4764.0040 HEALTH CARE HOME STANDARDS.

Subpart 1. **Access and communication standard; certification requirements.** The health care home must have a system in place to support effective communication among the members of the health care home team, the patient and family, other providers, and care team members. The health care home must do the following:

A. offer health care home services to all of the primary care services population that includes:

(1) identifying patients who have or are at risk of developing complex or chronic conditions;

(2) offering varying levels of coordinated care to meet the needs of the patient; and

(3) offering more intensive care coordination for patients with complex needs;

B. establish a system designed to ensure that:

(1) the health care home informs the patient 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 patients' medical record information, which must include the following for each patient:

(a) the patient's contact information, personal clinician's or local trade area clinician's name and contact information, and designated enrollment in intensive care coordination services;

(b) the patient's racial or ethnic background, primary language, and preferred means of communication;

(c) the patient's consents and restrictions for releasing medical information; and

(d) the patient's diagnoses, allergies, medications, and whether a care plan has been created for the patient; and

(3) the designated clinic staff, on-call provider, or phone triage system representative who has continuous access to the patient's medical record information will determine when scheduling an appointment for the patient is appropriate based on:

(a) the acuity of the patient'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 patients' cultural background, racial heritage, and primary language and describe how the health care home will apply this information to improve care;

D. document that the health care home is using the patient's preferred means of communication, if that means of communication is available within the health care home's capability;

E. inform patients that the patient may choose a specialty care resource without regard to whether a specialist is a member of the same provider group or network as the patient's health care home, and that the patient is then responsible for determining whether specialty care resources are covered by the patient's insurance; and

F. maintain policies and procedures that establish privacy and security protections of health information and comply with applicable privacy and confidentiality laws.

Subp. 2. **Access and communication standard; recertification requirements.** The health care home must demonstrate that the health care home encourages patients to take an active role in managing their health care, and must demonstrate patient involvement and communication by identifying and responding to one of the following: the patient's readiness for change, literacy level, or other barriers to learning.

Subp. 2a. **Access and communication standard; level 2 certification requirements.** The health care home must demonstrate:

A. incorporating screening processes to assess whole person care needs and use this information to determine risk and manage patient care;

B. offering options beyond the traditional in-person office visit such as expanded hours of operation, electronic virtual visits, delivery of services in locations other than the clinic setting, and other efforts that increase patient access to the health care home team and that enhance the health care home's ability to meet the patient's preventative, acute, and chronic care needs;

C. implementing care delivery strategies responsive to the patient's social, cultural, and linguistic needs; and

D. implementing enhanced strategies to encourage patient engagement through interventions that support health literacy and help the patient manage chronic diseases, reduce risk factors, and address overall health and wellness.

Subp. 3. **Patient registry and tracking patient care activity standard; certification requirements.** The health care home must use a searchable, electronic registry to record patient information and track patient care.

A. The registry must enable the health care home team to conduct systematic reviews of the health care home's patient population to manage health care services, provide appropriate follow-up, and identify any gaps in care.

B. The registry must contain:

(1) for each patient, the name, age, gender identity, 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.

C. The health care home must use the registry to identify gaps in care and implement remedies to prevent gaps in care.

Subp. 3a. **Registry and tracking standard; level 2 certification requirements.** The health care home must demonstrate:

A. expanding registry criteria to identify needs related to social determinants of health and other whole person care data elements in the clinic population; and

B. planning and implementing interventions to address unmet needs identified by the expanded registry.

Subp. 4. [Repealed, 47 SR 338]

Subp. 5. **Care coordination standard; certification requirements.** The health care home 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 patient, 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 patient 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 patient determine whether and how often the patient will have contact with the care team, other providers involved in the patient's care, or other community resources involved in the patient's care;

B. uses health care home teams to provide and coordinate patient 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 health care home must identify one personal clinician or local trade area clinician and one care coordinator as the primary contact for each patient and inform the patient 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 patient's chart or care plan:

(1) referrals for specialty care, whether and when the patient has been seen by a provider to whom a referral was made, and the result of the referral;

(2) tests ordered, and when test results have been received and communicated to the patient;

(3) admissions to hospitals or skilled nursing facilities, and the result of the admission;

(4) timely postdischarge planning according to a protocol for patients discharged from hospitals, skilled nursing facilities, or other health care institutions;

(5) communication with the patient'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 patient's care.

Subp. 6. **Care coordination standard; recertification requirements.** The health care home must enhance the health care home's care coordination system by adopting and implementing the following additional patient- and family-centered principles:

A. ensure that patients are given the opportunity to fully engage in care planning and shared decision-making regarding the patient's care, and that the health care home solicits and documents the patient's feedback regarding the patient's role in the patient'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 patients;

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

Subp. 6a. **Care coordination standard; level 2 certification requirements.** For the primary care services patient population, the health care home must demonstrate:

A. providing and coordinating care using an integrated care team;

B. supporting ongoing coordination of care and follow-up with partners by sharing information; and

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

Subp. 7. **Care plan standard; certification requirements.** The health care home must establish and implement policies and procedures to guide the health care home in the identification and use of care plan strategies to engage patients in their care and to support self-management. These strategies must include:

A. providing patients with information from their personal clinician or local trade area clinician visit that includes relevant clinical details, health maintenance and preventative care instructions, and chronic condition monitoring instructions, including indicated early intervention steps and plans for managing exacerbations, as applicable;

B. offering documentation of any collaboratively developed patient-centered goals and action steps, including resources and supports needed to achieve these goals, when applicable. Include pertinent information related to whole person care needs or other determinants of health;

C. using advanced care planning processes to discuss palliative care, end-of-life care, and complete health care directives, when applicable. This includes providing the care team with information about the presence of a health care directive and providing a copy for the patient and family; and

D. informing strategies with evidence-based practice guidelines when available.

Subp. 8. **Care plan standard; recertification requirements.** The health care home must integrate pertinent medical, medical specialty, quality of life, behavioral health, social services, community-based services, and other external care plans into care planning strategies to meet unique needs and circumstances of the patient.

Subp. 9. **Performance reporting and quality improvement standard; certification requirements.** The health care home must measure the health care home's performance and engage in a quality improvement process, focusing on patient experience, patient health, and measuring the cost-effectiveness of services, by doing the following:

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 patient 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 health care home has measured, analyzed, and tracked changes in at least one quality indicator selected by the health care home based upon the opportunity for improvement;

D. participating in the health care home learning collaborative through care team members that reflect the structure of the clinic and may include the following:

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

(2) care coordinators;

(3) other care team members;

(4) representatives from clinic administration or management; and

(5) patient representatives who were provided the opportunity and encouraged to participate with the goal of having patients 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 requirements.** The health care home must:

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

B. show that the health care home 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;

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; and

D. achieve the benchmarks for patient health, patient experience, and cost-effectiveness established under part 4764.0030, subpart 6, for the health care home's outcomes in its primary care services patient population.

Subp. 11. [Repealed, 47 SR 338]

Subp. 12. **Performance reporting and quality improvement standard; level 2 certification requirements.** The health care home must demonstrate:

A. using information and population health data about the community served to inform organizational strategies and quality improvement plans;

B. measuring, analyzing, tracking, and addressing health disparities within the clinic population through continuous improvement processes;

C. establishing procedures for sharing work on health equity and eliciting feedback from the health care home team and other staff regarding these activities; and

D. recruiting, promoting, and supporting patient representation to the health care home quality improvement team that reflects the diversity of the patient population.

Subp. 13. **Performance reporting and quality improvement standard; level 3 certification requirements.** The health care home must contribute to a coordinated community health needs assessment and population health improvement planning process by:

A. sharing aggregated information or de-identified data that describes health issues and inequities;

B. prioritizing population health issues in the community and planning for population health improvement in collaboration with community stakeholders;

C. implementing and monitoring progress of the population health improvement plan using shared goals and responsibility; and

D. sharing in the communication and dissemination of work on population health improvement and eliciting feedback from the community members and health care home staff regarding these activities.

Statutory Authority: *MS s 62U.03; 256B.0751; 256B.0752; 256B.0753*

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