Health Care Homes
Certification Assessment Tool- With Examples

Guidelines:

Certification Assessment Form Structure:
This is the self-assessment form that HCH applicants should use to determine if they meet the requirements for HCH certification. Applicants will also submit their HCH Certification Assessment form to MDH with their application prior to the certification site visit.

- Column one is the standard or criteria as stated in the HCH Rule 4764.0010- 0070
- Column two is the intent of the standard.
- Column three is the verification requirements and supporting data sources or documentation.
- Column four is where applicants note whether they meet the requirements (yes/no)
- Column five is the "HCH Progress" column. Applicants can use this during the self-assessment. Applicants will also use this column to communicate a brief description of how they meet the requirement when they submit the self-assessment form to MDH during the application process. Applicants will submit a limited number of documents to MDH prior to the site review and those are noted as "***submit at application.***"

Instructions:
Standards are designated by the timeline when they must be met. Some must be met at initial certification, while others must be met by recertification at the end of year one. End of the year one recertification standards allows applicants an additional year after the initial certification to implement standards that are more difficult. Documentation sources are listed as examples to meet the standards and criteria; sources are generally not proscriptive except in the circumstance where meeting the standard requires a policy / protocol in the HCH rule

Documentation data sources:
Each standard's criteria requires a form of documentation for verification. Enclosed are types of documentation that clinics need to have in place to demonstrate performance of a standard and criteria. Data sources include written policies; procedures; workflows; protocols; guidelines; forms; flowsheets; EMR screen shots; patient education materials; prepared resources; and pamphlets or reports, such as meeting minutes, registry documents, patient medical records, and records or files of HCH activities. Supporting document forms such as EMR screen shots, flowsheet or patient records should not be blank but include blinded information so the evaluator can clearly see how the form is used.

Submit at Application:
Only documents that say, ***submit at application*** will be downloaded into the Web portal and submitted to MDH in advance of the certification site visit. Other documents or data sources will be reviewed either electronically or on paper at the site visit during the interview process. For those other standards that do not require a submitted document at the time of application the applicant will write a brief summary of activities that meet the requirements in 500-1000 characters or less for each listed subpart or group of subparts.

Administrative Burden:
It is MDH's intent to limit the number of new documents that applicants need to prepare to submit in advance of the site visit. MDH has limited the number of standards / criteria that require a specific policy. MDH will place more emphasis on applicants' brief descriptions of how they meet the requirements in the self-assessment, and how MDH site evaluators observe the work in conjunction with the supporting documents at the site visit.

4764.0000	Rules Language	Intent	Verification Requirements Data Sources / Documentation	Meets Required Criteria Yes	 No	HCH Progress (THIS COLUMN CONTAINS EXAMPLES OF WHAT AN APPLICANT MIGHT WRITE)
0030 Subp. 1	**Certification and recertification procedures. Eligibility for certification.**		***Submit at application:*** **The applicant submits documentation to meets the requirements of health care home procedures A. Organizational structure, 0030 1, A, B B. Primary care mission or aim statement of services, 0030 1B**			
0030 Subp.1A NCQA- None	An eligible provider, supported by a care team and systems according to the requirements in part 4764.0040, may apply for certification as a health care home. **Definitions:** **Subp. 16. Eligible provider.** *"Eligible provider" means a personal clinician, local trade area clinician, or clinic that provides primary care services.*	The clinic provides care delivery using a team of staff (clinician, care coordinator and other staff as defined by the patient's needs and clinic's resources) to engage with participants in providing "whole person" care delivery.	Applicant demonstrates that clinicians are supported by a team care delivery system. There is evidence of team culture in which both team members and patients and families observe and understand how the team functions. 1. There is documentation of the clinic's organizational structure that shows the clinic's health care home team structure, such as an organizational chart that shows how the health care home team and participants are involved in the HCH. 2. There is description of services provided by the clinic and supported by the organization. At site visit: Team interview and participant interview **A. Organizational structure, 0030 1, A, B**	x		Clinic team reviews organizational structure at application and identifies questions related to how the HCH is structured in the clinic. *Services provided* *Culture* *Leadership support* *Org chart and structure* *#patients served*
0030 Subp.1B NCQA- None	A clinic will be certified only if all of the clinic's personal clinicians and local trade area clinicians meet the requirements for participation in the health care home. ***Subp. 28. Personal clinician.*** *"Personal clinician" means a physician licensed under Minnesota Statutes, chapter 147, a physician assistant licensed and practicing under Minnesota Statutes, chapter 147A, or an advanced practice nurse licensed and registered to practice under Minnesota statutes, chapter 148.* ***Subp. 31. Primary care****. "Primary care" means overall and ongoing medical*	The intent is to meet the requirements of the health care homes legislation "that encourages the provision of primary care services," and the Joint Principles for PPC-PCMH. Each patient has an ongoing personal relationship with a personal clinician trained to provide first point of contact, continuous and comprehensive care, including preventive, acute and chronic care.	HCH provides verification that clinician applicants provide the full range of primary care services, such as 1. Documentation showing board certification and / or licensure in primary care specialties for physicians, nurse practitioners and physician assistants. 2. A document showing evidence of organizational commitment to primary care services such as a mission or aim statement that demonstrates commitment to HCH model, care coordination and other components of the HCH criteria. **Primary care mission or aim statement of services, 0030 1B** **For Specialists Only:** 3. In addition, non-primary care applicant specialists must	x		Clinic describes process for credentialing or spreadsheet of credentials for applicants. Submits primary care mission or aim statement for review that includes a description of the health care home and how it's integrated into the clinic's system. *Primary care/acute care* *Mission and values* Audit tool for specialists, TBD.

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	responsibility for a patient's comprehensive care for preventive care and a full range of acute and chronic conditions, including end-of-life care when appropriate. **Subp. 29. *Preventive care.*** *"Preventive care" means disease prevention and health maintenance. It includes screening, early identification, counseling, treatment, and education to prevent health problems.* ***Subp. 26. Participant.*** *"Participant" means the patient and, where applicable, the patient's family, who has elected to receive care through a health care home.* ***Subp. 27. Patient and family-centered care.*** ***"****Patient and family-centered care" means planning, delivering, and evaluating health care through patient-driven, shared decision-making that is based on participation, cooperation, trust, and respect of participant perspectives and choices.* *It also incorporates the participant's knowledge, values, beliefs and cultural background into care planning and delivery. Patient and family-centered care applies to patients of all ages.*		provide evidence in the form of a chart audit that they are providing comprehensive primary care services including first point of contact acute care, preventive and chronic care themselves and not referring out primary care services. 4. In addition non-primary care applicant specialists must provide evidence by measurement that they are communicating to their patient population that they provide primary care services and their patients understand that is their role.			
0030 Subp. 2. A., B., C. – Subp. 4.	An application for certification or recertification is complete when the commissioner has received all information in subpart 2; the on-site review, if any, has been completed; and the commissioner has received any additional documentation requested under subpart 3.	The application process provides necessary information to verify the applicant meets the standards and criteria and there is sufficient information to evaluate the progress of HCHs for the state Legislature.	Required: Applicant submits through MDH Web portal: 1. Letter of intent 2. Application and HCH Certification Assessment form. Supporting documents that are ***submitted at application*** or reviewed at site visit. 3. Participates in site visit. 4. MDH review and notification 5. Variances as needed.			

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4764.0040 Subp. 1. Certification	**Access and communication standard; certification requirements. The applicant for certification must have a system in place to support effective communication among the members of the health care home team, the participant, and other providers. The applicant must do the following:**		***<u>Submit at application</u>*: Documentation that describes the applicant's procedures / workflows to meet the Access and Communication standard.** **A. Systematic screening / communication process Subp 0040 1, A** **B. Triage and scheduling protocol, Subp 0040 1, B3**			
0040, Subp. 1, A 1,2 NCQA-None- Participants are not informed.	A. offer the applicant's health care home services to all of the applicant's patients who: (1) have or are at risk of developing complex or chronic conditions; (2) are interested in participation.	The health care home population is the clinic population. The HCH is responsible for management of the clinic's population. The applicant establishes a process to **systematically screen patients to identify patients who would benefit from care coordination services based on the patient's medical and non-medical complexity.** The HCH screening process provides the foundation for patient participation and activation and defines the patient's risk level for services and billing. It is the trigger mechanism for communication with the organization about the patient's status as a health care home participant and the level of care coordination services.	A. Establish a systematic screening / communication process for HCHs that includes the following points: 1. The screening mechanism that is defined by the clinic which may include the registry, population-based screening mechanism, panel management or a combination of methods. <u>(There will be a recommended risk-assessment tool that defines the risk levels for billing and care coordination services.)</u> 2. The HCH has a process to discuss with patients the role of the HCH, including the following information: the purpose and the services of the HCH, the name of the patient's responsible primary clinician, the responsibilities of team members including the patient's and clinic's team members, the role of the care coordinator, the clinic's office hours, how to access the clinic after hours, referral coordination services and referral sources and access procedures, what is new and different from the coordination they previously received and the payment method for HCH. The patient is informed that <u>participation in the HCH is voluntary and is asked if he/she is interested in participation, and the patient's agreement to participate is documented.</u> 3. There is a written document (paper or electronic) that is provided to the participant that further explains and supports the verbal communication process and includes the previous elements in #2. 4. The clinic documents the participation discussion with the patient and flags in the patient's medical record or			The clinic submits their workflow, procedures or examples of their **systematic screening process** to determine which patients will need care coordination. At the site visit evaluators will observe that process and review the clinics materials they share with patients. In the interview patients and staff are asked about the process. *Describe introductory process* *Documents* *Brochure* *Flag in chart* *Clinic hours*

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			electronic health record the patient's participation status in the HCH so that everyone who has access to the patient's record knows the patient's status in the HCH. 5. The clinic develops a process to address needs of patient's who would benefit from HCH services and declines services, a documentation method to support this process and an option to re-evaluate services. At site visit: Observe process, interview patients, discuss with team.			
0040, Subp. 1, B. 1, 2 a., b., c., d. and 3 NCQA- participants are not informed. NCQA requires continuous clinician support but does not indicate continuous access to medical record information. If there is access to the medical record 24/7/365, then the following NCQA standards	B. establish a system designed to ensure that: (1) participants are informed that they have continuous access to designated clinic staff, an on-call provider or a phone triage system; *Subp. 13. **Continuous.** "Continuous" means 24 hours per day, seven days per week, 365 days per year.* (2) the designated clinic staff, on-call provider or phone triage system representative has continuous access to participants' medical record information, which must include the following for each participant: (a) the participant's contact information, personal clinician's or local trade area clinician's name and contact information, and designated enrollment in a health care home; (b) the participant's racial or ethnic background, primary language and preferred means of communication; (c) the participant's consents and restrictions for releasing medical information; (d) the participant's diagnoses, allergies, medications related to chronic and complex conditions, and whether a care plan has been created for the participant; and	The health care home designs a system where patients have continuous access during and after regular clinic hours to the HCH team and communicates with patients and families more effectively. The patient- and family-centered approach is that the patient knows who to contact on the HCH team and the team knows the patient's preferred communication method.	1. The HCH establishes a system with processes for how and when the HCH team, an on-call provider or phone triage system is contacted by the participant 24 hours per day, seven day per week, 365 days per year. 2. There **is a protocol** for the designated clinic staff, on-call providers or phone triage staff that has continuous access to the participant's medical record that establishes scheduling decision-making criteria, telephone response time and response to urgent calls within a specified time. The protocol includes scheduling standards based on the patient's risk level and the acuity of the patient's condition and the emergency plan in the patient's care plan. The protocol addresses the requirements for documentation access for HCH participants in 0040 B 1, 2, 3 and the data required in B 2, a,b,c with the goal of determining whether to schedule an appointment within one business day to avoid unnecessary emergency room visits and hospitalizations. 3. There is a communication system where clinic staff, on-call staff and the triage system knows that the patient is a HCH patient and the patient's risk level for care coordination. 4. The process for documentation of telephone triage and			The clinic describes their triage and after hours process in this section, such as, the clinic has continuous on-call services by a clinician on the health care home team. The clinic's after hours triage nurses have access to the patient's medical record and have been trained to identify those patients that receive care coordination in the HCH. Those patients are highlighted in the medical record. When a patient calls in after hours with urgent or emergent problems the nurse completes an assessment based with the patients using the standard assessment protocol and review the patients med list and care plan for the planned action and discusses with the patients what their thoughts are regarding the next steps. The nurse either implements that plan or calls the on-call physician. The name of the primary care provider and the patient's care coordinator are easily accessible to the triage nurse. The triage nurse can schedule an appointment based on the clinics

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apply to the access to medical record information: 1 A.1 and 4 A.1-2; 2 A.1, 7-9, 12; 2 A.13 must add meds and care plan; 1 A.1;	(3) the designated clinic staff, on-call provider, or phone triage system representative who has continuous access to the participant's medical record information will determine when scheduling an appointment for the participant is appropriate based on: (a) the acuity of the participant's condition; and (b) application of a protocol that addresses whether to schedule an appointment within one business day to avoid unnecessary emergency room visits and hospitalizations;		advice is outlined in the protocol. 5. **There is an <u>audit process</u> in place to collect data that demonstrates continuous access to HCH services** and timely responses to patients seeking care. The HCH will be notified of the process for selecting patients for audits. 6. Patient satisfaction or experience surveys address aspects of the patient's experience with access to care when scheduling appointments or after-hours access. <u>At site visit:</u> Observe process and **review protocol**, interview patients, discuss with team.			criteria for scheduling urgent / emergent appointments or sends a note to the care coordinator to facilitate that scheduling the next day. The patient is informed of the plan and timelines. The health care home team observes the process, discusses it with staff and reviews the audit that shows response times for patients seeking after hours care. The clinic defines how they want to do the audit and demonstrate response time based on their systems.
0040 Subp.1, C. NCQA 2 A.5-6 and 4 A.1 and 1 A.11	collect information about participants' cultural background, racial heritage, and primary language and describe how the applicant will apply this information to improve care;	Collecting the participant's language, ethnic and racial background lays the groundwork to provide relevant care, an evidence-based practice shown to improve both the likelihood the participant will adhere to medical advice by understanding information provided to the participant. This information also has a significant impact in the development of a culturally appropriate care plan.	1. The HCH establishes a process to assess barriers to communication, such as language, and trains HCH team members in the collection and application of cultural and language information. 2. There is a process to document language, cultural background and racial heritage in the patient's medical record. 3. There is documentation of training for health care home team staff in the collection and documentation of this information. 4. Preparations are made in advance for how staff are going to contact and use interpreter services for communication, care planning and education. <u>At site visit:</u> Observe process and interview patients, discuss with team. *Assess barriers* *Document processes* *Staff training* *Interpreter service*			The clinic has a process for collecting patient data at new patient registration and confirms that data on a specified basis, such as at each visit, monthly, annually. The patients preferred language and cultural information is collected and this is used in the planning for care delivery such as making arrangements for interpreters, culturally appropriate staff or education materials, integration of the patients cultural needs into the plan such as for pre-natal care, preparation for surgery, management of diabetes nutritional needs. The clinic has a process and each time an appointment is scheduled an interpreter is arranged for the patients visit and during pre-visit planning the patients language and cultural needs are considered. This is also consider in doing call reminders, arranging for transportation etc.

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0040 Subp.1, D. NCQA 2 A.18 and 4 A.2	document that the applicant is using participants' preferred means of communication, if that means of communication is available within the health care home's technological capability;	The clinic asks the patient and their family about their preferred method of communication, the method that is the most likely way the HCH will contact the patient. Note the method must be available to the HCH.	1. There is a systematic process for discussion with the patient on his/her preferred method of communication and it is documented in the patient's medical record where it is accessible to the HCH team, triage system after-hours care and scheduling staff. 2. The patient's satisfaction with communication processes is measured in a patient experience / satisfaction survey. At site visit: Observe process and interview patients, discuss with team. *Obtain the document-where; who can access*			Routinely patients are asked what is their preferred method of communication and this is documented in a centralized place in the medical record where everyone on the health care team knows where to find this information. The clinic determines how often the patient's preferred method of communication is updated. Site evaluators will talk with patients and staff regarding the process and it's effectiveness in communication.
0040 Subp.1, E NCQA - none	inform participants that the participant may choose a specialty care resource without regard to whether a specialist is a member of the same provider group or network as the participant's health care home, and that the participant is then responsible for determining whether specialty care resources are covered by the participant's insurance; and	The applicant provides objective information about optimal treatment and care options available through various providers, rather than basing a referral solely on which specialty provider is within the HCH's network. There is no evidence of gatekeeping or negative consequences to the patients for selection of referral resources.	1. There is a process in the clinic to communicate with patient regarding his/her choice of referrals to specialty providers. 2. The HCH demonstrates support of patient's decisions and continues to provide care coordination services for patients who chose to seek specialty services outside of the HCH's delivery system if applicable. At site visit: Observe process and interview patients and discuss with team. *Referral process* *Choice* *How do they support the patient's decision*			In the clinic when clinicians identify that a patient needs a referral to a specialist there is a process in place where the clinician and / or appropriately trained staff reviews the need for a referral and the recommended specialist. The person reviewing the information discusses the options for the referral with the patient and who based on the clinics experience might the patient see. During this discussion if the patient identifies another option the clinic discusses those options with the patient and the patients insurance status. Ultimately it is the patient's choice of where they seek specialists services and the clinic's responsibility to add this information to the care plan and tracking processes.

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0040 Subp.1, F NCQA - none	Establish adequate information and privacy security measures to comply with applicable privacy and confidentiality laws, including the requirements of the Health Insurance Portability and Accountability Act, Code of Federal Regulations, title 45, parts 160.101 to 164.534, and the Minnesota Government Data Practices Act, Minnesota Statutes, chapter 13.	Requires the HCH to comply with existing applicable law on information privacy and security. *EMR/social media exchange*	1. There are already established data security policies in place in the clinic that are regulated per applicable state and federal laws. 2. There are consistent processes in place for information management and release of information protocols.	x		The clinic provides an example or references existing policies, such as, the clinic has implemented an organizational policy for patient confidentiality and security that meets all Minnesota state and federal laws. The clinic has a process in place for patient's to sign a release of information that allows the care coordinator to discuss care coordination needs with others involved in the patient's plan.
4764.0040 Subp. 2. Re-certification	**Access and communication standard; recertification at the end of year one. By the end of the first year of health care home certification, the applicant for recertification**		***Submit at re-certfication application*: Documentation that describes the applicant's procedures / workflows to meet the Access and Communication standard.** **A. The applicants selected method to demonstrate one of the required initiatives that encourages active participation in the participants care. Subp. 2**			
0040 Subp. 2. Re-certification NCQA 4 A.1-2 and 4 B.1-7	Must demonstrate that the applicant encourages participants to take an active role in managing the participant's health care, and that the applicant has demonstrated participant involvement and communication by identifying and responding to one of the following: participants' readiness for change, literacy level, or other barriers to learning.	The HCH identifies one area of readiness annually for change, the participant's readiness for change, literacy level or other barriers to learning. Services then are designed to respond to the unique barrier experienced by the participant, to work with the participant overcome the barrier and therefore actively participate. By addressing these barriers, patients are more likely to understand health instructions, education documents and teaching methods.	The applicant selects one method to demonstrate one of the required initiatives that encourages active participation by participants in their care. 1. Adopt a process to routinely identify a participant's literacy level or barriers to literacy level and how the applicant uses that information in actively involving the patient in their care. 2. During care planning or other encounters discusses with and encourages patients to develop an awareness of their responsibilities for their health, assesses with the participant the participant's readiness for change, and connects participants to self-management support programs, patient education classes or other resources. *Identify method used*			The clinic describes the patient activation measure that they have decided to implement and submits that policy, procedure, workflow or example at recertification. The clinic describes the process in the clinic for identifying the patients literacy level the patients preferred method for learning and any barriers that the patient identifies for learning. The clinic shares any training, tools that they have developed during implementation of the process. There is also a plan established in the clinic for training clinicians and other health professionals on where this information is located in the medical record, how to use the information in their care

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						delivery and how to update or change the information with the patient. There is evidence in the medication record that consideration of the patients learning needs has been done when care planning or development of an education plan is completed.
4764.0040 Subp. 3.	**Participant registry and tracking participant care activity standard; certification requirements. The applicant for certification must use a searchable, electronic registry to record participant information and track participant care.**		***Submit at application:*** **Documentation that describes the applicant's procedures / workflows to meet the participant registry and tracking participant care activity standard.** **A. Submits the workflow that demonstrates the systematic use of the HCH registry. Subp A3**			
Subp. 3. A. NCQA 2 A-F Must be able to describe how the registry is used to support their quality goals. The systematic population review includes preventive health services.	The registry must enable the health care home team to conduct systematic reviews of the health care home's participant population to manage health care services, provide appropriate follow-up, and identify any gaps in care.	The HCH systematically manages patient information and uses the information for population management to support care coordination.	1. HCH designs, implements use of the registry and develops a process on how the registry is used with a method to identify patients to manage health care services, provide appropriate follow-up and identify any gaps in care. Site visit: At the clinic leadership interview, leaders describe how the registry is used to support their quality goals. **A. Submits the workflow that demonstrates the systematic use of the HCH registry. Subp A3** *Used for population health management* *Change in culture of how it is used*			The clinic has a workflow in place for the use of the health care home registry. The clinic describes the types of registry or registries the clinic uses such as disease specific registries, vaccine tracking, follow up to return to clinic appointment tracking registries, lab tests follow up or other elements of the registry. The clinic describes how the registry is used to identify gaps in care and the process.

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Subp. 3. B., 1., 2. NCQA 2 A.1-3, 7, 9 10 and NCQA 2 B.1-11 Need sufficient data elements that shows a gap in care for groups of participants with a chronic or complex condition.	The registry must contain: (1) for each participant, the name, age, gender, contact information, and identification number assigned by the health care provider, if any; and (2) sufficient data elements to issue a report that shows any gaps in care for groups of participants with a chronic or complex condition.	The HCH has readily accessible, clinically useful information on patients that allows it to treat patients comprehensively.	At site visit: The HCH demonstrates production of the registry report and required data elements and demonstrates how the registry is used for panel management and care coordination. The applicant provides a copy of the workflow and registry document with blinded patient information for the site evaluator's review and explains to the site evaluators how the data elements in criteria 2 were determined to meet the requirements. *Produce a report*			
Subp. 4.	**Participant registry and tracking participant care activity standard; Recertification at the end of year one. By the end of the first year of health care home certification,**		***Submit at re-certification application*: Documentation that describes the applicant's procedures / workflows to meet the participant registry and tracking participant care activity standard.** **A. Submit the workflow that demonstrates the systematic use of the HCH registry and follows-up services such as call reminders or pre-visit planning. Subp 4.**			The clinic describes how the registry is used to identify gaps in care and the process to managing those gaps such as pre-visit planning, or call reminders.
Subp. 4. NCQA 2 F.1-7 Does not require inclusion of identified staff time for care coordination and NCQA 3 D.1 Must be for entire certified HCH clinician panel.	The applicant for recertification must use the registry to identify gaps in care and implement remedies to prevent gaps in care such as appointment reminders and pre-visit planning.	The registry is the most useful tool for identifying gaps in services by allowing for a systematic process of review for failed appointments, tests and use of protocols to track referral services.	1. There is a documented process in place with identified staff time to complete pre-visit planning, or call reminders for services such as preventive care, specific tests or procedures, follow-up visits for chronic conditions, planned return to clinic appointments and developed guidelines to identify those patients that may have gaps in services. 2. There is evidence that the registry is actively worked by the HCH team members and a process for follow-up procedures. 3. There is an audit process that is completed routinely on the use of the registry.			The clinic submits their workflow, policy or procedure with this information and / or a copy of their audit process that demonstrates that staff is routinely using the audit. This could be as simple as % access to their electronic health record, a chart audit, a staffing plan that shows staff with designated time for work on the registry.

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Subp. 5. Certification	**Care coordination standard; certification requirements. The applicant for certification must adopt a system of care coordination that promotes patient and family-centered care through the following steps:**		***<u>Submit at application:</u>*** **Documentation that describes the applicant's procedures / workflows to meet the care coordination standard.** **A. Document with a list of care coordinator functions such as a job description and scheduled hours for care coordinator. Subp. 5D** **B. Systematic process for identifying the patient's personal clinician and documentation in the medical record of the personal clinician and care coordinator's name. Subp. 5 B**			
Subp. 5. A., 1, 2, 3 NCQA 3 C.1-4 Care team of non-physician staff is only described; Care team manages patient care for patient and not <u>with</u> patient. NCQA 3 D.3-4 Does not describe inclusion of patient. NCQA 1 A.1 Patient is scheduled with a primary care clinician. Patient needs to be informed of the name of clinician and care coordinator documents agreed upon planned visits with patient. NCQA 3 C.3-4 and 4 B.4-6 Must be for entire	Collaboration within the health care home, including the participant, care coordinator, and personal clinician or local trade area clinician as follows: (1) one or more members of the health care home team, usually including the care coordinator, and the participant set goals and identify resources to achieve the goals; (2) the personal clinician or local trade area clinician and the care coordinator ensure consistency and continuity of care; and (3) the health care home team and participant determine whether and how often the participant will have contact with the care team, other providers involved in the participant's care, or other community resources involved in the participant's care;	Central to the health care home is the relationships that are established between the personal clinician, the care coordinator and the participant. This is essential to effective information sharing, goal setting, care coordination, care planning and follow-up support that are basic principles in patient- and family-centered care and care coordination.	1. The health care home develops a system of care planning that includes goal setting with a consistent member of the HCH team, usually the care coordinator, which includes the participant's involvement. 2. There is ongoing communication between the personal clinician and the care coordinator regarding the patient's goals and progress in the clinic's procedures. The patient and the care coordinator determine how often the patient should come for planned clinic visits. 3. ~~The clinic has in place a patient experience / patient satisfaction survey that measures the patient's experience with the care planning process~~. *Patient Experience as designated by Statewide Quality Improvement Reporting.* 4. The clinic has completed a documentation audit to evaluate the effectiveness of care coordination documentation. (Instructions for audits will be provided.) *Documentation: self -audit*			The clinic has established a process for identifying patients who need a care plan by the primary care provider with the patient. (See care planning policy). There is a process for identification of the care coordinator and evidence that the care coordinator and patient are meeting either by phone, email or in person, preferably some of each of these. There is documentation in the medical record of active goal planning and a plan for when the patient and care coordinator will meet. The clinic provides the site evaluators with their patient experience data and discusses at the site review the process by which the data is collected, analyzed, shared with clinic staff and the follow-up planning process.

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				Yes	No	
certified HCH clinician panel, not just 3 conditions. Goal setting is done with the patient. NCQA 8 B.2 Patients are surveyed about their experiences with the practice. NCQA – no documentation audit of effectiveness of care coordination documentation.						
Subp. 5. B NCQA - none	Uses health care home teams to provide and coordinate participant care, including communication and collaboration with specialists. If a health care home team includes more than one personal clinician or local trade area clinician, or more than one care coordinator, the applicant must identify one personal clinician or local trade area clinician and one care coordinator as the primary contact for each participant and inform the participant of this designation;	Essential to implementation of the HCH is consistent selection of a designated personal clinician (primary care provider) and care coordinator for those patients who require care coordination. For continuity of care it is essential that all specialists providing care to the patient has access to this information.	1. There is a systematic process for selection of a participant's personal clinician (primary care provider) and care coordinator. The personal clinician and the care coordinator are documented in the medical record for every patient in the HCH who is receiving care coordination services. The documentation also indicates that the patient has been informed of who his/her personal clinician is. 2. The applicant shows that defined roles and accountabilities with patient- and family-centered care principles are in place for HCH team members in a summary document, such as job descriptions for team members that include these responsibilities. At site visit: Interview patients regarding their understanding of who their personal clinician and care coordinator are. **Systematic process for identifying the patient's personal clinician and documentation in the medical record of the personal clinician and care coordinator's name. Subp. 5 B**			The clinic submits their procedures for identifying and communication of the patient's primary care provider. The clinic describes the roles and accountabilities and at the site review team interview the evaluators review the job descriptions or role descriptions for team members. In the certification assessment tool the clinic may describe those roles and how teams work together and team members are identified.
Subp. 5. C.	Provides for direct communication in which routine, face-to-face discussions take place	Relationships evolve differently when face-to-face	1. There is an infrastructure that supports confidential provider and care coordinator face-to-face interaction.			This information is included in the chart audit and the clinic describes the

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				Yes	No	
NCQA - none	between the personal clinician or local trade area clinician and the care coordinator. *Definition: Subp. 15.* ***Direct communication.*** *"Direct communication" means an exchange of information through the use of telephone, electronic mail, video conferencing, or face-to-face contact without the use of an intermediary. For purposes of this definition, an interpreter is not an intermediary.*	contact is made, so that one person can see and respond to the physical demeanor and nonverbal cues of the other. The requirement that the care coordinator and the clinician have some face-to-face contact enhances the communication and cohesiveness of the care team. With a dedicated care coordinator who is more engaged in the care team based on personal relationships, the clinician has a greater ability and confidence to rely on the coordinator to meet the needs of the participant, therefore freeing the clinician to practice to the fullest extent of his/her license.	2. There is documentation of communication between the care coordinator and personal clinician such as regular meeting minutes, inbox messaging, and notes of personal clinician approval or orders for care delivery showing ongoing routine direct communication. At site visit: During the team interview discuss the communication mechanism that is established between personal clinician and care coordinator.			process for communication to the care coordinator in the assessment tool.
Subp. 5. D NCQA - none	provides the care coordinator with dedicated time to perform care coordination responsibilities; and	Designated protected time is essential to performing care coordination functions and making improvements in population outcome measurements.	1. Provides a care coordinator work schedule that shows there are designated scheduled hours for the care coordinator to complete the functions of care coordination. 2. There is a document with the functions of the care coordinator listed such as a job description for care coordinator. 3. Provide examples of tools available for the care coordinator to do care coordination. 4. Provide one example of training for the care coordinator in his/her new role. At site visit: Interview care coordinator regarding his/her role, observe work area and tools. **C. Document with a list of care coordinator functions**			The care coordinator hours and job description with functions is submitted to MDH.

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			such as a job description and scheduled hours for care coordinator. Subp. 5D			
Subp. 5. E, 1., 2., 3., 4., 5., 6., NCQA 7 A.1-4 Missing documentation of notifying patients of results and establishing a follow-up plan with the patient if necessary. NCQA 6 A.1-6 Missing the establishing a follow-up plan with the patient if necessary. NCQA 3 E.3-5; NCQA 5 B.1-15 Electronic Prescription Writing only, need to describe process for non-electronic prescription writing if applicable.	Documents the following elements of care coordination in the participant's chart or care plan: (1) referrals for specialty care, whether and when the participant has been seen by a provider to whom a referral was made, and the result of the referral; (2) tests ordered, when test results have been received and communicated to the participant; (3) admissions to hospitals or skilled nursing facilities, and the result of the admission; (4) timely post discharge planning according to a protocol for participants discharged from hospitals, skilled nursing facilities, or other health care institutions; (5) communication with participant's pharmacy regarding use of medication and medication reconciliation; and (6) other information, such as links to external care plans, as determined by the care team to be beneficial to coordination of the participant's care.	Care coordination processes reflect a plan for communication between the team and the participant and the shared understanding with the participant regarding these elements, including referrals for specialty care; tests ordered and when results will be provided; admissions to facilities; timely post-discharge planning and communication with the pharmacy; and links to external care plans.	1. There are written procedures for documentation of elements of care, items subp 5E, items 1-6 that include, referral tracking and follow-up; test results tracking, including processes to manage normal and abnormal test results and timely notification of test results to patients; post admission planning; timely discharge planning, including review of information from discharging facilities and coordination of discharged patients information; communication with the participant's pharmacy, such as medication refill protocols, medication reconciliation, addressing barriers when patients have not filled, refilled or taken prescribed medications; and links to for other information with external team members that provide care planning services that may beneficial to care coordination for the participant. 2. The HCH shows evidence of closing the loop on referrals, such as tracking the status of referrals, obtaining reports back for the personal clinician from specialists and notifying participants of referral results, and establishing a follow-up plan. 3. There is evidence in the patient's medical record that the workflow is being followed. Conduct a random audit of 10 patients. Instructions will be provided for random selection of charts prior to the site visit.			.
Subp. 6. Re-certification	**Care coordination standard; recertification at the end of year one. By the end of the first year of health care home certification, the applicant for recertification must enhance the applicant's care coordination system by adopting and implementing the following additional patient and family-centered principles:**		***Submit at re-certification application;*** **Documentation that describes the applicant's procedures / workflows to meet the care coordination standard.** **A. A document that reflects that patient and family centered care principles are included in the work scope of members of the health care home team, such as a job description. Subp. 6A** **B. The HCH's plan for ongoing partnership with one community resource. Subp. 6B**			*Recert 1 yr instruction and recert assessment tool.*

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				Yes	No	
Subp. 6. A. NCQA - none	Ensure that participants are given the opportunity to fully engage in care planning and shared decision-making regarding the participant's care, and that the health care home solicits and documents the participant's feedback regarding the participant's role in the participant's care;	Ensures that participants are given the opportunity to fully engage in planning their health care and share in decisions about their care. It requires the applicant to obtain and document feedback from participants regarding their care.	1. Workflows are established to solicit participant participation and shared decision-making in care planning and other aspects of care delivery, and there is documentation of the patient's participation in the process. 2. Patient- and family-centered care principles are incorporated into a document that reflects that patient and family centered care principles are included in the work scope of members of the health care home team, such as a job description into job descriptions of HCH team members. 3. The mission or aim statement described in 0030 HCH procedures for the HCH includes patient- and family-centered principles. **A document that reflects that patient and family centered care principles are included in the work scope of members of the health care home team, such as a job description. Subp. 6A**			A description is provided. TBD requirements for documentation.
Subp. 6. B NCQA - none	Identify and work with community-based organizations and public health resources such as disability and aging services, social services, transportation services, school-based services, and home health care services to facilitate the availability of appropriate resources for participants;	There is planning and partnership of HCH with community resources so that when patients need those resources the HCH and the community partner are ready. Referrals to community partners enhance the patient's quality of life.	1. The health care home demonstrates ongoing partnership with at least one community resource that the HCH typically provides referrals to. 2. There is a communication plan for HCH team members to learn about community resources, such as training about resources, "lunch and learns," the health care home collaborative, or other ongoing training about community resources or community meetings. **The HCH's plan for ongoing partnership with one community resource. Subp. 6B**			
Subp. 6. C NCQA 3 C.1-4 Needs to include a responsibility matrix or a workflow	Permit and encourage professionals within the health care home team to practice at a level that fully uses the professionals' training and skills; and	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.	1. There are defined roles and accountabilities consistent with full use of health care team member's education and licensure, such as a responsibility matrix or workflows where roles are defined for team members.			

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Subp. 6. D. NCQA 3 E.1, 2, 7-10 Does not have a process for anticipatory planning for health care-related transitions and does not describe patient engagement or shared decision making.	Engage participants in planning for transitions among providers, and between life stages such as the transition from childhood to adulthood.	The HCH has an important role in planning for transitions between providers when the HCH coordinates services across specialties and all ages and stages of health.	1. A process is in place for anticipatory planning for health care-related transitions, such as planning for referrals of children to adult providers, discussion with participants at key transitions, transition care planning when the patient transfers to a new personal clinician or resources that are in place that provides information about transitions.			
Subp. 7. Certification	**Care plan standard; certification requirements. The applicant for certification must meet the following requirements:**		***Submit at application:* Documentation that describes the applicant's procedures / workflows to meet the care planning standard.** **A. Submit the written care planning policy that references each of the criteria in Subp 7.**			
Subp.. 7. A. 1., 2., 3., 4., 5., 6., NCQA – none NCQA 4 B.7 describes writing a care plan based on self management goals to support patient for three important conditions only. Lacking a care planning policy and procedures, protocol. NCQA 3 E.6 External plans may come from organizations	Establish and implement policies and procedures to guide the health care home in assessing whether a care plan will benefit participants with complex or chronic conditions. The applicant must do the following in creating and developing a care plan: (1) actively engage the participant and verify joint understanding of the care plan; (2) engage all appropriate members of the health care team, such as nurses, pharmacists, dieticians, and social workers; (3) incorporate pertinent elements of the assessment that a qualified member of the care team performed about the patients health risks and chronic conditions; (4) review, evaluate, and, if appropriate, amend the care plan, jointly with the participant, at specified intervals appropriate to manage the participant's health and measure progress toward goals; (5) provide a copy of the care plan to the participant upon completion of creating or amending the plan; and (6) use and document the use of evidence-based	The HCH develops <u>a policy and procedure that guides the HCH in determining which patients in the HCH may benefit from a care plan</u>, based on the population receiving care planning services in the HCH. Not every patient with chronic or complex conditions will require a care plan. Factors such as risk level, patient type and patient interest in a care plan may be taken into consideration in development of the clinic's policy and procedures on care planning. (For instance, those patients who have the highest risk level (will most likely be required for level 4), patients the clinic may not typically care for, or patients who choose to have a care plan may be likely candidates to have a	1. There is a <u>written format for a care plan</u> in the medical record or electronic health record that is developed in collaboration between the HCH team members (including the participant). **Submit the written care planning policy that references each of the criteria in Subp 7.** 2. The applicant must establish and implement a policy for participants with a complex or chronic condition that sets criteria to guide who should have a care plan and how elements that should be included in this care plan as outlined in subp 7 are addressed by the HCH in care planning. 3. The care plan policy reflects a plan for communication between the team and the participant, and there is shared understanding with the participant of each of the elements listed in subp 7 A. 1,2,4,5 4. The process for completing risk assessment with designated qualified staff and documenting patient risks and diagnosis on the problem list is outlined in the care planning policy. 5. The HCH provides a schedule of encounters for care planning visits with the care coordinator and patients. Care plans from those visits are reviewed. Instructions will be provided on how to			

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other than inpatient or outpatient facilities or who are transitioning care. NCQA 3 A.1-3 Practice adopts and implements evidence-based diagnosis and treatment guidelines for 3 clinically important conditions- needs to expand to medical services and procedures.	guidelines for medical services and procedures, if those guidelines and methods are available;	care plan. Related to the risk assessment: A qualified member (within licensure to complete an assessment) of the clinical team completes the clinical risk assessment and determines the patient's diagnosis and documents the diagnoses on the problem list. The care coordinator incorporates relevant diagnosis on the care plan.	randomly select and audit patient's care plans. 6. The HCH adopts and implements evidence-based guidelines for medical services and procedures and demonstrates use of evidence guidelines for one important condition. This includes the source of the guideline, training for clinicians, auditing process, screen shot of template and how it is used by clinicians, and documentation requirements. The HCH explains how this important condition was selected. At site visit: The care coordinator is interviewed regarding care plan development and patients who have a care plan are identified and interviewed. The HCH team is interviewed regarding the use of evidence-based guidelines.			
Subp.. 7. B. 1., 2., 3., 4. and C NCQA- none, care plan must be developed with the patient and include goals and an action plan for conditions and the update of goals documented as frequently as is warranted by patient's condition.	A participant's care plan must include goals and an action plan for the following: (1) preventive care, including reasons for deviating from standard protocols; (2) care of chronic illnesses; (3) exacerbation of a known chronic condition, including plans for the participant's early contact with the health care home team during an acute episode; and (4) end-of-life care and health care directives, when appropriate; and C. the applicant must update the goals in the care plan with the participant as frequently as is warranted by the participant's condition.	An effective care plan includes the participant's goals, and an action plan must be developed with the participant and documented in the care plan, including these elements. The care plan is an active document that is updated based on the changing condition of the participant.	1. In the care planning policy, the applicant includes procedural elements for the health care home on how participant goals will be documented and updated, including a procedure about how often the care plans are updated and including all the elements of subp 7B, 1.2.3.4 and C. 2. An audit is completed to determine whether care plans are complete, participant goals are updated and the care plan includes the required elements. At site visit: Care plans are reviewed by the site visit evaluator team.			
Subp. 8. Re-Certification	**Care plan standard; recertification at the end of year one. By the end of the first year of health care home certification,**		***Submit at re-certification application:* Documentation that describes the applicant's procedures / workflows to meet the care planning standard.** **A. Submits the updated written care planning policy that references each of the criteria in Subp 7 and**			Submit self -audit and evaluation

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			includes the procedure for planning with community partners for patients with external care plans. Subp 8. **B. Each HCH submits three integrated care plans that have blinded patient information in them.**			
Subp. 8. NCQA - none	The applicant must ask each participant with a care plan whether the participant has any external care plans and, if so, create a comprehensive care plan by consolidating appropriate information from the external plans into the participant's care plan.	Professionals who prepare external care plans often have specific areas of expertise outside those in the HCH. The use of those care plans draws on that expertise and reduces confusion for the participant, who may have two different sets of care plans, and improves planning efficiency by promoting communication.	1. There is a process in place for those patients who identify external resources to include those members of the care team into planning. 2. Each HCH submits three integrated care plans that have blinded patient information in them for review.			
Subp. 9. Certification	**Performance reporting and quality improvement standard; certification requirements. The applicant for certification must measure the applicant's performance and engage in a quality improvement process, focusing on patient experience, patient health, and measuring the cost-effectiveness of services, by doing the following:**		**<u>At application</u> submits documentation that describes the applicant's procedures / workflows to meet the quality improvement standard.** **A. Submits the written membership of HCH quality team and learning collaborative team. Subp 9A & 9D** **B. Submits procedures for sharing information and giving input to and from the quality team and the learning collaborative team. Subp. 9B & 9E**			
Subp. 9. A., 1., 2., 3., 4. NCQA- none, does not describe a quality team, only states data collection	Establishing a health care home quality improvement team that reflects the structure of the clinic and includes, at a minimum the following persons at the clinic level: (1) one or more personal clinicians or local trade area clinicians who deliver services within the health care home; (2) one or more care coordinators; (3) two or more participant representatives who were provided the opportunity and encouraged	The quality team is essential to improvements in quality and outcomes for the HCH. Membership of the quality team includes those members of the clinic that are involved in direct care delivery, as well as participants. A patient- and family-centered health care home relies on	1. There <u>are quality team minutes</u> that document that clinic team members and participants were actively invited and involved and their voice considered in the quality team. 2. Documentation of quality team minutes is available for <u>six months.</u> 3. There is a <u>membership list with attendance</u> at quality team meetings. <u>At site visit:</u> Review HCH quality minutes and discuss key points at quality interview with HCH team members. **Submits the written membership of HCH quality team**			

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				Yes	No	
	to participate; and (4) if the health care home is a clinic, one or more representatives from clinic administration or management;	participants to support and provide input to the clinic's quality activities.	**for each unit to be certified (i.e. department or clinic)**			
Subp. 9 B. NCQA- none	Establishing procedures that the health care home quality improvement team uses to share their work and elicit feedback from health care home team members and other staff regarding quality improvement activities;	There is a process for direct input and communication regarding the HCH's quality planning.	1. The HCH has a written procedure for sharing the HCH's quality plan with opportunities to elicit feedback from HCH team members. At site visit: Interview HCH team members regarding feedback mechanism of quality team. **Submits procedures for sharing information and giving input to and from the quality team.**			
Subp. 9. C NCQA 8 A.1-3, does not include quality team involvement	demonstrating capability in performance measurement by showing that the applicant has measured, analyzed, and tracked changes in at least one quality indicator selected by the applicant based upon the opportunity for improvement; and	Quality improvement planning is critical to the success of the HCH.	1. Review quality plan, one data element and results of data, with tracking and plan. Document the action steps: What did you do? What are the interventions, actions you tried? What is the measurement? PDSA cycle. Site visit: Review quality plan, data and results. Discuss the rationale for picking the indicator.			
Subp. 9. D. 1., 2., 3., 4. NCQA- none	Participating in a health care home learning collaborative through representatives that reflect the structure of the clinic and includes the following persons at the clinic level: (1) one or more clinicians or local trade area clinicians who deliver services in the health care home; (2) one or more care coordinators; and (3) if the health care home is a clinic, one or more participants from clinic administration or management; (4) two or more participant representatives who were provided the opportunity and encouraged to participate with the goal of having two participants of the health care home take part; and	Implementation of major change is hard work for a team. The supportive environment of the learning collaborative for health care team members, including participants, is a critical success factor.	1. HCH team participation in the learning collaborative with membership from HCH team. **Submits the written membership of HCH learning collaborative team for each unit to be certified (i.e. department or clinic).** 2. Describe how participants were encouraged to participate. 3. Submit dates of attendance at HCH learning collaborative workshops.			
Subp. 9. E	Establishing procedures for representatives of the health care home to share information	Feedback between learning collaborative team members	1. The HCH has a written procedure for sharing the HCH's learning from learning collaborative meetings with			

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NCQA- none	learned through the collaborative and elicit feedback from health care home team members and other staff regarding information.	and the rest of the team is essential to bringing the whole team along with the changes.	opportunities to elicit feedback from HCH team members. **Submits procedures for sharing information and giving input to and from the learning collaborative team.**			
Subp. 10. Re-certification	**Performance reporting and quality improvement standard; recertification at the end of year one. By the end of year one of health care home certification, the applicant for recertification must:**		***<u>Submit at re-certification application:</u>*** **Documentation that describes the applicant's procedures / workflows to meet the quality improvement standard.** **A. Submits annual quality plan and quality report with data that has been measured, analyzed and tracked for the previous year. Subp. 10A**			
Subp. 10, A, C NCQA 8 F demonstrates capability to meet HCH rule part	Participate in the statewide quality reporting system by submitting outcomes for the quality indicators identified and in the manner prescribed by the commissioner; Submit health care homes data in the manner prescribed by the commissioner to fulfill the health care homes evaluation requirements in Minnesota Statutes section 256B.0752, subdivision 2	Future recertification is based on the HCH's achievements of benchmarks established by the Commissioner. For statewide measurement of outcomes and evaluation of HCHs, HCHs will submit outcomes data through the statewide quality reporting system.	1. The HCH attests to participate in the statewide quality reporting system and registers with the vendor selected by the state for data submission and submits the data in the manner prescribed by the Commissioner.			
Subp. 10, B., 1., 2., 3. NCQA 8 B.1-4 demonstrates capability to meet HCH rule part	Show that the applicant has selected at least one quality indicator from each of the following categories and has measured, analyzed, and tracked those indicators during the previous year: (1) improvement in patient health; (2) quality of patient experience; and (3) measures related to cost-effectiveness of services.	The focus for measuring performance outcomes is on the certified clinic's primary care service population, not just the outcomes for HCH care coordination participants. Progress will be based on the IHI "triple aim" outcomes measured simultaneously. This results in comprehensive measurement and avoids focus on only one measurement area.	1. HCH submits its annual quality plan and report with data that has been measured, analyzed and tracked for the previous year. 2. The HCH may select measures that the HCH has determined are relevant to the direct improvement of health care home's services in each of the measurement areas in Subp 10, 1, 2 and 3 or they may report quality data from the measures that are announced annually by the Commissioner.			

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				Yes	No	
Subp. 11 Re-certification	**Performance reporting and quality improvement standard; recertification at the <u>end of year two and subsequent years.</u>**		***<u>Submit at re-certification application:</u>*** **Documentation that describes the applicant's procedures / workflows to meet the quality improvement standard.** **A.** The HCH submits outcomes data in the manner prescribed by the commissioner annually.			
Subp. 11., A., B. NCQA 8 E demonstrates capability to meet HCH rule part	By the end of the second year of certification as a health care home, and each year thereafter, the applicant must continue to participate in the statewide quality reporting system by submitting outcomes for the additional quality indicators identified by the commissioner and in the manner prescribed by the commissioner. B. To qualify for recertification, the applicant's outcomes in primary care services patient population must achieve the benchmarks for patient health, patient experience, and cost-effectiveness established under part 4764.0030, subpart 6.	The HCH continues to be recertified based on annually reported outcomes.	1. The HCH submits outcomes data in the manner prescribed by the Commissioner annually.			