).

The information provided in this guide is not intended as an all-inclusive list of the strategies clinics could employ to meet each standard. It offers guidance in making gradual and lasting changes and provides a structure around which to base primary care transformation efforts.

Navigation Notes – What this guide provides

- Narrative descriptions of each HCH standard
- Important definitions included in text boxes
- Overview of each of the requirements for Foundational Level, Level 2, and Level 3 certifications
- Actions to consider as your team works to transform care and practice

- Quick links to appendices that provide helpful information as you navigate the HCH certification and recertification process
- How to get help

HCH eligibility

To seek HCH certification, an eligible clinician must deliver patient and family 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). An eligible clinician is a physician, advanced practice nurse or physician assistant that takes responsibility for the overall and ongoing medical responsibility for a patient's comprehensive care and provides the full range of **primary care** services. An individual clinician or a primary care clinic may be certified as a health care home. A clinic will be certified only if all the clinic's personal clinicians providing primary care meet the requirements for participation in a health care home. It is the clinic's responsibility to orient new clinicians and staff to the health care home's care delivery approach.

To maintain their status as health care homes certified, clinicians or clinics must renew their certification every three years.

"Border" clinics are eligible to be certified if they are in the "local trade area". As noted in the Office of the Revisor of Statutes, Minnesota Administrative Rules website CHAPTER 4764, HEALTH CARE HOMES, "Local trade area" means the geographic area surrounding the person's residence, including portions of states other than Minnesota, which is commonly used by other persons in the same area to obtain similar necessary goods and services.

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.

HCH Application

View the online HCH Application (PDF) for planning purposes.

Standards

The standards for certification cover five key areas to qualify as a patient-centered medical home. The standards align with the shared principles of primary care adopted by the national Primary Care Collaborative (Primary Care Collaborative, 2020).

1. Access and communication
2. Patient registry and tracking patient care activity
3. Care coordination
4. Care planning
5. Performance reporting and quality improvement

Standards are designed to support progressive implementation of the HCH model over time. As a health care home progresses to implementing advanced primary care functions and strategies, recognition is provided through a Level 2 and Level 3 certification. To be certified at Level 2, both Foundational Level and Level 2 requirements must be met. Level 3 certification is granted when requirements from Foundational Level, Level 2, and Level 3 are met.

An organization may seek to certify or recertify all clinics at the same level or may have clinics progress to different levels based on the ability of each to meet the requirements. Organizations will submit a list of all clinics and the level of certification each is pursuing: Foundational, Level 2 or Level 3. Progressing to an advanced level of certification may be done at initial certification, recertification or between recertifications.

Standard 1. Access and Communication

The Access and Communication standard directs the HCH clinic to deliver services that facilitate ongoing communication with the patient and the patient's family and provide care when patients need it.

Level 2 access and communication criteria enhances access to care and needed services through requirements that directs the HCH clinic to identify patient needs based on non-medical factors, offer more flexible options to access care, and promote patient engagement.

Requirement: Identify patients for care coordination and other services

The HCH is responsible for the management of the clinic's patient population. Effective **population management** includes using a systematic process for identifying patients with needs or risk factors that may require additional resources and support. A subset of these patients will be identified as a person who could benefit from the additional support of services provided through a designated care coordinator. This subset of patients receives more **intensive care coordination** because they are receiving services directly from a designated care coordinator. Other subsets of patients will also be identified, including those for whom only routine and preventative care management may be needed. Health care homes use a range of interventions, supports, and services to offer to patients based on unique needs and individual circumstances.

There are many factors that influence a person's health and wellbeing, including food security, housing, transportation, employment, income, education, lifestyle, social safety nets, and environmental and safety concerns. Progression to Level 2 population management strategies include identifying patients who need services based on non-medical factors and other determinants of health to better target care interventions and improve patient health outcomes.

Population management: the delivery of health care services toward the achievement of specific health care-related metrics and outcomes for defined populations.

Health care home services: the range of services and interventions offered at the primary care clinic. These are accessible, continuous, comprehensive, and coordinated care that is delivered in the context of family and community, and furthers patient-centered care.

Primary care services patient population: all patients receiving primary care services from the health care home.

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

Intensive care coordination: the services provided by a designated care coordinator. It is meant to distinguish from other supports and services offered to patients that aren't provided by a care coordinator.

Complex conditions: one or more medical conditions that require treatment or interventions across a broad scope of medical, social, or mental health services.

What needs to be in place:

Foundational Level
Offer **health care home services** to the **primary care services population** that includes doing the following:
Identify patients who have or are at risk of developing chronic or **complex conditions** **Actions to consider**: ✓ Electronic medical records (EMR) analytics or algorithms assign all patients a risk score and care is managed accordingly ✓ Population-based registry workflows identify target populations ✓ Accountable care organizations (ACO) reports identify target populations
Offer varying interventions or levels of coordinated care services to meet the identified needs of the patient **Actions to consider**: ✓ A targeted subset of the patient population is referred to work with a designated care coordinator to receive **intensive care coordination** ✓ Preventative and routine care needs are managed for specific subpopulations (i.e., Medicare wellness visits or Child & Teen Check-up visits) ✓ Patients with complex medication regimens are referred for medication therapy management ✓ Patients with a new diagnosis of diabetes are referred to a Certified Diabetes Educator ✓ Patients identified as high risk for readmission receive support in their care transitions, such as with transitional care management (TCM)
Offer more intensive care coordination for patients with complex medical and social needs who could benefit from the services of a care coordinator ✓ Remember intensive care coordination specifically refers to care coordination services from a designated care coordinator ✓ Clinics have the flexibility to determine which criteria and patients they will target for this specific resource

Actions to consider:

- ✓ Align criteria for patient referral to intensive care coordination with the clinic's quality goals and improvement efforts, i.e., referring patients not meeting optimal diabetes treatment goals to improve diabetes care.
- ✓ Patient participation in intensive care coordination is voluntary. Communicate the role of care coordination to patients in a way that is preferred and understood by them (verbal, written, or other). Document the patient's decision (whether participating or declined) in the medical record. Tracking patients who have declined intensive care coordination services allows the care team to re-visit this later and offer the service again, if needed.

Level 2

Progression also requires

Include processes that identify information about **social determinants of health** and other health and well-being factors to determine risk and manage care.

Actions to consider:

- ✓ Incorporate screening for social determinants of health into workflows, such as during the rooming process or in health questionnaires (Examples include use of screening questions or assessments related to food insecurity, substance use, mental health, safety concerns, social support, housing instability, or transportation concerns)
- ✓ Risk stratification or risk-based analytics include factors related to social determinants of health, such as zip code or other data

Level 3

Progression also requires

This area of the HCH standards does not have a Level 3 requirement

Requirement: Ensure patient access

Continuous access to a provider helps patients receive the right care at the right place at the right time and prevents hospitalization or unnecessary use of the emergency department. Patients should understand how to access care and stay connected to their provider.

Progression to Level 2 strategies increase options for how patients and their families can interact with their primary care provider and care team, enhancing the health care home's ability to meet preventative, acute, and chronic care needs.

Continuous: 24 hours per day, seven days per week, 365 days per year.

What needs to be in place:

Foundational Level

Has a system for providing continuous, 24-hour access to designated clinic staff, an on-call provider, or a phone triage system.

- ✓ It is important for the clinic to understand if continuous access processes are working as intended

- ✓ Self-audit processes or other means of tracking and monitoring timely and appropriate access to care can help the clinic identify improvement opportunities

Actions to consider:

- ✓ Centralized triage processes, such as a nurse line, provide continuous, 24-7 access to designated clinic staff
- ✓ Patients contact clinic staff during business hours and the phone rolls over to other parties after business hours (such as hospital staff, an on-call provider, or designated external party)

Designated staff providing continuous access can retrieve patients' medical record information.

- ✓ Most triage staff have access to the EMR during both business hours and after-hours, allowing them to be able to retrieve patients' medical record information
- ✓ If this is not the case, staff designated to providing continuous access must have specific components of the patients' medical record information available to them (see HCH Application (PDF))

Use triage protocols to schedule appointments based on acuity of patient's condition and that addresses scheduling within a business day to avoid unnecessary emergency room visits and hospitalization.

Actions to consider:

- ✓ Clinician has open time on schedule for same-day or next-day scheduling
- ✓ Use of decision support, such as the Schmitt-Thompson telephone triage protocols
- ✓ Standardized workflows for handling patient communications

Inform patients that they have continuous access to designated staff and provide information about how to access care when needed.

Level 2

Progression also requires

Offer enhanced access that includes options beyond the traditional in-person office visit that increase patient access to the care team and the ability to meet the patient's preventative, acute, and chronic care needs.

- ✓ Clinics address patient barriers to accessing care, assuring every patient can access care when they need it

Actions to consider:

- ✓ Clinics provide on-site primary care for patients residing in a group home or other long-term care setting to remove barriers in getting those patients to the clinic
- ✓ Clinics offer evening and weekend appointments to meet acute patient needs and for patients who have challenges in getting to the clinic during regular business hours

Level 3

Progression also requires

This area of the HCH standards does not have a Level 3 requirement

Requirement: Collect and use patient information

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. It is also important to have this information to identify health disparities.

Progression to level 2 strategies include implementing culturally competent care delivery strategies. A health care system which demonstrates cultural competence can help improve health outcomes and quality of care and can contribute to the reduction of health disparities.

Cultural Competence: the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes.

What needs to be in place:

Foundational Level
Collect information about patient cultural background, racial heritage, and primary language, (REL) and describe how it is applied to improve care. ✓ The collection of REL data aligns with Minnesota Community Measurement (MNCM) reporting requirements so clinics are usually already collecting this information ✓ MNCM has provided a comprehensive resource guide, Handbook on the Collection with Addendum 10.21.10 (jitbit.com) **Actions to consider:** ✓ Knowing that a patient's primary language is not English allows for scheduling interpreters ahead of visits and facilitates patient-centered care ✓ Knowing race, ethnicity, or country of origin allows for health care providers to customize care based on risk factors
Collect and use the patient's preferred means of communication. ✓ Individuals have the right to communicate through their chosen method and their choice should be acknowledged and respected. ✓ Use preferred method of communication within clinic capabilities.
Level 2 Progression also requires
Implement care delivery strategies responsive to the patient's social, cultural, and linguistic needs. ✓ Your data helps you understand the diversity among the patient population served at your clinic so that you can implement culturally competent approaches accordingly. **Actions to consider:** ✓ Assessing workforce needs to better match the cultural and life experience of the patients served. As care team positions become available, recruit to address these needs. This can be positive for both patient and employee satisfaction.

Level 3 Progression also requires
This area of the HCH standards does not have a Level 3 requirement

Requirement: Inform patients of choice in specialty care

Providing information about optimal treatment and care options shows support of patients' decisions, even when they choose care outside of the HCH delivery system.

What needs to be in place:

Foundational Level
Inform all patients of choice in specialty care and treatment options ✓ Referral processes at the clinic must support patient choice and allow for shared decision making to occur around specialty care options when needed ✓ Referral processes at the clinic should make the effort to provide patients with the information they need to make an informed choice, which often include financial implications
Level 2 Progression also requires
This area of the HCH standards does not have a Level 2 requirement
Level 3 Progression also requires
This area of the HCH standards does not have a Level 3 requirement

Requirement: Privacy and security

HCHs are required to comply with existing applicable laws on information privacy and security. This requirement is validated through attestation.

What needs to be in place:

Foundational Level
Maintain policies and procedures that establish privacy and security protections of health information and comply with applicable privacy and confidentiality laws. ✓ MDH HCH does not regulate data privacy, but does require policies and procedures that comply with applicable laws be in place ✓ Many health care systems have privacy and security departments and/or an information security officer that ensures these policies and procedures are in place and enforces their use ✓ You will be asked to attest to this during the certification process
Level 2 Progression also requires

This area of the HCH standards does not have a Level 2 requirement
Level 3 Progression also requires
This area of the HCH standards does not have a Level 3 requirement

Requirement: Patient engagement

Patient engagement in health care helps to improve health outcomes, promote better care, and achieve lower costs. HCH clinics are using approaches to better engage patients through education, self-management strategies, and in shared decision-making. Primary care that meets patients where they are enables the development of trust, collaboration in goal setting and action steps, and promotes the development of patient and caregiver confidence.

One way in which the HCH promotes patient engagement and communication is by identifying and addressing readiness for change or barriers related to literacy level or other learning needs experienced by patients. By addressing at least one of these, patients are more likely to understand health instructions, educational documents, and teaching methods, making them more likely to actively participate in their care.

Progression to Level 2 strategies require HCH clinics to implement more rigorous patient engagement strategies that increase **health literacy** and improve self-management skills.

Patient Engagement: a concept that combines a patient's knowledge, skills, ability, and willingness to manage their care with interventions and strategies designed to promote active and competent participation.

Attributes that support patient engagement include:

- Personalization
- Access to necessary resources
- Commitment to delivering quality care
- Positive, trusting relationships

Health literacy: the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

What needs to be in place:

Recertification: Foundational Level - by the first recertification or if certifying at Level 2 or Level 3, the certified health care home must meet the following additional requirement:
Identify and address at least one of the following areas to promote patient engagement: readiness for change, literacy level, or other barriers to learning

✓ Although a range of approaches to engage subsets of patients may be available, this is applicable to all patients receiving primary care services at the clinic

Actions to Consider:

✓ Many standard rooming procedures use the EMR to document learning style preferences or other barriers related to learning to make this information available to the care team
✓ The "readiness-change-ruler" is a simple tool that helps patients evaluate their readiness to change, as well as provides an opportunity to discuss confidence, motivation, and/or barriers. Knowing how ready a person is to change health behaviors will allow the care team to help the person choose goals that are realistic and individualized, as well as inform the care team's approaches.

Level 2

Progression also requires

Implement additional strategies or interventions to encourage patient engagement that increase health literacy and help the patient manage chronic diseases, reduce risk factors, and address overall health and wellness

✓ Although a range of approaches to engage subsets of patients may be available, this is applicable to all patients receiving primary care services at the clinic

Actions to consider:

✓ Self-management support groups provided at the clinic such as chronic pain, stress management, Living Well with Chronic Conditions classes, Diabetes Prevention Program classes
✓ Providing patients with educational tools to support self-management of chronic conditions, such as a home monitoring flowsheet or asthma action plan
✓ Using teach-back to provide patient care instructions and increase health literacy

Level 3

Progression also requires

This area of the HCH standards does not have a Level 3 requirement

Standard 2. Patient Registry and Tracking Patient Care

The Patient Registry and Tracking Patient Care standard requires clinics to maintain a patient registry, enabling the HCH to readily access clinically useful information on patients that can be used to manage health care services, provide appropriate follow-up, and identify gaps in care for their patient population. A registry is the basis of practice-based population health - an approach to care that uses information on a group of patients within a primary care practice to improve the care and outcomes within that practice.

Progression to Level 2 strategies add data elements to a patient registry that incorporate social determinants of health, enabling the clinic to address whole person health through the consideration of non-medical factors that affect health risks and outcomes for a population.

Requirement: Patient registry and tracking patient care

Use the registry to conduct systematic reviews of the patient population to manage health care services, provide appropriate follow-up, and identify gaps in care. The registry must contain: For each patient, the name, age, gender identity, contact information, and ID number assigned by the clinic, if any; and sufficient data elements to issue a report that shows any gaps in care.

Use the registry to identify gaps in care and implement remedies to prevent them.

What needs to be in place:

Foundational Level
The HCH must use an electronic, searchable patient registry to record patient information and conduct systematic reviews of the patient population in order track and manage care, provide appropriate follow-up, and identify gaps in care. ✓ Consider what data elements will be needed. Registries need to contain enough information to track and manage care so that key data about a target population is organized in one place for increased effectiveness and efficiency. ✓ Clinics have health information technology of varying capabilities. Not all EMRs have patient registry functionalities. Patient registries can be built outside of the EMR using an excel spreadsheet or other electronic, sortable tool. **Actions to consider:** ✓ Clinics usually begin small, with one to three registries, and progress over time by adding additional registries. It is most helpful to begin by using a registry that aligns with your quality goals. For example, if a clinic has identified an opportunity to improve optimal diabetes care, it is most useful to begin by using a disease-based patient registry that captures the elements around diabetes care for patients with a diagnosis of diabetes. ✓ Registries can also address preventative and maintenance care, such as colorectal cancer screening.
Implement remedies to prevent gaps in care. **Actions to consider:** ✓ Pre-visit planning ✓ Outreach to patients overdue for screenings or visits ✓ Best Practice Alerts (BPAs)
Level 2 Progression also requires
Expand registry elements to identify needs and manage care related to social determinants of health (SDOH) and other whole person care factors, including needs related to communities with which patients self-identify. ✓ HCH clinics have flexibility to determine which registry element(s) related to SDOH will be used, allowing them to consider the unique needs of the patient population and communities served, their own practice goals, as well as the capacity of their health information technology. ✓ Consider if there are screening tools in place to assess needs related to SDOH and consider how incorporating elements of those into a registry could be used to improve the care and outcomes.

- ✓ HCH clinics must be able to describe how they are using the expanded elements to improve care and address the needs of the population served.

Actions to consider:

- ✓ Add homelessness or housing instability elements to understand unmet optimal care management goals in this subset, identifying opportunities for improvement as appropriate.
- ✓ Add elements to provide data on the prevalence of food insecurity within the patient population and use this information to develop partnerships, plan interventions, and monitor progress over time.
- ✓ Add elements that allow for gender to be patient-defined and not restricted to two historic, binary designations or to indicate whether it differs from the gender they were assigned at birth
- ✓ Add elements that identify persons living with disabilities, to ensure whole-person care is provided with support to address any potential or actual barriers to improved health outcomes and optimal wellness
- ✓ Add elements to identify patients with chronic conditions and co-occurring mental health needs, such as depression, to better plan care.

Level 3

Progression also requires

This area of the HCH standards does not have a Level 3 requirement

Standard 3. Care Coordination

The Care Coordination standard directs clinics to have a system of **care coordination** focused on the patient and their family's needs.

Level 2 certification criteria advance these coordinated care systems, requiring a multidisciplinary care team to meet patient and family needs, ensuring information exchange, and implementing processes aimed at improving safety and reducing readmissions and unnecessary emergency department utilization.

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

Requirement: Collaboration within the care team

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.

Progression to Level 2 strategies integrate a broader set of disciplines and expertise into their care team to be able to address the whole person care needs identified through expanded screening processes.

Care coordinator: a person who has primary responsibility to organize and coordinate care with the patient and family in a health care home.

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

What needs to be in place:

Foundational Level
Collaboration within a team that, at a minimum, includes the patient, care coordinator, and primary care clinician to: ✓ Set patient goals and identify resources to achieve them, ✓ Ensure consistency and continuity of care, ✓ Determine how often the patient will have contact with the care team **Actions to consider:** ✓ It is usually the role of the care coordinator to work directly with the patient/family to set patient goals and determine appropriate action steps; these goals work to support the clinical goals to maintain optimal health. ✓ Frequency of patient encounters is usually determined by patient need and preference. ✓ Pre-determined minimum encounters, sometimes based on risk or other need-based factor, are also typically embedded in standardized care coordination workflows.
Level 2 Progression also requires
Provide and coordinate **integrated care** using a team consisting of multidisciplinary roles to meet patient and family needs. ✓ HCH clinics have flexibility to choose the make-up of the integrated care team based on the needs of their patient population and available resources. **Actions to consider:** ✓ A pediatric HCH clinic may choose to integrate behavioral health professionals into the care team to address attention deficit or hyperactivity concerns, school performance issues, parenting, substance use, peer groups, and more. ✓ A HCH clinic that serves an older adult population may choose to integrate a social worker into the care team to address needs and provide resources related to decreasing independence or cognitive impairments, advance care planning, social isolation, and more.
Level 3 Progression also requires
This area of the HCH standards does not have a Level 3 requirement

Requirement: Patient empanelment

All patients have a designated primary care provider, and if applicable a designated care coordinator. Establishing care with a designated primary care provider and the support of a care

coordinator provides consistency, communication, and continuity of care. Continuity of care is a core component of patient/family centered primary care and is associated with improved health care outcomes and patient experience.

Empanelment: the process of identifying and assigning active patients to clinicians or care teams to establish and maintain patient-clinician relationships.

What needs to be in place:

Foundational Level
A process to identify and assign a personal clinician and primary care coordinator (if applicable) as the contacts for each patient. ✓ Patients should be informed of who their designated primary care clinician is and who their designated care coordinator (if applicable) is.
Level 2 Progression also requires
This area of the HCH standards does not have a Level 2 requirement
Level 3 Progression also requires
This area of the HCH standards does not have a Level 3 requirement

Requirement: Direct communication

Effective communication benefits coordinated patient care and enhances cohesiveness of the team.

What needs to be in place:

Foundational Level
The care coordinator and the clinician have direct communication with some face-to-face time. ✓ **Direct communication** means an exchange of information using telephone, electronic mail, video conferencing, or face-to-face contact without the use of an intermediary. For purposes of this definition, an interpreter is not an intermediary. **Actions to consider:** ✓ Other processes that support direct communication between the care coordinator and primary care clinician include daily huddles, team meetings, care conferences, and shared visits. ✓ The electronic health record and other methods, like telephone or in-basket messaging, support face to face communication.
Level 2 Progression also requires

This area of the HCH standards does not have a Level 2 requirement
Level 3 Progression also requires
This area of the HCH standards does not have a Level 3 requirement

Requirement: Dedicated time for care coordinators

Care coordinators must have the dedicated time to be able to work with patients on things such as goal setting, action planning, connecting with resources, and follow-up in between clinic visits. Protected time ensures the care coordinator can perform the care coordination functions required to make improvements in health outcomes.

What needs to be in place:

Foundational Level
The care coordinator has dedicated time to perform care coordination responsibilities. Adequate job training and work tools are provided to the care coordinator to support care coordination work. ✓ HCH clinics have the flexibility to determine care coordination full time equivalents (FTEs) and the type of background and training that will be required. ✓ MDH HCH has a variety of learning resources available to support care coordinators
Level 2 Progression also requires
This area of the HCH standards does not have a Level 2 requirement
Level 3 Progression also requires
This area of the HCH standards does not have a Level 3 requirement

Requirement: Documentation of care coordination elements

For the entire clinic population (primary care services patient population), coordinated care and follow up support must be provided and include:

1. closed loop referrals for specialty care
2. follow up of tests ordered, test results and communication of results and plan of care to the patient
3. follow up of admissions to facilities
4. post-discharge planning
5. communication with the pharmacy
6. and other information determined to be beneficial to coordination of patient care, such as links to **external care plans**.

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

What needs to be in place:

Foundational Level
For the entire clinic population (primary care services patient population), there are procedures for documentation of care that include: ✓ Referral tracking and follow-up ✓ Tests ordered, results tracked and timely notification to patients ✓ Admissions to facilities ✓ Timely discharge planning ✓ Communication with patient's pharmacy regarding use of medication and medication reconciliation ✓ Other information that supports coordinated care, such as external team members or care plans, if applicable Evaluate these processes to ensure they are working as intended. There are several ways in which you can do that including self-audits or internal assessments, but regardless of how you choose to do this, you will need to: ✓ Evaluate your internal processes ✓ Identify opportunities for improvement ✓ Create action plans for any identified gaps **Actions to consider:** ✓ Self-audits are a good way to evaluate your processes. MDH HCH provides a Self-Audit Tool that can be used as a template; or clinics can develop their own internal tools to assess this. ✓ The documentation and tracking of these tasks enable the clinic to identify opportunities to improve coordinated care delivery.
Level 2 Progression also requires
This area of the HCH standards does not have a Level 2 requirement
Level 3 Progression also requires
This area of the HCH standards does not have a Level 3 requirement

Requirement: Shared decision-making

Patients and care team members are partners in making treatment decisions and this shared decision-making in care delivery is an expectation of the HCH. Processes, activities, and workflows should allow for a health care provider/care team member and patient to work together to make a health care decision that is best for the patient.

Shared decision-making: the mutual exchange of information between the patient and the provider or delegated care team member to assist with understanding the risks, benefits, and likely outcomes of available health care options so the patient and family or primary caregiver can actively participate in decision making.

What needs to be in place:

Recertification: Foundational Level - by the first recertification or if certifying at Level 2 or Level 3, the certified health care home must meet the following additional requirement:
Ensure that patients are given the opportunity to fully engage in care planning and **shared decision-making.** Solicit patient feedback about their care and how they can participate in their care. **Actions to consider:** ✓ Shared decision-making principles are typically part of a clinic's culture and this is demonstrated in how care and treatment plans are developed with patients. These principles are also typically embedded in the job descriptions of team members. ✓ Obtaining and documenting feedback from patients about their care ensures that patients can share in decisions and engage in planning of their own care.
Level 2 Progression also requires
This area of the HCH standards does not have a Level 2 requirement
Level 3 Progression also requires
This area of the HCH standards does not have a Level 3 requirement

Requirement: Community partnerships

Relationships between the HCH and community partners make it easy to connect patients with needed resources. Referrals to community partners improve health and wellbeing for the patient.

Progression to Level 2 strategies recognize the need to share relevant medical information about shared patients. Access to accurate and up-to-date information about patients results in coordinated care, which can improve quality and enhance patient safety.

What needs to be in place:

Recertification: Foundational Level - by the first recertification or if certifying at Level 2 or Level 3, the certified health care home must meet the following additional requirement:
Identify and work with community-based organizations and public health resources to facilitate the availability of appropriate resources for participants. ✓ Such as: social services, transportation services, school-based services, and home health care services

Level 2 Progression also requires
Support ongoing coordination of care and follow-up with partners by sharing information. ✓ There can be various challenges and barriers to sharing information among external partners, including technical limitations, concerns with patient data privacy and security, and lack of organizational processes. ✓ Clinics progressing to Level 2 are required to be working to improve information sharing processes, while also considering what is within the HCH clinic scope and control.
Level 3 Progression also requires
This area of the HCH standards does not have a Level 3 requirement

Requirement: Top of Licensure

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.

What needs to be in place:

Recertification: Foundational Level - by the first recertification or if certifying at Level 2 or Level 3, the certified health care home must meet the following additional requirement:
Encourage care team members within the HCH to practice at a level that fully uses their education, skills, and training. **Actions to consider:** ✓ Protocols using the full scope of the Registered Nurse, such as Medication refill protocols or Hypertension management protocols ✓ Staff do pre-visit planning and facilitate the scheduling of preventative care and/or addressing other gaps as per protocols. ✓ Using pharmacists to review complex medication regimens and provide recommendations, if indicated. ✓ Providing specialty care support for primary care clinicians in managing specific conditions. An example would be endocrinology or behavioral health specialists providing consultation and support for primary care clinicians to manage conditions like diabetes and depression. ✓ Assigning care coordination resources based on patient need/risk.
Level 2 Progression also requires
This area of the HCH standards does not have a Level 2 requirement
Level 3 Progression also requires

This area of the HCH standards does not have a Level 3 requirement

Requirement: Care during transitions

The HCH has an important role in managing transitions. Effective care transitions are key to improved outcomes, especially for patient populations with higher risk. Poorly coordinated care transitions result in higher costs, poor health outcomes, and adverse events such as medication errors and complications.

Progression to Level 2 strategies focus on reducing readmissions and unnecessary emergency department utilization, which aligns with current alternative payment arrangements, such as ACOs and efforts to reduce the cost of care.

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

What needs to be in place:

Recertification: Foundational Level - by the first recertification or if certifying at Level 2 or Level 3, the certified health care home must meet the following additional requirement:

Engage patients in planning for transitions among providers and between life stages.

Actions to consider:

- ✓ pediatric care to adult care transitions
- ✓ **end-of-life care** and planning
- ✓ primary care clinician to primary care clinician transitions, such as when a patient moves from the service area, or a clinician retires

Level 2

Progression also requires

Implement processes to improve care transitions that reduce readmission, adverse events, and unnecessary emergency department utilization.

Actions to consider:

- ✓ in-home visits to provide discharge follow-up and transitional care support
- ✓ tele-monitoring to provide discharge follow-up and transitional care support
- ✓ risk stratification tools or risk assessments to determine appropriate discharge follow-up
- ✓ CMS Transitional Care Management services (TCM)
- ✓ medication and prescription management
- ✓ refer to intensive care coordination
- ✓ post discharge appointment within 7 days or a telephonic/other electronic contact within 3 days from discharge

Level 3

Progression also requires
This area of the HCH standards does not have a Level 3 requirement

Standard 4. Care Plan

The Care Plan standard requires HCH clinics to establish and implement policies and procedures to guide the HCH in the identification and use of care plan strategies to engage patients in their care and to support self-management. Although the care plan standard is specific to the subpopulation of patients receiving intensive care coordination, these strategies may be used more broadly across other patient populations and are intended to align with other standard work.

Requirement: Care plan strategies

Clinics need flexibility to use care planning strategies and tools that are:

- individualized, based on each patient's unique needs and circumstances
- aligned with and in support of the clinic's standard work processes.

Progress in the development of technology, electronic health records, patient portals, online tools, and apps allows for multiple ways in which clinics may be sharing the elements of a **care plan** with patients, care team members, and external partners supporting the patient.

Care plan: an individualized written document, including an electronic document, to guide a patient's care.

Evidence-based practice: the integration of best research evidence with clinical expertise and patient values.

Preventive care: disease prevention and health maintenance. It includes screening, early identification, counseling, treatment, and education to prevent health problems.

What needs to be in place:

Foundational Level
Use of care planning strategies that provide patients with information from their personal clinician visit that includes: ✓ relevant clinical details ✓ health maintenance and **preventative care** instructions ✓ chronic condition monitoring instructions, including indicated early intervention steps and plans for managing exacerbations, as applicable **Actions to consider:** ✓ Most clinics provide patients with an after-visit summary (AVS) that provides this information ✓ Patients should receive and understand post visit clinical information, providing them an opportunity to see and have a record of their health information

- ✓ It is also a good practice for engaging patients in their own care and helping them to remember what happened during the office visit

Use of care planning strategies that offers documentation of any collaboratively developed patient-centered goals and action steps, including resources and supports needed to achieve these goals, when applicable.

- ✓ Include pertinent information related to whole person care needs or other determinants of health when applicable

Actions to consider:

- ✓ This care plan strategy captures the collaborative work the care coordinator does with the patient/family to achieve their health-related goals
- ✓ Effective action planning is a patient centered, collaborative approach that considers barriers to achieving goals, supports and resources that can help in achieving goals, and patient self-efficacy
- ✓ Action plans are a useful strategy that supports patient engagement and activation and self-management; flexibility allows this strategy to be used when it is beneficial to patient engagement or desired by the patient/family
- ✓ This could be in a written summary format, the use of pictorials or other visuals, provided via an online tool or other format

Use of care planning strategies that incorporate advance care planning processes, including discussion of palliative and end-of-life care and completion of health directives, when applicable. Provides the care team with information about the presence of a health care directive and provides a copy for the patient/family.

- ✓ End of life discussions can facilitate the development of a comprehensive treatment plan that is medically sound and agrees with the patient's wishes and values
- ✓ Clinics have flexibility to use advance care planning strategies when appropriate and within the clinic's own standardized work processes
- ✓ This requires clinics consider how these strategies can best be used for the patients they serve

Use **evidence-based practice** guidelines to inform these care planning strategies when applicable.

Actions to consider:

- ✓ Recommendations from the US Preventative Services Task Force
- ✓ Institute for Clinical Systems Improvement (ICSI) guidelines
- ✓ American Academy of Family Physicians (AAFP) guidelines
- ✓ Internally developed, system-wide practice guidelines

Level 2

Progression also requires

This area of the HCH standards does not have a Level 2 requirement

Level 3

Progression also requires

This area of the HCH standards does not have a Level 3 requirement

What needs to be in place:

Recertification: Foundational Level - by the first recertification or if certifying at Level 2 or Level 3, the certified health care home must meet the following additional requirement:
Integrate pertinent medical, medical specialty, quality of life, behavioral health, social services, community-based services, and other external care plans into care planning strategies to meet individual patient needs and circumstances. ✓ All care team members and community providers serving a patient should be taken into consideration for their expertise and role in supporting that person's health ✓ Integrate external care plans into the HCH patient care plan to the extent that information is useful to meeting patient needs and supporting patient goals ✓ Creating an exhaustive list of external care team members and other care providers is not the best use of clinic resources and staff time, nor is it all of value to the patient
Level 2 Progression also requires
This area of the HCH standards does not have a Level 2 requirement
Level 3 Progression also requires
This area of the HCH standards does not have a Level 3 requirement

Standard 5. Performance Reporting and Quality Improvement

The Performance Reporting and Quality Improvement standard directs the clinics to engage in continuous improvement processes that focus on patient experience, patient/population health, and the cost-effectiveness of services.

Level 2 certification criteria advance these processes through requirements to:

- use community health data to inform HCH clinic strategies and improvement plans
- address health disparities within the clinic population through quality improvement efforts
- ensure patient feedback reflects diversity of the patient population and includes underrepresented voices

Level 3 certification criteria broaden the focus from the clinic population to include community population health. The emphasis is on integrating community health efforts and requires that clinics participate and share responsibility in community-based health improvement efforts.

Requirement: Establishing a quality improvement team

A patient and family centered HCH relies on clinic staff to provide input to the clinic's quality improvement activities and includes opportunities for individuals and their families to shape the design, operation, and evaluation of the HCH.

Progression Level 2 strategies require clinics to ensure patient and family feedback reflects diversity of the patient population and includes underrepresented voices. Addressing appropriate solutions requires authentic patient engagement and the use of patient feedback.

What needs to be in place:

Foundational Level
The quality improvement team must reflect the structure of the clinic and include, at a minimum, the following persons at the clinic level: ✓ one or more personal clinicians who deliver services within the health care home ✓ one or more care coordinators ✓ two or more patient representatives who were provided the opportunity and encouraged to participate; and ✓ one or more representatives from clinic administration or management **Actions to consider:** ✓ Some quality improvement teams are structured to have patient representatives as members ✓ Some quality improvement teams obtain and use patient/family feedback about the HCH's operations and quality improvement efforts through separate patient/family advisory processes
Level 2 Progression also requires
Recruit, promote, and support patient representation to the HCH quality improvement team that reflects the diversity of the patient population. ✓ Previous requirements ensure that you have REL data that helps you understand the diversity among the patient population served at your clinic ✓ Use this information to determine if there are populations or communities you serve that are underrepresented in the provision of patient feedback and work to address these gaps, including but not limited to populations of color and American Indians, persons with disabilities, and individuals representing diverse socioeconomic backgrounds
Level 3 Progression also requires
This area of the HCH standards does not have a Level 3 requirement

Requirement: Sharing quality improvement work

Sharing information with the rest of the HCH team and eliciting their feedback helps the entire HCH team remain up to date and engaged in the quality improvement process.

Progression strategies requires that this information sharing, and feedback loop intentionally include the aspects of health equity (Level 2) and community-based population health improvement (Level 3).

What needs to be in place:

Foundational Level
Procedures to share information about the quality improvement work within the clinic and elicit feedback from team members, staff, and patients/families. **Actions to consider:** ✓ Communication mechanisms to share this information with team members and staff might include such things as team huddles, EMR dashboards, visual management boards, as agenda items during a team meeting, or through email ✓ Communication mechanisms to share this information with patients/families might include such things as newsletters, public facing website, or display materials in waiting rooms ✓ Allow opportunity for input and feedback from staff and patients/families when sharing this information
Level 2 Progression also requires
Procedures to share information about work on advancing health equity within the clinic and elicit feedback from team members, staff, and patients/families. ✓ These can be the same communication mechanisms used to share information about quality improvement activities and performance-related goals
Level 3 Progression also requires
Communicate and share information about work on community-based population health improvement efforts and elicit feedback from team members, staff, patient/families, and community members. ✓ These can be the same communication mechanisms used to share information about quality improvement and advancing health equity

Requirement: Performance measurement capability

Continuous quality improvement is critical to the success of the HCH and essential to improving health outcomes.

What needs to be in place:

Initial certification only: Foundational Level – the HCH's capacity to conduct continuous quality improvement will be validated in other areas of the application at recertification
Measures, analyzes, and tracks changes in at least one quality indicator to demonstrate performance improvement processes. ✓ Quality improvement planning is critical to the success of the HCH and essential to improving health outcomes **Actions to consider:**

- ✓ The HCH Learning Collaborative E-Learning has an on-demand, online e-Learning course titled *'Foundations of Health Care Homes Certification'*
- ✓ Your example may include quality measures that are submitted to the Statewide Quality Reporting and Measurement System or be based on other quality needs

Level 2 Progression also requires
This area of the HCH standards does not have a Level 2 requirement
Level 3 Progression also requires
This area of the HCH standards does not have a Level 3 requirement

Requirement: Participation in the HCH learning collaborative and sharing information

The **HCH Learning Collaborative** activities supports implementation and ongoing development of the HCH care delivery model, provides learning resources and support, and allows for networking opportunities and peer sharing among HCHs and other partners.

Health Care Home Learning Collaborative: an organization established under Minnesota Statutes in which health care home team members, patients, and other organizations that provide health care and community-based services work together in a structured way to improve the quality of their services by learning and sharing experiences.

What needs to be in place:

Foundational Level
Participates in the HCH Learning Collaborative and uses established procedures for sharing this information with other staff and patients/families.

- ✓ Participation in the HCH Learning Collaborative activities must occur through care team members that reflect the HCH structure and may include clinicians, care coordinators, integrated care team members, administrators/managers, patients, or others
- ✓ Be sure to subscribe to the HCH LEARN bulletin to stay informed and alerted of upcoming learning activities; encourage applicable care team members to subscribe as well

Actions to consider:

- ✓ The HCH Learning Collaborative provides learning opportunities through a variety of modalities; some clinics use the on-demand, online learning courses offered through the MDH Learning Center to on-board new HCH staff and/or care coordinators
- ✓ HCHs can share their learnings and best practices in multiple ways, including presenting a breakout session at HCH Learning Days, recording of an audiocast, recording a webinar, or providing subject matter expertise to an online learning course.
- ✓ Clinics use a range of communication mechanisms to share about the information learned from the MDH HCH Learning Collaborative with other care team members and staff including as agenda items/presentation of learnings at regular team meetings.

Level 2 Progression also requires
This area of the HCH standards does not have a Level 2 requirement
Level 3 Progression also requires
This area of the HCH standards does not have a Level 3 requirement

Requirement: Participation in SQRMS

A standardized and transparent measurement strategy drives quality improvement. Minnesota's standardized quality measure set is the **Statewide Quality Reporting and Measurement System (SQRMS**), part of the 2008 health reform legislation, and designed to create a uniform approach to quality measurement. Physician clinics have been reporting on standardized quality measures under this statewide system since 2010.

Minnesota Statewide Quality Reporting and Measurement System (SQRMS): a system that requires physician clinics and hospitals to submit data on a set of quality measures and establishes a standardized set of quality measures for health care providers across the state.

What needs to be in place:

Recertification: Foundational Level - by the first recertification or if certifying at Level 2 or Level 3, the certified health care home must meet the following additional requirement:
Participates in SQRMS by registering with the vendor selected by the state (Minnesota Community Measurement - MNCM) and submitting data to this vendor in the manner prescribed by the commissioner. ✓ Data submission requirements and timelines are outlined through MNCM
Level 2 Progression also requires
This area of the HCH standards does not have a Level 2 requirement
Level 3 Progression also requires
This area of the HCH standards does not have a Level 3 requirement

Requirement: Continuous quality improvement

Quality improvement in the HCH should pursue the Institute for Healthcare Improvement's (IHI) 'Triple Aim' (Triple Aim for Populations | IHI - Institute for Healthcare Improvement) and

measure progress towards that comprehensively. The Triple Aim approach seeks to optimize health system performance and increase the value of health care.

Progression Level 2 strategies use community health data and population-level information to inform HCH clinic strategies and improvement plans. Additionally, quality improvement plans and efforts at Level 2 must address health disparities within the clinic population. Making inequities visible brings them to the forefront for identifying potential solutions.

Community-integrated Progression Level 3 strategies broaden the focus from the clinic population to include population health and emphasize using data to collaboratively plan community-based health improvement efforts and develop shared responsibility for health among cross-sector partners.

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

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

What needs to be in place:

Recertification: Foundational Level - by the first recertification or if certifying at Level 2 or Level 3, the certified health care home must meet the following additional requirement:

Demonstrates performance improvement and uses a quality plan that measures, analyzes, and tracks indicators from each of the Triple Aim components during the last year:

- ✓ patient health/health outcomes
- ✓ patient experience
- ✓ cost-effectiveness

Actions to consider:

- ✓ MDH provides an example template of how you might present your quality report, but you can present your quality improvement work in any format of your choosing
- ✓ You are required to use data about patient experience in planning and implementing quality improvement activities, but how you do this is up to you
- ✓ MDH HCH does not require the use of a standardized tool to capture data about patient experience although there several available including CAHPS Clinician & Group Survey (CG-CAHPS), Midwest Clinicians Survey, and others

Level 2

Progression also requires

1. Uses information and population health data about the community served to inform organizational strategies and quality improvement plans.

- ✓ Community health data can identify key social and well-being drivers that influence the health of the HCH's patient population.
- ✓ Examples of these data sources include community health assessment (CHA), community health needs assessment (CHNA), county health rankings, or other community data sources available from health plans or other partners

2. Measures, analyzes, tracks, and addresses health disparities within the clinic population through continuous improvement processes.
✓ In addition to the Triple Aim components of patient health, patient experience, and cost-effectiveness, the HCH's quality improvement processes must address advancing health equities or addressing health disparities

Actions to consider:

✓ Address individual, social, or environmental factors to raise awareness about health disparities, engage others in conversations about the problem and solutions, and take action for change
✓ Stratify quality indicators by race, ethnicity, and language to identify health disparities and describe how at least one of these measures were addressed based upon the opportunity for improvement
✓ Review quality indicators for persons with disabilities to detect potential health disparities and formulate action steps to reduce or eliminate any identified inequities

Level 3

Progression also requires

Contribute to a coordinated community health needs assessment and population health improvement planning process by:

1. Sharing aggregated information or de-identified data that describes health issues and inequities
✓ Comprehensive data sources are essential to understanding community health needs and population health. HCH clinics have important information and data to contribute to a comprehensive community health assessment and monitor impact of community planning efforts over time.
2. Collaborating with community partners and other vested organizations and individuals in prioritizing population health issues and planning improvement efforts
✓ Population health requires a multi-sector approach. The most effective, efficient, and sustainable way to improve population health is for health care organizations to develop the infrastructure, capacity, and relationships to partner effectively with community assets.
3. Sharing the responsibility in implementing and monitoring progress of the population health improvement plan
✓ All partners, including clinic partners, have shared responsibility in addressing the health needs of the community and for the ongoing monitoring and tracking of data to determine the impact of efforts.

Requirement: Achieves HCH benchmarking

HCH certification acknowledges that standardized measurement in healthcare is critical. Performance on standardized measures demonstrates accountability for outcomes and is a key component in defining the value of care an organization is providing. Also critical is understanding the context and larger picture in which those outcomes exist. Organizational culture, the infrastructure of the care delivery system, and the factors that contribute to health in the patient population all have an impact on performance and is information that should be used in quality improvement plans. The HCH benchmarking process incorporates all these components to tell the story of process improvement at the organization and to allow for MDH HCH staff to support that work.

What needs to be in place:

Recertification: Foundational Level – by the first recertification or if certifying at Level 2 or Level 3, the certified health care home must meet the following additional requirement:
Use benchmarks to demonstrate accountability for outcomes in patient health, patient experience, and cost-effectiveness in the primary care services patient population and engage in process improvement to impact these outcomes. ✓ Benchmarks use standardized measures to compare the performance of an organization or clinics to others with the goal of improving quality, cost-effectiveness, and patient experience. Benchmarking information should be used to identify opportunities for improvement, facilitate discussions among HCH teams and support their taking action, as well as assist in applying best practices and learning from others. ✓ Organizations/clinics use multiple standardized measure sets in their practice. These may include: the Minnesota Statewide Quality Reporting and Measurement System (SQRMS) quality measure set; the Uniform Data System (UDS) used by Health Resources and Services Administration (HRSA); Government Performance and Results Act (GPRA) performance measures; and many others that clinics are using through their participation in alternative payment arrangements and to meet contractual obligations with health plans, for reporting to the Centers for Medicaid and Medicare (CMS), and more. ✓ Organizations/clinics lead a discussion during the team meeting that allows for them to demonstrate how they are meeting requirements related to continuous quality improvement and HCH benchmarking. See the guided outline in Appendix E for expectations for leading a quality improvement and performance benchmarking presentation and discussion at the team meeting. **Actions to consider:** ✓ Clinics are encouraged to follow quality results closely and incorporate these measures into quality improvement planning.
Level 2 Progression also requires
This area of the HCH standards does not have a Level 2 requirement
Level 3 Progression also requires
This area of the HCH standards does not have a Level 3 requirement

Certification process

To obtain health care homes certification, an applicant must do the following:

- Use this guide to develop a clear understanding of the intent behind each standard to determine if the practice has services, policies, and procedures in place to meet the criteria.
- Meet the requirements for foundational level certification and if desired, meet the optional requirements for level 2 or level 3 certification in addition to recertification requirements.

- Complete and submit the HCH electronic application. One application can be completed for the entire organization. Organizations may certify all clinics at the same level or submit a list of which clinics are certifying at each of the following levels: Foundational, Level 2 and Level 3.
- Protected health information (PHI) should be removed or blacked out from documents submitted, including patient identifiers.
- Participate in a site review. MDH HCH staff will conduct a site visit to verify the clinician or clinic practice and patient experience accurately reflects the standards and measures attested to in the application. (See Appendix D)
- Plan to participate (or continue to participate) in Statewide Quality Reporting and Measurement System (SQRMS) by submitting data to Minnesota Community Measurement (MNCM).

MDH Health Care Homes staff is available to support applicants throughout their HCH journey, including the certification and recertification process. Please reach out to your designated HCH Practice Improvement Specialist for assistance. If you are not aware of your assigned HCH staff, please contact the HCH program by e-mail at health.healthcarehomes@state.mn.us.

Recertification process

To retain certification, a health care home must be recertified every three years by doing the following (See Appendix B and Appendix C):

- Continue to meet the requirements for Foundational Level certification and, if applicable, Level 2 and Level 3 certification.
- Meet the recertification requirements for each health care home standard, including the requirement that the health care home achieves outcomes in its primary care services patient population for patient health, patient experience, and cost-effectiveness as established by the commissioner.
- Complete and submit the Health Care Homes electronic application. Protected health information should be removed or blocked out from documents submitted, including patient identifiers.
- Participate in a team meeting with HCH program staff. (See Appendix E)

Recertification may begin up to 6 months prior to the certification end date.

MDH Health Care Homes staff is available to support applicants throughout their HCH journey, including the recertification process. Please reach out to your designated HCH Practice Improvement Specialist for assistance. If you are not aware of your assigned HCH staff, please contact the HCH program by e-mail at health.healthcarehomes@state.mn.us.

Check-ins

Certified Health Care Homes (HCH) are offered an optional check-in with their assigned Practice Improvement Specialist halfway (eighteen months) between recertification cycles. No preparation is required for the check-in. It is an informal exchange of information; the organization decides who attend and how the meeting is conducted. A certified HCH may request additional contact and support or decline a check-in offer at any time.

The intent of the HCH check-in is to:

- Provide coaching and/or technical assistance to certified HCH organizations, allowing them to set the agenda and get the support they desire
- Build and maintain connections between MDH HCH staff and HCH certified organizations
- Support ongoing HCH recertification needs
- Review HCH learning opportunities
- Receive feedback related to HCH concerns
- Verify organization and clinic information and update if needed

Optional Steps

Level 2 or Level 3 Certification

An organization may seek to certify or recertify all clinics at the same level or may have clinics progress to different levels based on the ability of each to meet the requirements. Organizations will submit a list of all clinics and the level of certification each is pursuing: Foundational, Level 2 or Level 3. Progressing to an advanced level of certification may be done at initial certification, recertification or between recertifications.

The organization must demonstrate how clinics seeking advanced certification have met the Level 2 or Level 3 requirements (See Appendix A) and do the following:

- Meet all Foundational Level certification and recertification requirements.
- Address how the Health Care Home is working to resolve any outstanding requirements (variances) if applicable.
- If requested, participate in a site visit or team meeting and provide additional information or documentation necessary to make the determination that one or more of the Health Care Home clinics should be certified at Level 2 or Level 3.
- If seeking Level 2 or Level 3 certification at initial certification or at recertification, clinics will use the online certification/recertification application available in the HCH portal.
- If seeking Level 2 or Level 3 certification after initial certification, but BEFORE first recertification, clinics will need to complete the first recertification application process.

- If seeking Level 2 or Level 3 in between certification cycles, and the clinic has been recertified at least once, clinics have the option to use the online level progression application available in the HCH portal and keep their next HCH recertification date in place.

Variance

Variance: a specified alternative or an exemption from meeting part of a requirement.

Variances can be approved for the following:

- When small parts of a requirement are not fully implemented. In these instances, the clinic generally meets the requirements or has a well-developed plan and implementation timeline on specific elements.
- When the clinic fails to use benchmarks to demonstrate accountability for their performance and engage in process improvement strategies to impact the patient population it serves (as per the HCH benchmarking requirement).
- When the clinic experiences a hardship. A hardship is considered something greater than an inconvenience, or the process may result in costs to the clinic to implement or the process is difficult to implement.
- When the clinic is implementing an innovative or experimental approach that meets the intent of the requirement or is actively participating in a health care home research project that contributes to innovation and improvement of care.

The HCH certification/recertification process will identify which standards are:

- fully met
- fully met with a recommendation(s)
- partially met with a variance(s) and recommendation(s)
- partially met with a variance(s)
- not met

Applicants who do not fully meet a requirement at certification or recertification will work with their assigned PIS to utilize the variance process and determine if an action plan for improvement is needed. If a variance is needed in between recertification cycles for a hardship or other reason, the HCH should work with the HCH staff to initiate a variance process.

The HCH and assigned PIS will work together to establish a timeline for the variance. The goal is to resolve variances within this established timeline, but variances can be extended if there is justification for a continued variance. The PIS will check-in with the clinic at periodic intervals to receive updates and then resolve the variance when appropriate.

Recommendations

Recommendations are observations made by the site visit evaluators during HCH certification or recertification reflecting opportunity for improvement. They will be communicated to organizations through their official report. Recommendations are not prescriptive and may be addressed by the certifying organization as appropriate. Recommendations are reviewed at the following recertification to determine if and how they were addressed.

Other PCMH program recognition

There are several national programs that award patient-centered medical home (PCMH) recognition, including the Accreditation Association for Ambulatory Health Care (AAAHC), The Joint Commission, the National Committee for Quality Assurance (NCQA), and the Utilization Review Accreditation Commission (URAC). Some states and private insurers also offer accreditation. Many of the requirements for national program recognition align with the MDH HCH standards for certification.

The Minnesota Department of Health provides an expedited HCH certification pathway for organizations already recognized by a national program. Please contact the MDH HCH program if you are interested.

Need help?

Please visit the HCH website for more information. While you are there, sign up for the HCH newsletter and Learn bulletin at the top right corner of the website's homepage.

Support your Health Care Homes transformation by visiting the HCH Learning Collaborative webpage, your gateway to online courses, conferences, webinars and other resources designed for Health Care Homes partners at all levels of learning. This includes the *Foundations of Health Care Homes Certification* course that takes organizations through the HCH certification and recertification process.

The MDH Health Care Homes staff is available to answer questions and provide ongoing support for clinicians, clinics and organizations considering HCH certification or that are already HCH certified. You can reach the HCH staff by e-mail health.healthcarehomes@state.mn.us.

Nationally, the Primary Care Collaborative (PCC) is a coalition that works to develop and advance an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home (PCMH) model. Their Clinical Practice Transformation Quick Start Guide provides multiple resources to Boost Patient and Family Engagement in Clinical Practice. The PCC website also includes a Transforming Clinical Practice Initiative Guide.

Appendix A

Levels of HCH Certification with requirements: Progression

Standard 1: Access and Communication

The health care home must have systems in place to support effective communication among members of the health care home team, the patient and family, and other providers by meeting the following requirements:

FOUNDATIONAL LEVEL	LEVEL 2	LEVEL 3
Offer health care home services to all the primary care services population that includes doing the following: (1) identify patients who have or are at risk of developing complex or chronic conditions (2) offer varying levels of coordinated care to meet the needs of the patient (3) offer more intensive care coordination for patients with complex medical and social needs	Include processes that identify information about social determinants of health and other factors affecting a patient's health and wellbeing to determine risk and manage patient care.	No Level 3 requirement
Has a system for providing continuous, 24-hour, access with triage protocols and that the patient is informed and equipped with the knowledge about access to care, including: (1) inform patients that they have continuous access to designated clinic staff, an on-call provider, or a phone triage system. (2) designated clinic staff, on-call providers, or phone triage system representative have continuous access to patient' medial record information (3) Use triage protocols to schedule appointments based on acuity of patient's condition and that addresses scheduling appointments within a business day to avoid unnecessary emergency room visits and hospitalizations.	Offer enhanced access that includes options beyond the traditional in-person office visit that increase patient access to the health care home team and to enhance the health care home's ability to meet the patient's preventative, acute, and chronic care needs.	No Level 3 requirement
Collect information about patient cultural background, racial heritage, and primary language, and describe how it is applied to improve care.	Implement care delivery strategies responsive to the patient's social, cultural, and linguistic needs	No Level 3 requirement
Document how the clinic uses the patient's preferred means of communication	No Level 2 requirement	No Level 3 requirement

Inform all patients of choice in specialty care and treatment options	No Level 2 requirement	No Level 3 requirement
Maintain policies and procedures that establish privacy and security protections of health information and comply with applicable privacy and confidentiality laws.	No Level 2 requirement	No Level 3 requirement
In addition to the above, the following requirements must be met for recertification, and with all LEVEL 2 or LEVEL 3 applications		
Encourages patients to take an active role in managing their health care and demonstrate patient involvement and communication by identifying and addressing at least one of the following methods used for the HCH population: readiness for change, literacy level, or other barriers to learning.	Implement strategies to encourage patient engagement through interventions that support health literacy and help the patient manage chronic diseases, reduce risk factors, and address overall health and wellness.	No Level 3 requirement

Standard 2: Patient Registry and Tracking Patient Care

The health care home must use an electronic, searchable patient registry to record patient information and track care that meets the following requirements:

FOUNDATIONAL LEVEL	LEVEL 2	LEVEL 3
Use the registry to conduct systematic reviews of the patient population to manage health care services, provide appropriate follow-up, and identify gaps in care. The registry must contain: • For each patient, the name, age, gender identity, contact information, and ID number assigned by the clinic, if any; and sufficient data elements to issue a report that shows any gaps in care. • Use the registry to identify gaps in care and implement remedies to prevent them.	Expand registry criteria to identify needs related to social determinants of health and other whole person care factors for the patient population. Plan and implement interventions to address unmet needs identified by the expanded registry.	No Level 3 requirement

Standard 3: Care Coordination

The health care home must adopt a system of care coordination that promotes patient and family centered care through the following steps and requirements:

FOUNDATIONAL LEVEL	LEVEL 2	LEVEL 3
Collaboration within a team, at a minimum including the patient, care coordinator, and personal clinician to: (1) set patient goals and identify resources to achieve them, (2) ensure consistency and continuity of care, and (3) determine how often the care team and patient will have contact.	Provide and coordinate care using an integrated care team.	No Level 3 requirement
The care team provides and coordinates care, including communication and collaboration with specialists, designating one clinician for each patient in the clinic's population and one care coordinator as the primary contact for each patient receiving intensive care coordination services and inform the patient of this designation.	No Level 2 requirement	No Level 3 requirement
The clinician and care coordinator communicate with each other directly and includes routine, face-to-face discussions.	No Level 2 requirement	No Level 3 requirement
The care coordinator has dedicated time to perform care coordination responsibilities.	No Level 2 requirement	No Level 3 requirement
Document in the chart or care plan: •referrals to specialists and results of referrals •ordered tests, test results communication to patient •admissions to facilities •discharge planning •communication with pharmacy and medication reconciliation •Other information determined to be beneficial to coordination of patient care, such as links to external care plans	No Level 2 requirement	No Level 3 requirement
In addition to the above, the following requirements must be met for recertification, and with all LEVEL 2 or LEVEL 3 applications		

Provide patients with the opportunity to fully engage in care planning and shared decision-making. Solicit and document patient feedback.	No Level 2 requirement	No Level 3 requirement
Identify and work with community-based organizations and public health resources to facilitate the availability of appropriate resources for patients.	Support ongoing coordination of care and follow-up with partners by sharing information.	No Level 3 requirement
Permit and encourage team members to work at a level that fully uses their licensure, training, and skills.	No Level 2 requirement	No Level 3 requirement
Engage patients in planning for transitions among providers and between life stages.	Implement processes to improve care transitions that reduce readmission, adverse events, and unnecessary emergency department utilization.	No Level 3 requirement

Standard 4: Care Plan

The health care home must establish and implement policies and procedures to guide the health care home in the identification and use of care plan strategies to engage patients in their care and to support self-management. These strategies must include:

FOUNDATIONAL LEVEL	LEVEL 2	LEVEL 3
Provides patients with information from their personal clinician visit that includes relevant clinical details, health maintenance and preventative care instructions, and chronic condition monitoring instructions, including indicated early intervention steps and plans for managing exacerbations, as applicable. Offers documentation of any collaboratively developed patient-centered goals and action steps, including resources and supports needed to achieve these goals, when applicable. Pertinent information related to whole person care needs or other determinants of health are included. Uses advance care planning processes to discuss palliative care, end-of-life care, and complete health directives, when applicable. Provides the care team with information about the presence of a health care directive and provides a copy for the patient/family. Uses evidence-based practice guidelines to inform these strategies when available.	No Level 2 requirement	No Level 3 requirement
In addition to the above, the following requirements must be met for recertification, and with all LEVEL 2 or LEVEL 3 applications		
Integrate pertinent medical, medical specialty, quality of life, behavioral health, social services, community-based services, and other external care plans into care planning strategies to meet individual patient needs and circumstances.	No Level 2 requirement	No Level 3 requirement

Standard 5: Performance Reporting and Quality Improvement

The health care home must measure the health care home'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:

FOUNDATIONAL LEVEL	LEVEL 2	LEVEL 3
Establish 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: •one or more personal clinicians who deliver services within the HCH •one or more care coordinators •two or more patient representatives who were provided the opportunity and encouraged to participate; and •one or more representatives from clinic administration or management	Recruit, promote, and support patient representation to the health care home quality improvement team that reflects the diversity of the patient population.	No Level 3 requirement
Establishes procedures for the team to share quality improvement work within the clinic and elicit feedback from team members and other staff.	Establish procedures to share about work on health equity within the clinic and elicit feedback from team members and other staff.	Communicate and share about work on population health improvement and elicit feedback from team members, other staff, and community members.
Measures, analyzes, and tracks changes in at least one quality indicator. *Note: Not applicable after initial certification as this is addressed elsewhere for subsequent recertifications.*	No Level 2 requirement	No Level 3 requirement
Participates in the HCH learning collaborative through care team members that reflect the clinic structure that may include clinicians, care coordinators, other care team members, administration or management, and patients.	No Level 2 requirement	No Level 3 requirement
Establishes procedures for representatives to share information from learning collaborative(s) and elicit feedback.	No Level 2 requirement	No Level 3 requirement
In addition to the above, the following requirements must be met for recertification, and with all LEVEL 2 or LEVEL 3 applications		

Participate in SQRMS as required by MDH.	No Level 2 requirement	No Level 3 requirement
Measure, analyze, and track at least one quality indicator in each of the following categories during the previous year: • Improvement in patient health • Quality of patient experience • Measures related to cost effectiveness of services	Uses information and population health data about the community served to inform organizational strategies and quality improvement plans. Measures, analyzes, tracks, and addresses health disparities within the clinic population through continuous improvement processes.	Contribute to a coordinated community health needs assessment and population health improvement planning process by: Sharing aggregated information or de-identified data that describes health issues and inequities. Prioritizing population health issues in the community and planning for population health improvement in collaboration with community partners and other vested organizations and individuals. Implementing and monitoring progress of the population health improvement plan using shared goals and responsibility.
Achieve established HCH benchmarks.	No Level 2 requirement	No Level 3 requirement

Appendix B

First Recertification Reporting Requirements

Begin working on your recertification process by:

1. Continuing to meet all initial requirements for foundational level certification.
2. Completing new additional requirements for foundational level recertification using this guide:

    - Standard 1. Access and communication: Requirement: Patient engagement
    - Standard 3. Care coordination: Requirement: Shared decision-making
    - Standard 3. Care coordination: Requirement: Community partnerships
    - Standard 3. Care coordination: Requirement: Team-based care-working at the top of license
    - Standard 3. Care coordination: Requirement: Care during transitions
    - Standard 4. Care plan: Requirement: Integrate external services into care plan.
    - Standard 5. Performance reporting and quality improvement: Requirement: Participation in SQRMS
    - Standard 5. Performance reporting and quality improvement: Requirement: Continuous Quality Improvement
    - Standard 5. Performance reporting and quality improvement: Requirement: Achieves HCH benchmarking

3. Addressing all variances and recommendations given at initial certification.

    - Describe in the application how a recommendation given by MDH at initial certification was addressed.
    - Provide evidence of work done to resolve a variance to ensure the standard is met. If the variance is not resolved, work with your assigned HCH staff to develop an action plan.

Appendix C

Health Care Homes (HCH) Second and Subsequent Recertification Requirements

Organizations that have been HCH recertified once and are applying for a subsequent recertification should follow the reporting requirements as outlined below.

Complete the online portal HCH application. Recertification takes place in a team meeting format with MDH HCH staff and the certified organization's HCH team. Members of the team including patient partners may participate in-person, by phone, or other remote technology.

Ongoing recertification reporting requirements

1. Continue to meet all initial certification and recertification requirements

2. Address all variances and recommendations made from the previous recertification.
    - Describe in the application how a recommendation given by MDH at initial certification was addressed.
    - Provide evidence of work done to resolve a variance to ensure the standard is met. If the variance is not resolved, work with your assigned HCH staff to develop an action plan.

Appendix D

What to expect during an initial HCH certification site visit

Health Care Homes (HCH) staff will conduct a site visit at initial certification to assess the care delivery process within the organization to understand how the intent of the patient-centered model of care is integrated into the practice. HCH staff will verify the clinician or clinic practice and patient experience accurately reflects the standards and actions attested to in the application. The HCH staff will collaborate with the organization to identify practice needs, barriers to implementation, and areas of improvement needed to successfully implement HCH standards.

Preparing for the Site Visit Day

- Work with your assigned MDH RN staff (Practice Improvement Specialist) to set a date for the site visit. They will provide a detailed schedule template customized for your site visit.
- Arrange interview and meeting times, along with meeting space, for each interview and meeting scheduled during the visit. This will include care coordinators, clinicians, front and back-office team members and leadership. Complete the provided site visit schedule template indicating specific names times and locations.
- Notify and prepare all clinic staff of visit date and time. MDH staff will be validating the information provided in the application and verifying that the requirements for certification are met. Demonstration of this work, when applicable, may be asked for at the site visit.
- Prepare the opening health care home and quality improvement presentation as described in the 'Sample Agenda for Site Visit' below.

Include Patients in the Site Visit

A key element of the site visit is inclusion of and interaction with patients who receive intensive care coordination. MDH staff will inform you how many patients will be needed for interviews. Select patients to participate in the site visit who are willing to share their care experiences. MDH visitors will need a copy of the patient's care plan strategies as we will discuss individualized approaches taken with each patient. Consider your clinic's cultural diversity in selecting patients so MDH can get a complete view of how your HCH accommodates these differences.

Documents

Documentation verifying processes are submitted in advance of the site visit through the application process. If additional information is needed during the site visit, this will be requested ahead of time.

All information submitted to MDH should be de-identified.

Documents to make available at the Site Visit include:

- Copy of the patient care plan strategies or similar document for each patient interviewed (de-identified)
- Examples or documentation that supports quality improvement work to be presented during the quality team meeting.
- Other information as requested by MDH
- Note: MDH does not access individual patient records

Sample Agenda for Initial HCH Certification Site Visit

This is an example agenda for the site visit. Please feel free to schedule the day to fit your clinic's needs. Site visitors will include a minimum of one MDH staff, a health care professional, and a consumer. MDH will e-mail organizations a schedule template for the site visit, the organization is asked to customize the schedule to their clinic flow and assign staff or patients to designated interview times.

1. **Introductions/clinic tour (20 min)**

- Introduce HCH team and site visitors
- Tour of the clinic to familiarize site visitors with the facility.
- Review agenda (if needed)

2. **Health care home presentation and team meeting (1 hour)**

   This opening session is an opportunity for the HCH team to inform MDH and site visitors about how HCH has been implemented in the clinic. Ideas on what the presentation might include:

- How the clinic established a HCH (history, journey)
- Care coordination activities and involvement of clinicians
- Efforts to promote HCH internally and externally
- Stories that illustrate how clinic is promoting patient and family centered care
- How the clinic has changed since implementing HCH
- The care team model
- Patient and family involvement in development of HCH or quality work
- Discussion of lessons learned

3. **Interviews and process/document review sessions throughout the day (30-60 min/each)**

- Work with MDH to determine the number of providers, staff, and patients needed for interviews. Please schedule 30 minutes and meeting space for patients, PCP's and team member interviews and 60 minutes and meeting space for care coordinators.
- Schedule time and meeting space for 3 simultaneous interviews (3 staff from MDH working separately) with Care coordinators, patients,
- Have patient care plans or other patient specific document for the patients scheduled to be interviewed available to the MDH staff. Documents such as registries can be viewed on computer screens.

4. **Presentation of quality teamwork (up to 1 hour – over lunch is an option)**

- Present quality plan, data indicators tracked, measured, and analyzed
- Share outcomes
- Include patient partners involved in quality work if possible.

5. **MDH document review/MDH internal team review of criteria (approx. 30 minutes)**

6. **Debrief, next steps and concluding comments from MDH site visit evaluators (30 min)**

Appendix E

What to expect during a recertification team meeting

The HCH recertification process includes a team meeting to discuss the HCH model progression within the certified organization and clinics to present and share their process improvement work and use of performance benchmarks. The team meeting is a collaborative process in which the MDH HCH team seeks to learn from you and support your organization/clinic's quality improvement efforts.

Work with your assigned MDH RN staff (Practice Improvement Specialist) to set a date for the team meeting and to determine an appropriate length for the team meeting (generally speaking, team meetings last about 1.5-2 hours, but can vary in length depending on the amount of items that the organization wants to share). MDH team members usually include one Health Care Homes RN plus a consumer representative. Participants attending from the HCH organization should include the HCH Primary Contact/Implementation Lead, the Care Coordination Lead, the Quality Improvement Manager/Quality Lead, and/or other population health staff as appropriate. Other key staff to consider, at the organization's discretion, include a clinician/HCH clinical champion, care coordinator(s), and clinic leadership.

It is encouraged, but not required, to include patients or family members who serve on quality improvement teams (such as those on a patient advisory council) or patients receiving care coordination services. Patients who attend provide a unique perspective and their stories are highly valued.

Clinics lead the team meeting, presenting information on organizational updates highlighting new programs, workflows, and/or projects since the previous certification/recertification. If this is the first HCH recertification, clinics should focus on how they are meeting the additional HCH recertification standards that have been added since initial certification.

A primary component of the team meeting is the presentation that clinics provide to demonstrate that they are meeting requirements for continuous quality improvement and performance measurement/benchmarking (refer to pages 31-34 in COMPASS as needed). Clinics may use quality reports, dashboards, or other methods of communication to show the work being done. The following is a guided outline of how to structure this part of your presentation. Please note this is intended to help clinics in leading their presentations to ensure essential elements are captured and discussed, but that it is not a required format and clinics may choose to tell their stories however they wish.

Consider presenting about your organization's:

- Performance Measures
    - What performance measures does your organization/clinic prioritize and focus resources towards?
    - Why these?

- How does your organization/clinic use these measures to benchmark performance?
- Briefly describe the assessment of your organization/clinic's performance using these benchmarks.

- Process Improvement
  - What does process improvement look like at your organization/clinic?
  - How does your organization/clinic use data to make change?
  - How does your organization/clinic engage providers and teams in this work?
  - How does your organization/clinic incorporate the patient perspective and patient voice in this work?
  - Include examples of quality improvement work from each of the triple aim components: health outcomes, patient experience, and cost-effectiveness/efficiency.
  - For organizations pursuing Level 2 or 3 certification for any of their clinics, also include:
    - the type(s) of community and population health data used to inform organizational strategies or quality improvement initiatives;
    - how this data has impacted or contributed to managing care for your organization/clinic's patient population;
    - a demonstration of quality improvement work done to advance health equity or address health disparities in your organization/clinic's patient population, including specific indicators used to measure and track that.
  - For organizations pursuing Level 3 certification for any of their clinics, also include:
    - a description of the partners with whom your organization/clinic works with in contributing to a coordinated community health needs assessment process;
    - an overview of the community health needs assessment process, including how your organization/clinic contributed to this process and the types of de-identified data or aggregated information that was shared;
    - which population health issues were prioritized based on the needs assessment, how these were determined, their impact on health equity, and the plan for population health improvement that was developed as a result;
    - an overview of how your organization/clinic is engaged in, share responsibility, and monitor progress ongoing of the population health improvement plan;

        - as applicable (if part of an organization with multiple clinics), explore how each of the clinics applying for Level 3 certification are involved in the community health/population health efforts being described. How does this communication occur? How are clinics directly involved?

- Successes
    - What is your organization/clinic the proudest of accomplishing? Consider
        - where the largest gains were made,
        - improvement in a specific subgroup of patients or within an underserved population,
        - an impact with qualitative aspects that is difficult to measure using any traditional outcome measures,
        - other progress/impact that you are proud of accomplishing.
    - What was the 'secret sauce' in this success?
    - What is working well?
- Challenges
    - What has been most challenging?
    - Are there measures that your organization/clinic just can't seem to 'move the needle on' despite efforts to do so?
    - What are the barriers?
- HCH Team
    - Do you capture feedback or collect information about staff engagement or workforce satisfaction?
    - What are your organization/clinic's workforce challenges?
    - How does this impact your organization/clinic's process improvement work?
    - How are workforce challenges being addressed in your organization/clinic?
- Patients
    - Do you capture feedback or collect information about patient engagement or satisfaction with their care?
    - Are there differences in subgroups, such as persons with disabilities, people of color, LGBTQ+?

MDH HCH staff will come to the team meeting prepared with publicly available information about your organization's performance on standardized measurement, including Minnesota Statewide Quality Reporting and Measurement System (SQRMS) measures when available, and look to engage in a dialogue that can facilitate strategic thinking. MDH HCH staff will also be looking to identify opportunities to promote peer interaction and sharing across certified HCHs.

This includes identifying areas in which your organization/clinic may be a resource to others and areas in which your organization/clinic may want to hear more about from other HCHs. If there are additional resources, data, or other profiles available that could provide value to your organization/clinic, MDH HCH staff will facilitate accessing this information.