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4764.0000	MN Health Care Home Rule Language	Intent	Verification Requirements Data Sources /	NCQA Standard	Notations: HCH / NCQA
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** MDH allows for significant flexibility in how clinics demonstrate the HCH standards. Our goal is not to add additional significant burden in requiring detailed verification elements. **A. Organizational structure, 0030 1, A, B Primary care mission or aim statement of services, 0030 1B**	**Levels of recognition:** There are 3 levels of recognition; each reflects the degree to which a practice meets the required elements. **100 points, 27 elements, 6 must-pass elements.** Recognition levels reflects the degree to which a practice meets the requirements of the elements Level 1 = 35-59 points & all 6 must-pass elements Level 2 = 60-84 points & all 6 must-pass elements Level 3 = 85-100 points & all 6 must-pass elements 6 of 6 elements are required for each level. Score for each "must-pass" element must be ≥ 50%. Special Acknowledgement for practices reporting results from CAHPS-PCMH. Practices earn distinction for collecting data through a certified	**PCMH 2014 – Elements of Program** • More integration of behavioral healthcare • Additional emphasis on team-based care • Focus care management for high-need populations • Encourage involvement of patients and families in QI activities. • Alignment of QI activities with the Triple Aim; improved quality, cost and experience of care • Alignment with health information technology MU Stage 2.
0030 Subp.1A	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. ~~Primary care~~ mission or aim statement of services, 0030 1B**	**Eligibility**: NCQA PCMH Recognition Program is a practice based evaluation for clinicians who provide care in primary care specialties. Recognition status lasts for 3 years. Clinicians who qualify for PCMH: • Clinicians who hold a current, unrestricted license as MD, DO APRN, or PA. • Only clinicians that a patient can select as a "personal clinician" are eligible to be listed • Physicians, APRNs and PAs who practice in specialty of Internal Med, Family Medicine or Pediatrics, with intent of serving as personal clinician for their patients • Physician-led practices applying with identified APRN;s or PA's	

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0030 Subp.1B	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 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*	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 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 communicate to their patient population that they provide primary care and pts understand role.	**NCQA *Definition of Practice***: One or more clinicians (including all eligible primary care clinicians) who practice together and provide patient care at a single geographical location. Practice together means that all the clinicians in a practice: • Follow the same procedures and protocols. • Have access to and share medical records for all patients treated at the practice site. • Electronic and paper based systems and procedures support clinical and administrative functions e.g. scheduling, treating patients, ordering services, prescribing, maintaining medical records and follow-up. **NCQA *Definition of Multi-Site group***: • 3 or more primary care practice sites using the same systems and processes, including an electronic medical record system. • Must submit a Multi-Site Approval request form to cover all sites, • For a minimum of 3 months practice sites must have shared and used in the same way a practice management system, registry or EMR to document patient care for administration and billing *See standards for clinicians who do not quality and special circumstances.	At HCH application the applicant is asked if the practice team follows the same protocols, has a consistent leadership structure and has implemented the HCH in a consistent manner. The applicant is also asked to complete a survey to identify if they have an EMR and what structural elements are in place in their EMR or will be implemented. Primary care providers are certified, see the definitions in subp. 28, 29, 31, and an eligible provider provides the full scope of primary care as defined in subp. 16.

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	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*			**Practice Readiness Evaluation:** Practices can conduct a readiness and self-evaluation on the PCMH standards and elements before submitting the Survey Tool to NCQA. The survey tool estimates the score for each standard and element and provides an overall preliminary score. NCQA does not review readiness assessment documentation prior to survey submission.	**Certification Assessment Tool**: HCH provides a certification assessment tool on-line and a second version with examples for training purposes. This tool is not submitted ahead of time. The tool is designed to help clinics self-assess and determine their readiness for certification.
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	The application process provides necessary information to verify the applicant meets the standards and criteria and there is sufficient information to evaluate the	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.	Six PCMH Standards and one overall score. Each standard has several specific elements. 1 . Patient Centered Access -3 elements 2. Team Based Care-4 elements 3. Population Health Management-5 elements 4. Care Management and Support-5 elements	The HCH certification process is a quality improvement process. There are five HCH standards implemented over two yrs. HCH Five Standards: 1. Access & Communication 2. Registry & Tracking 3. Care Coordination 4. Care Plan 5. Performance Reporting & Quality

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			4. MDH review and notification 5. Standards are met or not met. Variances are implemented as needed as defined in chapter 0050 in the HCH rule.	**Complete the NCQA Application: 5 steps** 1. Order application tool 2. Access online application system 3. Sign Business Associate Agreement 4. Submit on-line application 5. Submit the application fee	**Initial HCH Certification Process**: 1. Submit LOI 2. Submit Application 3. Complete Assessment in portal 4. Site Visit
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:**		***Submit at application***: **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**	**NCQA Standard Structure:** Element, Factor, Scoring, Explanation and Examples. • Each element has up to 5 possible scores: 100%, 75%, 50%, 25%, 0% • Required documentation listed in examples: Policy & Procedures in place for a least 3 months, Data no more than 12 months old.	
0040, Subp. 1, A 1,2	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. Subp. 32. **Primary care services patient population.** "Primary care services patient population" means all of the patients who are receiving primary care services from the health care home, regardless of whether a patient has chosen to participate in the health care	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	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. (There will be a recommended risk-assessment tool ~~that defines the risk levels for billing and care coordination services.~~) 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	**PCMH 2: Team Based Care** The practice provides continuity of care using culturally and linguistically appropriate team based approaches. **Element B: Medical home responsibility:** The practice has a process for informing pts / families about the role of the medical home and give pts/families materials that contain the following information: **1.** The practice is responsible for coordinating patient care across multiple settings; **2.** Instructions on obtaining care and clinical advice during office hours and when the office is closed; **3.** The practice functions most effectively as medical home if pts provide a complete medical hx and info about care received outside practice.	

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		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.	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 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. 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 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-	**4.** The care team provides access to evidence based care, patient/family education and self-management support **5.** The scope of services available within the practice include how behavioral health needs are assessed. **6.** The practice provides equal access to all of their patients regardless of source of payment **7.** The practice give uninsured patients information about obtaining coverage. **8.** Instructions on transferring records to the practice, including a point of contact at the practice. **PCMH 3: Population Health Management** The practice uses a comprehensive health assessment & evidence based decision support based on complete pt. info and clinical data to manage the health of the entire population. **Element C: Comprehensive Health Assessment** – To understand the health risk and information needs of patients/ families the practice collects and regularly updates a comprehensive health assessment that includes: Age/gender, family, social, cultural characteristics, communication needs, medical history of patient/family, advance care planning, behaviors affecting health, mental health/ substance use history, developmental screening using standardized tool, depression screening for adults, adolescents, assessment of health literacy	

				PCMH 4: Care Management and Support The practice systematically identifies individual patients and plans, manages and coordinates care based on need. **Element A: Identify Patients for Care Management –** The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process include consideration of the following: 1. Behavioral health conditions 2. High Cost/High Utilization 3. Poorly Controlled or complex conditions 4. Social Determinants of Health 5. Referrals by outside organizations (insurers, health system, ACO, Practice staff or patient/family /caregiver) 6. The practice monitors the percentage of the total patient population identified through its process and criteria (Critical factor)	
0040, Subp. 1. B. 1. 2 a..	B. establish a system designed to ensure that:	The health care home designs a system	1. The HCH establishes a system with	**PCMH 1 Patient Centered Access (A,B,C)**	

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b., c., d. and 3 A.1;	(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	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.	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 advice is outlined in the protocol	**Element A: Patient Centered Appointment Access (MUST-PASS)** The practice has a written process and defined standards for providing access to appointments and regularly assesses it performance on: 1. Providing same-day appointments for routine and urgent care (CRITICAL FACTOR) 2. Providing routine and urgent care appointments outside regular business hours. 3. Providing alternative types of clinical encounters 4. Availability of appointments 5. Monitoring no show rates 6. Acting on identified opportunities to improve access. **Element B: 24/7 Access to Clinical Advice** The practice has written process and defined standards for providing access to clinical advice and continuity of medical record information at all times and regularly assesses its performance on: 1. Providing continuity of medical record information for care and advice when office is closed 2. Providing timely clinical advice by telephone (CRITICAL FACTOR) 3. Providing timely clinical advice using a secure, interactive electronic system 4. Documenting clinical advice in patient records.	

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	(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		5. **There is an audit process 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. At site visit: Observe process and review protocol, interview patients, discuss with team.	**Element C: Electronic Access** The following information and services are provided to patients/families/caregivers as specified through a secure electronic system. More than 50% of pts have online access to their health information 1. within 4 business days of when the information is available to the practice 2. More than 5% of pts view and are provided the capability to download their health info or transmit their health info to a 3rd party. 3. Clinical summaries are provided within 1 business day for >50% of office visits. 4. A secure message was sent by >5 % of pts 5. Pts have two-way communication / practice	
0040 Subp. 1, C.	collect information about participants' cultural background, racial heritage, and primary language and describe how the applicant will apply this information to improve care;	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	**PCMH 2: Team Based Care** - The practice provides continuity of care using culturally and linguistically appropriate team based approaches. **Element C: Culturally and Linguistically Appropriate Services** The practice engages in activities to understand and meet the cultural and linguistic needs of its patients/families by: 1. Assessing the diversity of the population 2. Assessing the language needs of its population 3. Providing Interpretation or bilingual services to meet the language needs of the population. 4. Providing printed materials in the languages of its population.	

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			At site visit: Observe process and interview patients, discuss with		
0040 Subp. 1, D.	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	**PCMH 3: Population Health Management Element A: Patient Information** – The practice uses an electronic system to record patient information including capturing information for factors 1-13 as structure searchable data for more than 80% of its patients. Includes: DOB, Sex, Race, Ethnicity, Preferred language, telephone numbers, email address, occupation, dates of previous clinic visits, legal guardian, health care proxy, primary caregiver, advanced directive, health insurer and name and contact information of other health care professionals involved in patients care.	
0040 Subp. 1, E	inform participants that the participant may choose a specialty care resource without regard to whether a specialist is a member of the same provider group or network as the participant's health care home, and that the participant is then responsible for determining whether specialty care resources are covered by the participant's insurance; and	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	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		
0040 Subp. 1, F	establish adequate information and privacy security measures to comply with applicable privacy and	Requires the HCH to comply with existing applicable law on information privacy	1. There are already established data security policies in place in the clinic that are regulated per applicable state and federal laws.		

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	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.	securit y.	2. There are consistent processes in place for information management and release of information protocols.		
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**		***<u>Submit at re-certification application</u>*: 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**		
0040 Subp. 2. Re-certificati on	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	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	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		

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	level, or other barriers to learning.	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.	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.		
4764.0040 Subp. 3.	**Participant registry and tracking participant activity standard; certification requirements. applicant for certification must use a search electronic registry to record participant infor track participant care.** **c a r e The a b l e, mation and**		***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**	***NCQA Requires Implementation of an Electronic Health Record for Recognition As well as implementation of Stage 1 and 2 of Meaningful Use Criteria.***	
Subp. 3. A.	The registry must enable the health care home team to conduct systematic reviews of the health care home's participant population to manage health care services, provide appropriate follow-up, and identify any gaps in care.	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**	**PCMH 3 Population Health Management: Element D: Use Data for Population Management (MUST-PASS):** At least annually the practice proactively id's populations of pts and reminds them or families/caregivers of needed care based on pt info, clinical data, health assessments and evidence based guidelines including: 1. At least 2 different preventive care services 2. At least 2 different immunizations 3. At least 3 different chronic or acute care services 4. Pts not recently seen by practice 5. Medication monitoring or alert.	
Subp. 3. B., 1., 2.	The registry must contain: (1) for each participant, the	The HCH has readily accessible,	At site visit: The HCH demonstrates production of the	**PCMH 3 Population Health Management: Element B: Clinical Data**	

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	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.	useful information on patients that allows it to treat patients comprehensively.	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.	The practice uses an electronic system with functionality (structured searchable data). 1. Up to date problem list with current active dx for more than 80% of pts 2. Allergies, including medication allergies, adverse reactions for more than 80% pts 3. Blood pressure with date of update, for more than 80% of pts 3 years and older 4. Height/length for more than 80% of pts 5. Weight for more than 80% of patients 6. System Calculates BMI 7. System plots / displays growth charts BMI 8. Status of tobacco use for pt 13 older 80% pt 9. List prescribed meds / date of updates 80%	
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,**		***<u>Submit at re-certification application</u>*: 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 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	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	**PCMH Standard 3 – Population Health Management / Element E: Implement Evidence-Based Decision Support** The practice implements clinical decision support (i.e. point of care reminders) following evidence-based guidelines for: 1. A mental health or substance use disorder	

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		service s.	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.	2. A chronic medical condition 3. A acute condition 4. A condition related to unhealthy behaviors 5. Well child or adult care 6. Overuse / appropriateness issues.	
Subp. 5. Certificati on	**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:**		***Submit at application:*** **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**		
Subp. 5. A., 1, 2, 3	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	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	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	**PCMH 2: Team-Based Care – Element D: The Practice Team (MUST-PASS) 1-7** The practice uses a team to provide a range of patient care services by: 1. Defining roles for clinical and nonclinical team members 2. Identifying the team structure and staff who lead and sustain team based care 3. Hold scheduled patient care team meetings or structure communication process focused on individual patient acare (CRITICAL	

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	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	planning and follow-up support that are basic principles in patient- and family-centered care and care coordination.	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. 4. The clinic has completed a documentation audit to evaluate the effectiveness of care coordination documentation. (Instructions for audits will be	4. Using standing orders for services. 5. 5. Training and assigning members of the 6. care team to coordinate care for individual patients 6. Training and assigning members of the 7. care team to support patients/families/ caregivers in self-management, self-efficacy and behavior change.	
Subp. 5. B	uses health care home teams to provide and coordinate participant care, including communication and collaboration with specialists. If a health care home team includes more than one personal clinician or local trade area clinician, or more than one care 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	**PCMH 2: Team Based Care** The practice provides continuity of care using culturally and linguistically appropriate team based approaches. **Element A: Continuity 1-3** The practice provide continuity of care by: 1. Assisting patients/families to select a personal clinician and document the selection in practice records. 2. Monitor % of patient visits with selected clinical or team 3. Have a process to orient new patients to the practice.	Monitoring the % of patient visits with a selected clinician or team is a common data method to demonstrate this criteria for HCH.

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			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. C.	Provides for direct communication in which routine, face-to-face discussions take place between the personal clinician or local trade area clinician and the care coordinator. *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.*	Relationships evolve differently when face-to- face contact is made, so that one person can see and respond to the physical demeanor and nonverbal cues of the other. The requirement that the care coordinator and the clinician have some face-to-face contact enhances the communication and cohesiveness of the care team. With a dedicated care coordinator who is more engaged in the care team based on personal relationships, the clinician has a greater ability and confidence to rely on the coordinator to meet the needs of the participant, therefore freeing the clinician to	1. There is an infrastructure that supports confidential provider and care coordinator face-to-face interaction. 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.		
Subp. 5. D	provides the care coordinator with dedicated	Designated protected time is	1. Provides a care coordinator work schedule that shows there	None	

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	care coordination responsibilities; and	performing care coordination functions and making improvements in population outcome measurements.	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 such as a job description and scheduled hours for care coordinator. Subp. 5D**		
Subp. 5. E, 1., 2., 3., 4., 5., 6.,	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;	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	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	**PCMH 4 Care Management & Support Element C Med Management** MUST-PASS The practice has a process for managing medications and systematically implements the process in the following ways: 1. Reviews/Reconciles meds > 50% of pts received from care transitions (CRITICAL FACTOR) 2. Reviews/Reconciles meds with pts/ family >80% of care transitions. 3. Provides info about new Rx's to >80% of patients/families/caregivers	

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	(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.	facilities; timely post-discharge planning and communication with the pharmacy; and links to external care plans.	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.	4. 5. Assesses response to meds/barriers to adherence >50% of pts / dates assessment. 5. 6. Documents over-the-counter meds, herbal therapies, supplements >50% of pts, and dates updates. **6. PCMH 4: Element D: Use of E-Prescribing** 7. 1. >50% of eligible Rx's written by practice are compared to drug formularies and electronically sent to pharmacies. 8. 2. Enters electronic med orders in med record for > 60% of medications 9. 3. Performs patient-specific checks for drug-drug and drug-allergy – interactions. 4.Alerts prescribers to generic alternatives. **PCMH 5 Care Coordination & Care Transitions** **The practice systematically tracks tests, coordinates care across specialty care, facility-based care, community organizations.** **Element A: Test Tracking & Follow-up: The practices has documented process / demos:** 1. Track lab test until results available, flagging & following up on overdue results (CRITICAL FACTOR) 2. Track imaging tests until results available, flagging/follow-up on overdue results (CRITICAL FACTOR) 3. Flag abnormal lab results, bring to attention of clinician. 4. Flab abnormal imaging results, bring to attention of the clinician 5. Notifies pts/family of normal/abnormal lab & imaging test results 6. Follows up with inpt. Facility re newborn	

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				7. More than 30% of lab orders are electronically recorded in patient record. 8. More than 30% of radiology orders are electronically recorded in patient record 9. Electronically incorporates more than 55% of all clinical lab results into structure fields in EMR. 10. More than 10% of scans and tests that result in an image are accessible electronically. **PCMH 5: Element B: Referral Tracking & Follow-up (MUST PASS).** The practice: 1. Considers available performance info on consults/specialists when making referrals. 2. Maintains formal/informal agreements with a subset of specialist based on est criteria. 3. Maintains agreements with behavioral health providers 4. Integrates behavioral healthcare providers within the practice site. 5. Gives the consultant/specialist the clinical questions, required timing, type of referral. 6. Gives the consultant/specialist pertinent demographic / clinical data, including test results and current care plan. 7. Has capacity of electronic exchange of key clinical info and provides electronic summary 8. Tracks referrals until consultant or specialist report available, flagging and following up on overdue reports (CRITICAL FACTOR) 9. Documents co-management arrangements in the patients' medical record. 10. Ask pt /family about self-referrals/ request	

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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:**		***<u>Submit at re-certification application;</u>*** **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**		
Subp. 6. A.	ensure that participants are given the opportunity to fully engage in care planning and shared decision-making regarding the participant's care, and that the health care home solicits and documents the participant's feedback regarding the participant's role in the participant's care;	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	**PCMH 4: Care Management & Support. Element E: support Self-care & Shared Decision Making** The practice has & demos use of materials to support pts/families/caregivers in self-management & Shared Decision Making. The practice: 1. Uses HER to id pt-specific education resources & provide to >10% of pts. 2. Provides educ material & resources to pts. 3. Provides self-management tools/ record self-care results 4. Adopts shared decision making aids 5. Offers /refers pts to structure health educ programs, groups, classes / peer support. 6. Maintain current resource list on 5 topics/key	

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			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**		
Subp. 6. B	identify and work with community-based organizations and public health resources such as disability and aging services, social services, transportation services, school- based services, and home health care services to facilitate the availability of appropriate resources for participants;	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**		
Subp. 6. C	permit and encourage professionals within the health care home team to practice at a level that fully uses the professionals' training and skills; and	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	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.		
	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	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	**PCMH 2 Team Based Care: Element A: Continuity-** The practice provides continuity by 4.Collaborating with the patient/family to develop a written care plan for patients	

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		services across specialties and all ages and stages of health.	transition care planning when the patient transfers to a new personal clinician or resources that are in place that provides information about transitions.	**PCMH 5: Care Coordination & Care Transitions** **Element C: Coordinate Care Transitions** 1. Proactively id pts with unplanned hospital admissions & ER visits 2. Share clinical info with admitting hospitals and ERs 3. Consistently obtain pt. discharge summaries from hospitals & Other facilities 4. Proactively contact pt/family for appropriate f/ up care within an appropriate period following hospital admit or ER visit. 5. Exchange pt. info with the hospital during hospitalization. 6. Obtain proper consent for release of info ; have process for secure exchange of info and coordination with community partners 7. Exchange key clinical info with facilities and provide electronic summary of care to another facility > 50% of pt transitions of care	
Subp. 7. Certification	**Care plan standard; certification requirements. The applicant for certification must meet the following requirements:**		***<u>Submit at application</u>*:** **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.,	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;	The HCH develops a policy and procedure that guides the HCH in determining which patients in the HCH may benefit from a care plan, 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	1. There is a written format for a care plan 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	**PCMH 3: Population Health Management Element C: Comprehensive Health Assessment** To understand the health risks and information needs of patients/families the practice collects and regularly updates a comprehensive health assessment that includes: 1. Age, gender, immunizations, screenings 2. Family/social/cultural characteristics 3. Communication needs 4. Medical history of patient and family 5. Advance care planning (NA for pediatric practices) 6. Behaviors affecting health 7. Mental health/substance sue history of patient and family. 8. Developmental screening using a standardized tool (NA for practices with no peds patients) 9. Depression screening for adults, adolescents using a standardized tool 10. Assessment of health literacy.	No requirement in NCQA for written policy in their standards, however it's a format for verification for 2C.

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	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 guidelines for medical services and procedures, if those guidelines and methods are available;	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 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.	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 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	**PCMH 4 Care Management & Support, Element B: Care Planning and Self-Care Support:** The care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes the following features for at least 75% of the patients identified in element A. 1. Incorporates patient preferences and functional/lifestyle goals 2. Identifies treatment goals 3. Assesses and addresses potential barriers to meeting goals. 4. Includes a self-management plan 5. Is provided in writing to the patient/family/ caregiver.	
Subp.. 7. B. 1., 2., 3., 4. and C	a participant's care plan must include goals and an action plan for the following: (1) preventive care, including reasons for	An effective care plan includes the participant's goals, and an action plan must be developed	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		

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	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.	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.	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. 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,**		***<u>Submit at re-certification application</u>:*** **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 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.	the applicant must ask each participant with a care plan whether the participant has any	Professionals who prepare external care	1. There is a process in place for those patients who identify external resources to include those members		

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	plans and, if so, create a comprehensive care plan by consolidating appropriate information from the external plans into the participant's care plan.	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	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:**		**At application 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**		
Subp. 9. A., 1., 2., 3., 4.	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	The quality team is essential to improvements in quality and outcomes for the HCH. Membership of the quality team includes	1. There are quality team minutes 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 six	**PCMH 2: Team-Based Care – Element D: The Practice Team (MUST-PASS) 8-10** The practice uses a team to provide a range of patient care services by: 4. Holding schedule team meetings to address practice functioning	

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	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 to participate; and (4) if the health care home is	clinic that are involved in direct care delivery, as well as participants. A patient- and family-centered health care home relies on participants to support and provide input to the clinic's quality activities.	3. There is a membership list with attendance at quality team meetings. At site visit: Review HCH quality minutes and discuss key points at quality interview with HCH team members. **Submits the written membership of HCH quality team for each unit to be certified (i.e. department or clinic)**	5. Involving care team staff in the practices performance evaluation and quality improvement activities. 6. Involving patients/families/caregivers in quality improvement activities or in on the practice's advisory council.	
Subp. 9 B.	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**	**PCMH 6 Performance Measurement & QI** **Element F: Report Performance**. The practice produces performance data reports using measures from Elements A-C. 1. Individual clinician performance c practice 2. Practice-level performance results 3. Individual clinician/practice publically 4. Individual clinician/practice results c pts.	
Subp. 9. C	demonstrating capability in performance measurement by showing that the applicant has measured, analyzed, and tracked changes in at least one quality indicator selected by the applicant based upon the opportunity for improvement; 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.	**PCMH 6: Performance Measurement & Quality Improvement Element A- Measure Clinical Quality Performance**: At least annually practice measures or receives data on: 1. At least 2 immunization measures 2. At least 2 other preventive measures 3. At least 3 chronic or acute care clinical measures 4. Preformed data stratified for vulnerable populations (assess	

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Subp. 9. D. 1., 2., 3., 4	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	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.	Many States that have NCQA add Learning Collaborative as a requirement by the State. (Source?)	
Subp. 9. E	establishing procedures for representatives of the health care home to share information learned through the collaborative and elicit feedback from health care home team members and other staff regarding information.	Feedback between learning collaborative team members and the rest of the team is essential to bringing the whole team along with the changes.	1. The HCH has a written procedure for sharing the HCH's learning from learning collaborative meetings with 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:**	***Submit at re-certification application:*** **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**		

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Subp. 10, A, C	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.	**PCPMH 6: Performance Measurement & QI Element D: Implement Continuous QI** (Must Pass) The practice using an ongoing QI process to: 1. Set goals & analyze at least 3 clinical quality measures from Element A. 2. Act to improve at least 3 clinical quality measures from Element A. 3. Set goals & analyze at least 1 measure from Element B. 4. Act to improve at least 1 measure From Element B. 5. Set goals & analyze at least 1 pt experience measure from Element C. 6. Act to improve at least one pt. experience measure from Element C. 7. Set goals & address at least 1 identified disparity in care / service identified for identified population.	Continues in recertification in 11B, however HCH's submit data every 15 months and NCQA every three years.

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Subp. 10, B., 1., 2., 3.	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	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.	**PCMH 6: Performance Measurement and QI Element B: Measure Resource Use and Care Coordination.** At lease annually the practice measures or receives quantitative data on: 1. At least 2 measures related to care coordination. 2. At least two utilization measures affecting health care costs. **Element C: Measure Pt./Family Experience** At least annually, practice obtains feedback from pt/family on their experiences with practice/care. 1. Conduct Survey (any instrument) to evaluate pt/family experien: access, communication, coordination, whole person care 2. Uses PCMH CAHPS Tool 3. Feedback on experience of vulnerable pts 4. Feedback from pt/family qualitative means	
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.	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	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.	**PCMH 6: Performance Measurement & QI Element E. Demonstrate CQI**. The practice demonstrates quality improvement by: 1. Measure effectiveness of actions it takes to improve the measures selected in Element D. 2. Achieve improve performance on at least 2 clinical quality measures. 3. Achieve improved performance on 1 utilization of care coordination measure 4. Achieve improved performance on at least 1	Continues from recertification in 10A/ B however HCH's submit data every 15 months and NCQA every three years.

4764.0000 NCQA 2014	MN Health Care Home Rule Language	Intent	Verification Requirements Data Sources / Documentation	NCQA Standard	Notations
	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.				
				PCMH 6: Performance Measurement & QI Element G: Use Certified EMR Technology. The practice uses a certified EMR system. 1. EMR stems has been certified (CMS) 2. Security risk analysis of EMR done & updates as necessary 3. Demonstrates capability to submit electronic surveillance data to public health 4. Demonstrates capability to id & report cancer cases to public health 5. Demonstrate capability to id & report specific cases o specialized registry 6. Report clinical quality measure to Medicare / Medicaid as required for MU 7. Capability to submit data to immunization registries 8. Access to a health information exchange 9. Bidirectional exchange with a health information exchange 10. Generates lists of pts, based on preferred method of communication reminds >10% about preventive/ follow-	