4764.0040 HEALTH CARE HOME STANDARDS.

Subpart 1. **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:

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; and

(2) are interested in participation;

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;

(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; and

(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

(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;

C. collect information about participants' cultural background, racial heritage, and primary language and describe how the applicant will apply this information to improve care;

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;

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

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

Subp. 2. **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 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.

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.

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.

B. The registry must contain:

(1) for each participant, the name, age, gender, contact information, and identification number assigned by the health care provider, if any; and

(2) sufficient data elements to issue a report that shows any gaps in care for groups of participants with a chronic or complex condition.

Subp. 4. [Repealed, 47 SR 338]

Subp. 5. **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:

A. 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;

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;

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;

D. provides the care coordinator with dedicated time to perform care coordination responsibilities; and

E. 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 postdischarge 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.

Subp. 6. **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:

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;

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;

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

D. engage participants in planning for transitions among providers, and between life stages such as the transition from childhood to adulthood.

Subp. 7. **Care plan standard; certification requirements.** The applicant for certification must meet the following requirements:

A. establish and implement policies and procedures to guide the health care home in assessing whether a care plan will benefit participants with complex or chronic conditions. 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 patient's 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 guidelines for medical services and procedures, if those guidelines and methods are available;

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

(1) preventive care, including reasons for deviating from standard protocols;

(2) care of chronic illnesses;

(3) exacerbation of a known chronic condition, including plans for the participant's early contact with the health care home team during an acute episode; and

(4) end-of-life care and health care directives, when appropriate; and

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

Subp. 8. **Care plan standard; recertification at the end of year one.** By the end of the first year of health care home certification, 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.

Subp. 9. **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:

A. establishing a health care home quality improvement team that reflects the structure of the clinic and includes, at a minimum, the following persons at the clinic level:

(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 to participate; and

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

B. establishing procedures for the health care home quality improvement team to share their work and elicit feedback from health care home team members and other staff regarding quality improvement activities;

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;

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

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

(2) one or more care coordinators;

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

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

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.

Subp. 10. **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:

A. participate in the statewide quality reporting system by submitting outcomes for the quality indicators identified and in the manner prescribed by the commissioner;

B. show that the applicant has selected at least one quality indicator from each of the following categories and has measured, analyzed, and tracked those indicators during the previous year:

(1) improvement in patient health;

(2) quality of patient experience; and

(3) measures related to cost-effectiveness of services; and

C. 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.

Subp. 11. [Repealed, 47 SR 338]

Statutory Authority: *MS s 256B.0751; 256B.0752; 256B.0753*

History: *34 SR 591*
Published Electronically: *November 16, 2022*