Health Care Homes Recertification Progression 2012

Rule	Standard / Criteria Description	Certification	Recertification at end of year one	Recertification at end of year two
4764.0030 Subp. 1A & B ***Subp. 2 (recertification standard)***	*Certification Procedures: Application processing & documentation*	The health care home applicant completes initial certification application process. • Shows evidence of compliance with initial certification standards. • Provides a brief explanation & supporting documentation as defined on the Certification. Assessment Document. • Submits documentation of the organizational structure. • Describes the HCH structure. • Provides evidence of a care team that provides "whole person" care. • Provides board certification and licensure information for all providers seeking certification. • Submits documentation that the applicant provides the full range of primary care services including acute, preventive &chronic care.	The health care home applicant completes recertification application process. • Shows evidence of compliance with all initial certification standards & submits by exception documentation of any updates. • For end of year one new standards shows evidence of compliance by providing a brief explanation & supporting documentation. • Participates in HCH modified site visit or team meeting.	Health care home applicant completes recertification application process. • Shows evidence of compliance with all certification standards & submits by exception documentation of any updates on required elements **OR** • May apply for variance for superior outcomes & continued progress on standards if eligible. • Demonstrates only one approach that is new for standards 1 - 4. • Participates in a HCH modified site visit or team meeting based on assessment of previous year's report of recommendations and/or variances.

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		• Participates in HCH site visit.		
4764.0040, Subp. 1	*Access and Communication Standard and Criteria: Services to all patients with chronic & complex conditions interested in participation*	• Submits evidence of a systematic population based screening process to identify/inform patients appropriate for HCH services. • Develops a process to discuss with patients the role of the HCH. • Develops a written document describing HCH services that is provided to the participant. • Shows evidence that patients in the HCH know how to & can access services 24/7/365. • Provides evidence that care is patient and family centered • Collects cultural and language information & applies information to improve care. • Documents the patient's preferred method of communication.	The HCH builds on initial requirements.	Submits the clinics process for identifying patients with complex or chronic conditions.

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		• Communicates with patients his/her choice of referrals to specialty providers. • Complies with information privacy and security law		
4764.0040, Subp. 2	*Patient Activation*	None	Demonstrates participant involvement by identifying one of the following: • Participant's readiness for change. • Literacy level. • Or other barriers to learning.	Demonstrates participant involvement • By identifying one of the following: participant's readiness for change, literacy level, or other barriers to learning. • Reports on progress from the previous year or selects a new element of readiness for change. • Provides documentation that supports ongoing patient activation.
4764.0040, Subp. 3 Subp. 4 (recertification)	*Registry and Tracking Participant Care Standard and Criteria*	Demonstrates: • Searchable electronic registry to record/track participant information and care. • Systematic use of a HCH registry to identify gaps in care. • Identifies remedies to	• Builds on initial requirements • Submits workflow that demonstrates use of registry and follow up services, call reminders, or pre-visit planning	Submits by exception documentation of any updates to registries or processes to search for gaps in care.

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		prevent gaps in care. • Registry contains all required elements.		
47464.0040 Subp. 5	*Care Coordination Care Standard and Criteria*	• Develops a systematic process for identifying the patient's PCP and care coordinator that supports an ongoing relationship between patient and provider. • Reports the number of care coordination patients. • Establishes a system of care planning. • Submits care coordinator job description. • Provides evidence of a process for participants to set goals & identify resources to achieve goals. • Team and patient determine frequency of contact • Has a patient experience/ satisfaction survey that measures care planning process • Completes an audit to evaluate the effectiveness of care coordination	• Builds on initial requirements. • Reports the number of care coordination patients. • Completes an audit for each certified clinic.	Reports the numbers of care coordination patients.

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		documentation • Provides evidence of routine face-to face discussion between PCP & care coordinator • Provides dedicated time & tools for care coordinator to perform job functions • Develops written procedures on tracking referrals, tests results & notification, planning admissions, discharges, transfers, medication reconciliation & links to external care plans		
4764.0040 Subp. 6A Enhanced care coordination	*Engagement in shared decision making*	None	• Provides documentation that patient & family centered care principles are included in work scope of team members. • Documents feedback from patients regarding their care. • Establishes work flows that solicit patient participation and shared decision-making.	Provides example of work in patient & family centered care such as shared decision making.

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4764.0040 Subp. 6B	*Engagement with community-based resources and development of partnerships*	None	Provides Evidence of an ongoing partnership with one community resource.	Provides example of engagement with community-based resources and partnership, building on the previous year or outcomes from partnerships.
4764.0040 Subp. 6C	*HCH team practices at top of licensure*	None	Defines roles and accountabilities to allow full use of team member's licensure and education.	
4764.0040 Subp. 6D	*Care transitions*	None	Develops process for anticipatory planning for health care-related transition planning.	Submits evidence of improved processes for anticipatory healthcare transition planning
4764.0040 Subp. 7	*Care Plan Standard & Criteria*	• Submits written care planning policy. • Develops process for risk assessment. • Actively engages participant and all appropriate members of HCH team in care planning. • Develops a schedule of encounters for care plan updates. • Provides a copy of care plan to the patient • Uses evidence based guidelines for medical	• Builds on initial requirements. • Reports the number of care plans in the past year.	Reports the number of care plans in the past year.

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		services. • Develops care plan that includes goals& action plan for preventive care, care for chronic illnesses, exacerbations of chronic conditions		
4764.0040 Subp8	*Comprehensive Care Plans: Incorporation of external care plans*	None	• Submits procedure for planning with community partners for patients with external care plans. • Submits 3 integrated care plans that have blinded patient information in them.	Submits 2 care plan examples from each clinic for a maximum of 20 care plans **OR** A care planning audit with results and plan.
4764.0040 Subp. 9 A 1,2,3,4 9B	*Performance Reporting and Quality Improvement Standard and Criteria*	Establishes a health care home quality improvement team. • Provides evidence that quality team is in place with dates of meetings, names of members.	Health care home quality team is growing in capabilities. • Provides evidence that quality team is in place with dates of meetings, names of members	Quality team continues to grow and is making progress with outcomes measurement. • Provides evidence that quality team is in place with dates of meetings, names of members
4764.0040 Subp. 9C, 10B	*Measurement of Triple Aim*	• Shows evidence of quality team functioning at a basic level. • Submits at least one quality indicator; how it was measured analyzed, & tracked.	• Submits HCH quality plan. • Shows evidence that team has identified, measured, analyzed and tracked improvement for an indicator that focuses on each quality area; health, patient experience, and	Continues to show evidence of quality work defined in each year and provides a quality plan for each of the triple aim. **OR** May apply for variance for superior outcomes & continued progress on standards if

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			measures of cost-effectiveness.	eligible. Is not required to show an example for performance improvement.
4764.0040 Subp. 9D 1,2,3,4 9E	*Learning Collaborative and Feedback Mechanism*	• Established membership of the learning collaborative. • Develops procedures to share learning in the clinic. • Lists participants, dates of attendance & topics in learning collaborative work.	• Continued participation in learning collaborative. • Continues to share ongoing learning in the clinic. • Lists participants, dates of attendance & topics in learning collaborative work.	• Continued participation in learning collaborative. • Continues to share ongoing learning in the clinic. • Lists participants, dates of attendance & topics in learning collaborative work.
4764.0030 & 4764.0040 Subp. 10A, 11A	*Reports to the Statewide Quality Reporting Systems. Outcomes measurement & benchmarking.*	• Agrees to participate in the state wide measurement reporting system. • Is notified of quality measures that will be submitted to the state wide measurement system at the end of year one. • If the applicant has been reporting to MNCM will establish baseline benchmarks at certification.	• Submits data to the state wide measurement reporting system for end of year one. • Is notified of the quality measurements that will be submitted to the statewide measurement system for year two. • If has not been reporting to MNCM at certification will establish baseline benchmarks at year one recertification or year one comparison to baseline benchmark.	• Continues to submit outcomes data to statewide measurement system. • Year 2 comparison to benchmarks. • May submit each year for variance for superior outcomes and continued progress on standards if eligible or may submit a variance for low performance.