Health Care Homes (HCH) Application

Overview

This document serves as a template of the HCH online application. It may be used to gather information prior to beginning the online application. Please see the:

- HCH COMPASS (PDF) for a full explanation of the standards
- Portal User Guide (PDF) for technical assistance in navigating the online HCH Portal

The application has 7 forms. Each form is either a section of the application or represents one of the HCH five standards. Each tab within a form includes one or more requirements.

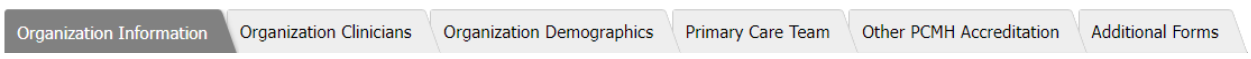
Document to the highest level of certification you are seeking for one or more clinic(s) within your organization.

- Level 2 must also complete all foundational level and recertification level documentation requirements.
- Level 3 must also complete all Level 2, foundational level, and recertification level documentation requirements.

Note: Required fields are labeled with a red asterisk *. You will only be able to submit if all required fields have been completed.

Portal Form: Organization Demographics

Tab: Organization Information



Organization Demographic

Organization Name _____

**Organization NPI* _____

**Primary Street Address* _____

Primary Street Line 2 (i.e. Apt#) _____

**Primary Zip Code* _____

Primary City _____

Primary State _____

**Primary Phone* _____

*Do you need to add additional clinics? (Note: To view a list of your clinics, select 'Yes')

- ☐ *Yes*
- ☐ *No*

If Yes,

- *Clinic Name* _____
- *Street 1* _____
- *Street 2* _____
- *Postal Code* _____
- *City* _____
- *County* _____
- *State* _____
- *Clinic NPI* _____
- *Federal Tax ID* _____
- *Certification Level* _____

EMR

*Do you use an electronic medical record (EMR)?

- ☐ *Yes*
- ☐ *No*

*If Yes, what is the name of your EMR? _____

Reimbursement

Do you receive reimbursement for care coordination services?

☐ *Yes*

☐ *No*

If Yes, from which payer(s) do you receive reimbursement (select all that apply)?

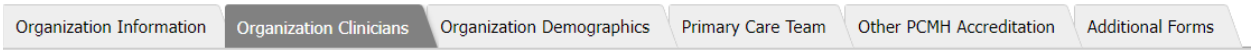
☐ *Medicaid*

☐ *Medicare (CMS)*

☐ *Commercial Payer*

☐ *Other (briefly describe)* _____

Tab: Organization Clinicians



Upload

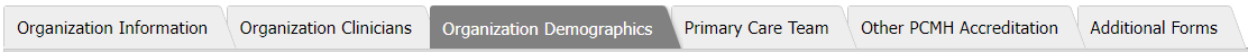
I. Click the "Download Clinicians Roster" button to obtain an excel file of previously uploaded clinicians. If you are a new applicant, this will be a blank list.

II. Edit the list so that it reflects the current clinicians practicing as part of the certified Health Care Home clinics.

- **Remove clinicians no longer practicing in certified HCH Clinics by deleting their clinician information (delete the entire row).**
- **Add new clinicians, including the following clinician information. Please highlight new clinicians in yellow.**
    1. *column A: first name*
    2. *column B: last name*
    3. *column C: credential [MD, DO, PA, NP, CNM]*
    4. *column D: specialty [Family Medicine, Internal Medicine, Pediatrics, Med Peds, Geriatrics, Other (specify)]*
    5. *column E: other clinician specialty - may be left blank*
    6. *column F: NPI*
    7. *column G: certification begin date – for any new clinicians, please add their official start date at your organization*
    8. *column H: certification end date - this date will be the certification end date*

III. Click the "Import Clinicians Roster" button to upload the updated excel file of HCH certified clinicians.

Tab: Organization Demographics



Demographics

Demographics of the patient population receiving primary care services (reported at the organizational level, does not need to be broken down by each clinic): age, race, ethnicity, language, and payer

Estimate Age Distribution

Please put a percentage for each age distribution. This should total to 100%

* *Percent of Patients Age: 0-17* _____
* *Percent of Patients Age: 18-64* _____
* *Percent of Patients Age: 65 +* _____
* *Percent of Patients Age Unknown* _____

Estimate Race Distribution

Please put a percentage for each race distribution. This should total to 100%

* *Percent of Patients who identify as American Indian or Alaska Native* _____
* *Percent of Patients who identify as Hawaiian or Other Pacific Islander* _____
* *Percent of Patients who identify as Asian* _____
* *Percent of Patients who identify as White* _____
* *Percent of Patients who identify as Black or African American* _____
* *Percent of Patients who identify as Multi-race* _____
* *Percent of Patients who Choose not to disclose/Declined* _____
* *Percent of Patients Race Unknown* _____

Estimate Ethnicity Distribution

Please put a percentage for each ethnicity distribution. This should total to 100%

* *Percent of Patients Hispanic or Latino* _____
* *Percent of Patients Not Hispanic or Latino* _____

* *Percent of Patients Ethnicity Unknown _____*

Estimate distribution of Primary Language spoken

Please put a percentage for each primary language distribution. This should total to 100%

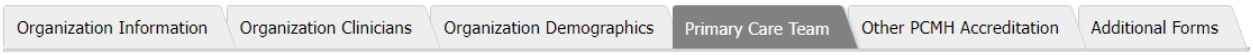
* *Percent of Patients Primary Language spoken is English _____*
* *Percent of Patients Primary Language spoken is Non-English _____*

Estimate percentage of patients by payer mix

Please put a percentage for each Payer. This should total to 100%

* *Percent of Patients on Medicare _____*
* *Percent of Patients on Minnesota Health Care Program (MNCare, General Assistance Medical Care, Medicaid) _____*
* *Percent of Patients Dual Eligible (Medicare, Medicaid) _____*
* *Percent of Patients on Commercial insurance _____*
* *Percent of Patients Uninsured _____*
* *Percent of Patients on Other/unknown insurance _____*

Tab: Primary Care Team



Primary Care Team

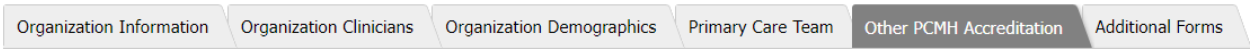
A clinic or clinician that provides primary care services and is supported by a care team and systems to meet standards of a HCH.

*The primary care team includes (check all that apply):

- ☐ *Physician*
- ☐ *Nurse Practitioner/Advanced Practice Nurse*
- ☐ *Physician Assistant*
- ☐ *Registered Nurse*
- ☐ *Social Worker*
- ☐ *Licensed Practical Nurse*
- ☐ *Community Health Worker*
- ☐ *Medical Assistant*

- ☐ *Care Coordinator*
- ☐ *Registration Staff*
- ☐ *Scheduling Staff*
- ☐ *Referral Staff*
- ☐ *Pharmacist*
- ☐ *Behavioral Health Professionals*
- ☐ *Other (briefly describe)* _____

Tab: Other PCMH Accreditation



Other PCMH Accreditation

Other PCMH accreditation or certification the organization currently has

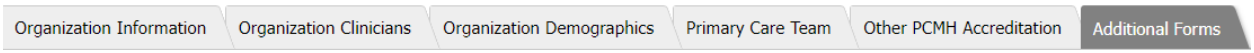
*Do you have another form of Patient Centered Medical Home (PCMH) certification, recognition, or accreditation?

- ☐ *Yes*
- ☐ *No*

  *If Yes, what type?

  - ☐ *National Committee for Quality Assurance (NCQA)*
  - ☐ *Other (Briefly describe)* _____

Tab: Additional Forms



Next Steps

Based on your responses you will be prompted to complete additional forms.

These forms will be available on your Applications > Continue page, please be sure to complete all the forms in your application.

***Portal Form*: Standard One – Access and Communication**

Tab: Patient Identification

Patient Identification | Patient Access | Patient Information | Specialty Care | Patient Engagement

Foundational Level Requirements

Offer health care home services to all the primary care services population that includes doing the following:

- identify patients who have or are at risk of developing complex or chronic conditions;
- offer varying levels of coordinated care to meet the needs of the patient; and
- offer more intensive care coordination for patients with complex medical and social needs

*What processes are used to identify needs and determine risk of the population you serve? (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *Electronic Medical Record (EMR) adjusted risk score*
- ☐ *HCH tiering tool*
- ☐ *Predictive analytics algorithm*
- ☐ *Payer/Accountable Care Organization (ACO) utilization data or risk reports*
- ☐ *non-medical criteria or factors (such as social determinants of health)*
- ☐ *Other (describe below)* _____

Optional Narrative _____

*What are the range of interventions and coordinated care services you offer to patients based on needs (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *Patients who could benefit from more intensive care coordination are identified and offered the services of a designated care coordinator*
- ☐ *Patients with a one-time or short-term need are addressed by the care team*
- ☐ *Patients with identified risk factors are referred and/or provided with additional education or receive rising risk management outside of more intensive care coordination services*
- ☐ *Care is coordinated with another provider for patients with needs best met through other coordinated care programs (e.g. Behavioral Health Home - BHH services)*
- ☐ *Medication Therapy Management (MTM)*
- ☐ *Transitional Care Management (TCM)*
- ☐ *Managing routine and preventative care needs for subpopulations e.g. Medicare wellness visits (describe below)* _____

Optional Narrative _____

*What criteria are used to identify patients who could benefit from intensive care coordination services? (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *Patients determined to be high or rising risk*
- ☐ *Patients identified through registry*
- ☐ *Patients with 2 or more chronic conditions*
- ☐ *Patients with a complex condition or multiple co-morbidities*
- ☐ *Clinician/staff requests or recommendations*
- ☐ *Patient/family request*
- ☐ *High level of resource use (e.g. office visits; medications; treatments)*
- ☐ *Frequent urgent or emergency care*
- ☐ *Frequent hospitalizations*
- ☐ *Lack of social or financial support that impedes ability to get care*
- ☐ *Other (describe below)* _____

Optional Narrative _____

*Total number of patients receiving care coordination services using a care coordinator/s _____

Level 2 Requirements

Progression to Level 2 also requires:

Include processes that identify information about social determinants of health and other factors affecting a patient's health and wellbeing to determine risk and manage patient care.

What criteria and/or screening processes have been implemented to include social determinants of health and other whole person health factors in determining risk and managing patient care (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *Mental health*
- ☐ *Substance/alcohol use*
- ☐ *Tobacco use*
- ☐ *Food insecurity*
- ☐ *Housing instability*

- ☐ *Transportation barriers*
- ☐ *Socioeconomic factors (e.g. employment; income; education; health insurance)*
- ☐ *Safety/security*
- ☐ *Lifestyle factors/behaviors effecting health*
- ☐ *Social support (isolation; loneliness)*
- ☐ *Functional status*
- ☐ *Language and literacy*
- ☐ *Access to mass media and emerging technologies (cellphone; internet; social media)*
- ☐ *Other (describe below)* _____

Optional Narrative _____

Do you use a standardized screening tool(s) or standardized assessment(s) to collect this information?

- ☐ *Yes*
- ☐ *No*

If yes, Which one(s)? Check all that apply

- ☐ *Protocol for Responding to and Assessing Patients' Assets/Risks/Experiences (PRAPARE)*
- ☐ *Centers for Medicare & Medicaid Services (CMS) Health-Related Social Needs (HRSN) Screening Tool*
- ☐ *Embedded EMR tool(s) (describe below)*
- ☐ *Screening to Brief Intervention (S2BI)*
- ☐ *Social Needs Screening Tool (AAFP EveryONE Project)*
- ☐ *Self-Sufficiency Outcomes Matrix (OneCare Vermont)*
- ☐ *Hunger Vital Signs (endorsed by AAP and CMS)*
- ☐ *Alcohol Use Disorders Identification Test Consumption screening tool (AUDIT-C/AUDIT-C Plus 2)*
- ☐ *Patient Health Questionnaire (PHQ)-2 items/PHQ-9*
- ☐ *Other (describe below)* _____

Briefly describe how you use the screening information to meet patient's social and whole-person needs: _____

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Tab: Patient Access

Patient Identification | Patient Access | Patient Information | Specialty Care | Patient Engagement

Foundational Level Requirements

Has a system for providing continuous, 24-hour, access with triage protocols and that the patient is informed and equipped with the knowledge about access to care, including:

(1) inform patients that they have continuous access to designated clinic staff, an on-call provider, or a phone triage system;

(2) designated clinic staff, on-call providers, or phone triage system representative have continuous access to patient' medial record information to include:

- Patient contact information
- Personal clinician and care coordinator names and contact information
- Patient's racial or ethnic background, primary language, and preferred means of communication
- Patient consents and restrictions for releasing medical information
- Patient diagnosis, allergies, medications, and if a care plan is available

(3) Use triage protocols to schedule appointments based on acuity of patient's condition and that addresses scheduling appointments within a business day to avoid unnecessary emergency room visits and hospitalizations

*How does your system/clinic(s) provide continuous access (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *Triage provided by clinic staff (i.e. nurse triage line) during business hours*
- ☐ *Triage provided by clinic staff (i.e. nurse triage line) provides after-hours access*
- ☐ *Phone system staffed by external party provides after-hours access*
- ☐ *Hospital staff assumes after-hours access*
- ☐ *On-call staff assume after-hours coverage*
- ☐ *Other (describe below)* _____

Optional Narrative _____

Staff providing continuous access have access to the following components of the patient's medical record:

*Patient contact information

- ☐ Yes
- ☐ No

*Personal clinician and care coordinator contact information

- ☐ Yes
- ☐ No

*Patient diagnosis, allergies, medications, and if a care plan is available

- ☐ *Yes*
- ☐ *No*

*Patient's racial or ethnic background, primary language, and preferred means of communication

- ☐ *Yes*
- ☐ *No*

*Patient consents and restrictions for releasing medical information

- ☐ *Yes*
- ☐ *No*

*Briefly describe triage protocols or triage processes used to address appointment scheduling based on patient's needs/acuity and avoid unnecessary emergency room visits and hospitalizations _____

*How do you communicate the continuous access process to patients? (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *Print materials information brochure and/or other printed materials (i.e. magnets/bookmarks/signs/advertising)*
- ☐ *Website*
- ☐ *After visit summary*

- ☐ *Care plan*
- ☐ *Patient portal*
- ☐ *Patient education*
- ☐ *Other (describe below)* _____

Optional Narrative _____

Level 2 Requirements

Progression to Level 2 also requires:

Offer enhanced access that includes options beyond the traditional in-person office visit that increase patient access to the health care home team and to enhance the health care home's ability to meet the patient's preventative, acute, and chronic care needs.

How does your system/clinic(s) improve patient access to the care team and enhance the health care home's ability to meet preventative, acute, and chronic care needs of patients: (check all that apply and provide additional details as needed in the narrative box below)

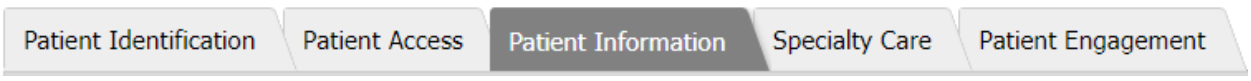
- ☐ *Expanded hours of operation beyond Monday - Friday/8am – 5pm*
- ☐ *Offer same-day appointments*
- ☐ *Offer unscheduled walk-in appointments*
- ☐ *Virtual visits/e-visits/telehealth visits*
- ☐ *Mobile unit/teams offering care remotely or off-site (services provided "outside the clinic walls": such as in school-based clinics/homeless shelters/long term care settings/group homes/home visits)*
- ☐ *Other (describe below)* _____

Optional Narrative _____

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Tab: Patient Information



Foundational Level Requirement: race, ethnicity, and primary language

Collect information about patient cultural background, racial heritage, and primary language, (REL) and describe how it is applied to improve care.

*The clinic collects race, ethnicity, and language (REL) data

- ☐ *Yes*
- ☐ *No*

*If yes, Briefly describe an example of how this information is used to improve care _____

Level 2 Requirements

Progression to Level 2 also requires:

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

Briefly describe the primary social, cultural, and linguistic needs of the patient population at your clinic(s) (i.e. communities served; language needs; marginalized populations) _____

What care delivery strategies are in place to respond to the social, cultural, and linguistic needs of the patient population served by your clinic(s)? (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *Printed and/or online materials available in language(s) other than English*
- ☐ *Patient education/patient groups offered in language(s) other than English*
- ☐ *Recruiting and hiring care team members and clinic staff that reflect the communities being served*
- ☐ *Recruiting and hiring bilingual staff to meet linguistic needs*
- ☐ *Use Community Health Workers to engage patients in underserved communities/outside the clinic walls*
- ☐ *Training to reduce implicit bias within the organization and in patient care*
- ☐ *Other (describe below)* _____

Optional Narrative _____

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Foundational Level Requirement: preferred means of communication

Document how the clinic uses the patient's preferred means of communication.

*The clinic collects and documents the patient's preferred method of communication

- ☐ *Yes*
- ☐ *No*

*Briefly describe the procedure/process used to collect the patient's preferred method of communication: _____

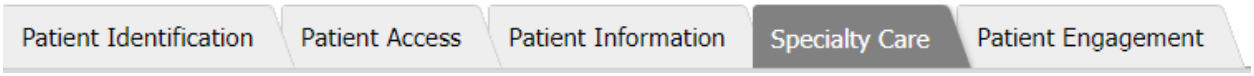
Level 2 Requirements – None

This area of the HCH standards does not have any Level 2 requirements.

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Tab: Specialty Care



Foundational Level Requirements

Inform all patients of choice in specialty care and treatment options.

*Patients are informed of choice in specialty care and treatment options?

- ☐ *Yes*
- ☐ *No*

Level 2 Requirements – None

This area of the HCH standards does not have any Level 2 requirements.

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Tab: Patient Engagement

Patient Identification | Patient Access | Patient Information | Specialty Care | Patient Engagement

Foundational Level Requirements – Recertification

Foundational Level - Recertification Requirement: by the first recertification or if certifying at Level 2 or Level 3, the certified health care home must meet the following additional requirement:

Encourages patients to take an active role in managing their health care and demonstrate patient involvement and communication by identifying and addressing at least one of the following methods used for the primary care services patient population: readiness for change, literacy level, or other barriers to learning.

Which area(s) are identified and addressed to promote patient engagement and self-management (check all that apply)

- ☐ *Patient's readiness for change*
- ☐ *Patient's literacy level*
- ☐ *Other barriers to learning*

Describe the method or methods used to activate, engage, or address associated barriers with patients in your HCH population(s) _____

Level 2 Requirements

Progression to Level 2 also requires:

Implement 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.

What interventions are in place that promote health literacy and help patients manage chronic diseases, reduce risk factors, and/or address overall health and wellness? (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *Verbal communication skills (e.g. use plain language; common words; confirm understanding; train staff on health literacy awareness and communication principles)*
- ☐ *Written communication (e.g. easy to read materials; limit medical jargon/define terms; use check boxes on forms when able)*
- ☐ *Visual aids (e.g. include pictures/video)*
- ☐ *Assess patient understanding/health literacy (e.g. with teach-back/ask me 3 or other validation; ask open-ended questions; ask for patient feedback)*

- ☐ *Identification of patient education opportunities and ways to support self management; offer or refer to groups or other supportive programming*
- ☐ *Use of technology or peer-based social networks as support*
- ☐ *Incorporating OpenNotes philosophy in the practice/sharing clinical notes and medical record*
- ☐ *Staff training specific to the clinic's approach to patient engagement (e.g. stages of change; motivational interviewing techniques; trauma informed care; etc.)*
- ☐ *Other (describe below)* _____

Optional Narrative _____

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Portal Form: Standard Two – Patient Registries and Tracking Patient Care

Tab: Patient Registries and Tracking Patient Care

Patient Registries and Tracking Patient Care

Foundational Level Requirements

Use the registry to conduct systematic reviews of the patient population to manage health care services, provide appropriate follow-up, and identify gaps in care.

The registry must contain:

- For each patient, the name, age, gender identity, contact information, and identification number assigned by the clinic, if any; and
- Sufficient data elements to issue a report that shows any gaps in care

Use the registry to identify gaps in care and implement remedies to prevent them.

*Registry is located in (check all that apply)

- ☐ *Electronic health record*
- ☐ *Excel spread sheet*
- ☐ *Outside of the EHR in separate practice management system or add-on software product*
- ☐ *Other (describe below)* _____

*List the types of registries that are in place and being used. _____

*How is the registry used to identify gaps in care and implement remedies to prevent gaps in care? (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *health maintenance appointment reminders*
- ☐ *outreach to patients overdue for screenings or tests*
- ☐ *pre-visit planning*
- ☐ *target health promotion activities*
- ☐ *enable coordinated patient communication*
- ☐ *risk identification and management*
- ☐ *other (describe below)* _____

Optional Narrative _____

*Registries contain patient demographics, including at least name, age, gender identity

- ☐ *Yes*
- ☐ *No*

*Registries contain or can link to patient contact information and clinic identifying information (if applicable)

- ☐ *Yes*
- ☐ *No*

*Registries contain sufficient data to identify gaps in care or health care need

- ☐ *Yes*
- ☐ *No*

*Provide patient registry example. Please choose one

- ☐ *Agree to demonstrate the patient registry at the site visit to verify the required elements are in place*
- ☐ *Upload a deidentified screenshot of the electronic patient registry that includes the required elements above*

If chosen, Upload deidentified screenshot

Level 2 Requirements

Progression to Level 2 also requires:

Expand registry criteria to identify needs related to social determinants of health and other whole person care factors for the patient population, including needs related to communities with which patients self-identify.

Plan and implement interventions to address unmet needs identified by the expanded registry.

List the expanded registry data elements in place that facilitates management of needs related to social determinant of health and other whole person care factors. (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *Food insecurity*
- ☐ *Housing instability*
- ☐ *Transportation barriers*
- ☐ *Socioeconomic factors (employment; income; education)*
- ☐ *Safety/security*
- ☐ *Behavioral health (describe below)* _____
- ☐ *Other (describe below)* _____

Optional Narrative _____

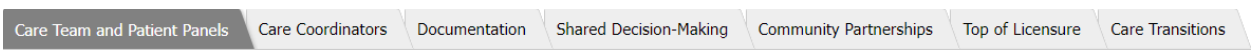
Briefly describe how you use the expanded registry to address social determinant of health and needs of the population served _____

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Portal Form: Standard Three – Care coordination

Tab: Care Team and Patient Panels



Foundational Level Requirement: Collaboration within the care team

Collaboration within a team, at a minimum, includes the patient, care coordinator, and personal clinician to:

- Set patient goals and identify resources to achieve them,
- Ensure consistency and continuity of care, and
- Determine how often the care team and patient will have contact.

Briefly describe the processes for patients receiving more intensive care coordination.

*1) Briefly describe how and which HCH team member(s) set goals and identify steps or resources to achieve the goals with the patient _____

*2) Briefly describe how the clinician and care coordinator ensure consistency and continuity of care for patients _____

*3) Briefly describe how frequency of patient contact with the care coordination team determined _____

Upload patient stories (optional) - We welcome success stories from your staff and patients regarding care coordination

Upload Optional patient stories

Level 2 Requirements

Progression to Level 2 also requires:

Provide and coordinate care using an integrated care team consisting of multidisciplinary roles to meet patient and family needs.

Which multidisciplinary roles are a part of the clinic(s) integrated care team? (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *Mental health professional(s)*
- ☐ *Addiction professional(s)*
- ☐ *Dental health professional(s)*
- ☐ *Pharmacist(s)*
- ☐ *Integrative medicine*

- ☐ *Social worker(s)*
- ☐ *Community Health Worker(s)*
- ☐ *Peer support staff*
- ☐ *Community paramedic(s)*
- ☐ *Other (describe below)* _____

Optional Narrative _____

Briefly describe how care is coordinated across the integrated care team to meet the needs of the patients/populations served by your clinic(s) _____

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Foundational Level Requirement: Patient Empanelment

The care team provides and coordinates care, including communication and collaboration with specialists, designating one clinician for each patient in the clinic's population and one care coordinator as the primary contact for each patient receiving intensive care coordination services and inform the patient of this designation.

*The clinic has a process to assign patients to a primary care provider for continuity of care?

- ☐ *Yes*
- ☐ *No*

*The clinic has a process to assign patients receiving care coordination services to a primary care coordinator for continuity of care?

- ☐ *Yes*
- ☐ *No*

*Each patient is informed of who their designated primary care clinician is and if applicable, who their designated care coordinator is?

- ☐ *Yes*
- ☐ *No*

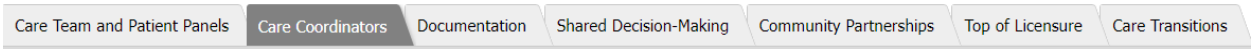
Level 2 Requirements – None

This area of the HCH standards does not have any Level 2 requirements.

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Tab: Care Coordinators



Foundational Level Requirements: Direct communication

The clinician and care coordinator communicate with each other directly and includes routine, face-to-face discussions.

*Care coordinators have direct communication with primary care clinicians on a routine basis

- ☐ *Yes*
- ☐ *No*

*How it this done? (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *Individual face to face meetings*
- ☐ *Huddles*
- ☐ *Team meetings/Care conferences*
- ☐ *Electronic messages (EMR or e-mail)*
- ☐ *Telephone*
- ☐ *Other (describe below)* _____

Optional Narrative _____

Level 2 Requirements – None

This area of the HCH standards does not have any Level 2 requirements.

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Foundational Level Requirement: Dedicated time for care coordinators

The care coordinator has dedicated time to perform care coordination responsibilities

*The care coordinator has dedicated time for care coordination duties?

- ☐ *Yes*
- ☐ *No*

*Number of care coordinators: _____

*Full time equivalent of care coordinators _____

*Care coordinators background and training (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *Registered Nurse*
- ☐ *Social Worker*
- ☐ *Licensed Practical Nurse*
- ☐ *Medical Assistant*
- ☐ *Community Health Worker*
- ☐ *Other (describe below)* _____

Optional Narrative _____

*What tools, resources or training do you use to support care coordination work? (check all that apply and provide additional details as needed in the narrative box below):

- ☐ *Dedicated space/computer/telephone*
- ☐ *EMR specific tools and functions such as tasks/alerts/dashboards*
- ☐ *Care coordination patient registries*
- ☐ *Standard care coordination workflows*
- ☐ *Care coordinator cohort meetings to share best practices and discuss challenges*
- ☐ *MDH HCH provided learning/resources*
- ☐ *Health coaching training*
- ☐ *Motivational interviewing training*
- ☐ *Mental health first aid training*
- ☐ *Disease or condition-specific training (describe below)* _____

- ☐ *Advance care planning training and resources*
- ☐ *Other (describe below)* _____

Optional Narrative _____

Level 2 Requirements – None

This area of the HCH standards does not have any Level 2 requirements.

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Tab: Documentation

Care Team and Patient Panels | Care Coordinators | **Documentation** | Shared Decision-Making | Community Partnerships | Top of Licensure | Care Transitions

Foundational Level Requirements

Document in the chart or care plan:

- referrals to specialists and results of referrals
- ordered tests, test results communication to patient
- follow up of admissions to facilities
- post-discharge planning
- communication with pharmacy and medication reconciliation
- other information determined to be beneficial to coordination of patient care, such as links to external teams and care plans

*Selection confirms each of the following are completed and documented in the patient's chart or care plan

- ☐ *Specialty care referral tracking and follow-up*
- ☐ *Tests ordered/results tracked and timely notification to patients*
- ☐ *Admissions to facilities are tracked if known*
- ☐ *Discharge planning from healthcare facilities (if known) is completed*
- ☐ *Communication with patient's pharmacy and medication reconciliation as needed*
- ☐ *Links to external team members and care plans as appropriate*

*How do you verify your processes are in place and working as intended? (check all that apply and provide additional details as needed in the narrative box below; upload supporting documentation)

- ☐ *Self-audit (can use HCH or own tool)*
- ☐ *Quality improvement/Plan; Do; Study; Act (PDSA)*
- ☐ *Policy/procedure/workflow*
- ☐ *Internal assessment*
- ☐ *Patient survey*
- ☐ *Other (describe below)* _____

Optional Narrative _____

Upload any supporting documentation

Upload file

Level 2 Requirements – None

This area of the HCH standards does not have any Level 2 requirements.

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Tab: Shared Decision-Making

Care Team and Patient Panels | Care Coordinators | Documentation | **Shared Decision-Making** | Community Partnerships | Top of Licensure | Care Transitions

Foundational Level Requirements – Recertification

Foundational Level – Recertification Requirement: by the first recertification or if certifying at Level 2 or Level 3, the certified health care home must meet the following additional requirement

Provide patients with the opportunity to fully engage in care planning and shared decision-making. Solicit and document patient feedback.

How does the clinic involve patients in care planning and shared decision-making that actively engages them and respects personal health goals? (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *Techniques such as Motivational Interviewing / Health coaching*
- ☐ *Workflows reflect shared decision making*

- ☐ *Shared Decision Making tools (or decision aids)*
- ☐ *Policies referring to Patient and Family Centered Care*
- ☐ *Job descriptions with reference to engaging patients*
- ☐ *Assess individual/family needs*
- ☐ *Education programs*
- ☐ *Patient access to medical records/patient portal*
- ☐ *Clinic-wide patient engagement workflow*
- ☐ *Other (describe below)* _____

Optional Narrative _____

What process does the clinic use to obtain and document feedback from patients regarding their role in their own care? (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *Patient questionnaires/surveys*
- ☐ *Patient stories affirming opportunities to engage*
- ☐ *Assess patient activation levels*
- ☐ *Quality Improvement/reaching patient goals*
- ☐ *Patient/family advisors*
- ☐ *Other (describe below)* _____

Optional Narrative _____

Upload patient stories (optional) - We welcome success stories from your staff and patients regarding patient feedback.

Upload optional file

Level 2 Requirements – None

This area of the HCH standards does not have any Level 2 requirements.

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Tab: Community Partnerships

Foundational Level Requirements – Recertification

Foundational Level – Recertification Requirement: by the first recertification or if certifying at Level 2 or Level 3, the certified health care home must meet the following additional requirement:

Identify and work with community-based organizations and public health resources to facilitate the availability of appropriate resources for patients.

Briefly describe an ongoing partnership with at least one community resource that benefits patients. _____

Level 2 Requirements

Progression to Level 2 also requires: Support ongoing coordination of care and follow-up with partners by sharing information.

How does the clinic(s) coordinate care and share information with community partners? (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *Care team meetings/case reviews with partners*
- ☐ *Closed loop referral and follow-up processes*
- ☐ *Technology supported community referral platform that supports the tracking of referral outcomes (e.g. NowPow or Healthify)*
- ☐ *Systems integration with EMR (i.e. integrated portal)*
- ☐ *Expanded health information exchange/increased interoperability*
- ☐ *Community-based care coordination infrastructure (e.g. Pathways Hub)*
- ☐ *Other (describe below)* _____

Optional Narrative _____

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Tab: Top of Licensure

Foundational Level Requirements

Foundational Level – Recertification Requirement: by the first recertification or if certifying at Level 2 or Level 3, the certified health care home must meet the following additional requirement:

Permit and encourage team members to work at a level that fully uses their licensure, training, and skills.

Provide ***one*** of the following

- ☐ *Briefly describe how the care team model encourages team members to work at the top of their roles/skills (describe below) _____*
- ☐ *Briefly describe an example of workflow implementation where employees were given an opportunity to work at a level that fully uses their education; training; and skills (describe below) _____*
- ☐ *Upload a responsibility workflow; swim lane or a job description that demonstrates care team members fully uses their training and skills (upload below)*

Level 2 Requirements – None

This area of the HCH standards does not have any Level 2 requirements.

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Tab: Care Transitions

Care Team and Patient Panels | Care Coordinators | Documentation | Shared Decision-Making | Community Partnerships | Top of Licensure | Care Transitions

Foundational Level Requirements – Recertification

Foundational Level – Recertification Requirement: by the first recertification or if certifying at Level 2 or Level 3, the certified health care home must meet the following additional requirement:

Engage patients in planning for transitions among providers and between life stages.

Provide **one** of the following

- ☐ *Briefly describe how your clinic engages patients in transitions across care settings; through life stages; or circumstances (describe below) _____*
- ☐ *Upload a process/workflow/policy document that indicates patient engagement in transitions of care (upload below)*

Level 2 Requirements

Progression to Level 2 also requires:

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

What processes are in place to improve care transitions that reduce readmission, adverse events, and unnecessary emergency department utilization? (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *In-home visits to provide discharge follow-up and transitional care support*
- ☐ *Tele-monitoring to provide discharge follow-up and transitional care support*
- ☐ *Risk stratification tools or risk assessments to determine appropriate follow-up (describe below)* _____
- ☐ *CMS Transitional Care Management Services (TCM)*
- ☐ *Medication and prescription management*
- ☐ *Refer to intensive care coordination*
- ☐ *Post-discharge appointment within 7 days or a telephonic/ other electronic contact within 3 days from discharge*
- ☐ *Other (describe below)* _____

Optional Narrative _____

Briefly describe how you measure and track progress on improving care transitions **OR** share a quality improvement initiative aimed at improving care transitions

- ☐ *Briefly describe how you measure and track progress on improving care transitions (describe below)* _____
- ☐ *Share a quality improvement initiative aimed at improving care transitions (describe below)* _____

Optional file upload

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Portal Form: Standard Four – Care plan

Care Plan Strategies | Integrate Pertinent Information

Tab: Care Plan Strategies

Foundational Level Requirements

At a minimum, the following care plan strategies must be in place *for the subpopulation of patients receiving intensive care coordination*. Although clinics may also use these strategies to engage and support other patient populations or even the entire patient population as a part of standard work, this HCH standard and its corresponding requirements is specific to the subpopulation of patients receiving care coordination.

1. Provides patients with information from their personal 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.
2. Offers documentation of any collaboratively developed patient-centered goals and action steps, including resources and supports needed to achieve these goals, when applicable. Pertinent information related to whole person care needs or other determinants of health are included.
3. Uses advance care planning processes to discuss palliative care, end-of-life care, and complete health directives, when applicable. Provides the care team with information about the presence of a health care directive and provides a copy for the patient/family.
4. Uses evidence-based practice guidelines to inform these strategies when available.

*1) How does the clinic provide patients with information from their clinic visit/s? (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *After-visit summary*
- ☐ *Care plan*
- ☐ *Action plan*
- ☐ *Electronic/patient portal*
- ☐ *Other (Describe below)* _____

Optional Narrative _____

This information includes at least the following elements

*Relevant clinical details

- ☐ *Yes*

☐ *No*

*Health maintenance and preventative care instructions

☐ *Yes*

☐ *No*

*Chronic condition monitoring instructions, including indicated early intervention steps and plans for managing exacerbations, as applicable

☐ *Yes*

☐ *No*

*Upload supporting documentation (such as a template of an after-visit summary) to verify this

Upload File

*2) Briefly describe the process OR upload a policy/procedure document that describes how your clinic offers documentation of any collaboratively developed patient-centered goals and action steps, including resources and supports needed to achieve these goals, to any patients who want to receive this information or for whom it may be a beneficial strategy to engaging them in their care

☐ *Describe the process* _____

☐ *Upload*

*Upload a de-identified example or other supporting documentation that would provide an example for how this looks at your clinic

Upload File

*3) How does the clinic incorporate advance care planning processes into patient care? (check all that apply and provide additional details as needed in the narrative box below)

☐ *Annual Medicare wellness visits*

☐ *Coordination with palliative/hospice care*

☐ *Health care directives*

☐ *Provider orders for life-sustaining treatment*

☐ *Other (describe below)* _____

Optional Narrative _____

*The care team has information about the presence of a health care directive, if applicable

- ☐ *Yes*
- ☐ *No*

*Patients/families are provided copies of health care directive, if applicable

- ☐ *Yes*
- ☐ *No*

*4) What evidence-based practice guidelines inform the clinic's care plan strategies (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *Recommendations from the US Preventive Services Task Force*
- ☐ *Institute for Clinical Systems Improvement guidelines*
- ☐ *America Academy of Family Physicians guidelines*
- ☐ *System-wide guidelines developed internally*
- ☐ *Other (describe below)* _____

Optional Narrative _____

Level 2 Requirements – None

This area of the HCH standards does not have any Level 2 requirements.

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Tab: Integrate Pertinent Information

Care Plan Strategies | Integrate Pertinent Information

Foundational Level Requirements – Recertification

Foundational Level – Recertification Requirement: by the first recertification or if certifying at Level 2 or Level 3, the certified health care home must meet the following additional requirement:

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 individual patient needs and circumstances.

Describe the process **OR** upload a policy/procedure document that describes how your clinic integrates pertinent medical, medical specialty, quality of life, behavioral health, community-based services, and other external care plans into care planning strategies to meet individual patient needs and circumstances.

- ☐ *Describe the process* _____
- ☐ *Upload*

Upload a de-identified example or other supporting documentation that would provide an example for how this looks at your clinic.

Upload File

Level 2 Requirements – None

This area of the HCH standards does not have any Level 2 requirements.

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Portal Form: Standard Five – Performance reporting and quality improvement

Tab: Quality Improvement (QI)

Quality Improvement (QI) | Performance Measurement | HCH Learning Collaborative | Participation in SQRMS | Continuous QI | HCH Benchmarking

Foundational Level Requirements: Establishing a quality improvement team

Establish 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:

- one or more personal clinicians who deliver services within the health care home
- one or more care coordinators
- two or more patient representatives who were provided the opportunity and encouraged to participate; and
- one or more representatives from clinic administration or management

*Which staff roles serve as a member to the HCH quality improvement team? (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *Primary care clinician/s*
- ☐ *Care coordinator/s*
- ☐ *Administration/Clinic manager*
- ☐ *Patient/Family*
- ☐ *Other (describe below)* _____

Optional Narrative _____

If patients are not on the HCH quality improvement team, briefly describe the process for involving patients/families in HCH operations and quality improvement efforts _____

*Briefly describe **OR** upload document that describe quality improvement structure within the organization/clinic

- ☐ *Describe* _____
- ☐ *Upload [document]*

Level 2 Requirements

Progression to Level 2 also requires:

Recruit, promote, and support patient representation to the health care home quality improvement team that reflects the diversity of the patient population.

List the patient/family representation on the quality team and how they reflect the diversity of the patient population _____

If applicable, describe other ways that enable patient/family participation and feedback on the clinic(s) quality and operations: (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *focus groups*
- ☐ *orientation; job description; or other strategies to prepare patients/families to be advisors and participate in decision-making at the clinic(s)*
- ☐ *participation through telephone; electronic messaging; or virtual meetings*
- ☐ *patient/family representation to other clinic operations teams and/or on interview panels*

- ☐ *Other (describe below _____)*

Optional Narrative _____

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Foundational Level Requirement: Sharing quality improvement work

Establishes procedures for the team to share quality improvement work within the clinic and elicit feedback from team members and other staff.

*How does the system/clinic(s) share quality improvement work and elicit feedback with all staff in the health care home: (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *Routine team huddles*
- ☐ *Electronic Medical Record dashboards*
- ☐ *Visual management board*
- ☐ *Routine team meetings*
- ☐ *Intranet or email*
- ☐ *Other (describe below) _____*

Optional Narrative _____

*How does your system/clinic(s) share about quality improvement work with patients/families: (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *Display in waiting rooms and/or patient rooms*
- ☐ *Public website*
- ☐ *Newsletters*
- ☐ *Other (describe below) _____*

Optional Narrative _____

Level 2 Requirements

Progression to Level 2 also requires:

Establish procedures to share about work on health equity within the clinic and elicit feedback from team members and other staff.

Do the communication mechanisms used to share about and elicit feedback from staff about quality improvement work intentionally include work that advances health equity or addresses a health disparity within the clinic?

- ☐ *Yes*
- ☐ *No*

Do the communication mechanisms used to share about quality improvement work with patients/families intentionally include work that advances health equity or addresses a health disparity?

- ☐ *Yes*
- ☐ *No*

If another mechanism(s) is used to share about quality improvement work that advances health equity or addresses a health disparity within the clinic, or to provide opportunities for feedback/input, briefly describe or list the other communication processes _____

Level 3 Requirements

Progression to Level 3 also requires:

Communicate and share about work on population health improvement and elicit feedback from team members, other staff, and community members.

Do the communication mechanisms used to share about and elicit feedback from staff about quality improvement and advancing health equity work intentionally include work on population health improvement?

- ☐ *Yes*
- ☐ *No*

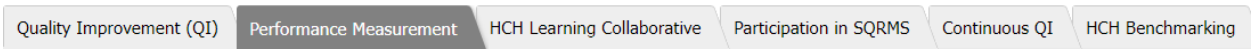
Do the communication mechanisms used to share about quality improvement work with patients/families/community members intentionally include work on population health improvement?

- ☐ *Yes*
- ☐ *No*

If another mechanism(s) is used to share about population health improvement, or to provide opportunities for feedback/input, briefly describe or list the other communication processes

_____

Tab: Performance Measurement



Foundational Level Requirements – Initial Certification only

Foundational Level – Complete this tab at Initial Certification only. If you are recertifying or certifying at Level 2 or Level 3 you may skip this tab:

The HCH's capacity to conduct continuous quality improvement will be validated in other areas of the application at recertification.

Measures, analyzes, and tracks changes in at least one quality indicator.

Is this your first time certifying as a Health Care Home and if so, are you seeking Foundational level certification for all of your clinics? (If "No" is chosen, no further action is required.)

- ☐ *Yes*
- ☐ *No*

If yes, The quality team measures, analyzes, and tracks changes in at least one quality indicator and will provide an overview of the HCH's quality improvement work to demonstrate this at the site visit

- ☐ *Yes*
- ☐ *No*
  - If yes, Which quality indicator(s) are you tracking, and what is your specific goal?

    _____

Optional: upload supporting documentation to demonstrate quality improvement work

Level 2 Requirements – None

This area of the HCH standards does not have any Level 2 requirements.

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Tab: HCH Learning Collaborative

Quality Improvement (QI) | Performance Measurement | **HCH Learning Collaborative** | Participation in SQRMS | Continuous QI | HCH Benchmarking

Foundational Level Requirements: Participation

Participates in the HCH learning collaborative through care team members that reflect the clinic structure that may include clinicians, care coordinators, other care team members, administration or management, and patients.

*Designated staff know about the MDH HCH learning collaborative and receive MDH HCH communications about the opportunities available.

- ☐ *Yes*
- ☐ *No*

*Have any staff had the opportunity to participate in the MDH HCH learning collaborative?

- ☐ *Yes*
- ☐ *No*

  *If yes, please provide any comments or feedback you have about the MDH HCH learning collaborative and its activities (i.e., those you find of most value for your team, ideas for future opportunities, etc.) _____

Level 2 Requirements – None

This area of the HCH standards does not have any Level 2 requirements.

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Foundational Level Requirements: Sharing information

Establishes procedures for representatives to share information from learning collaborative(s) and elicit feedback.

*How does your system/clinic(s) share about information learned from the MDH HCH learning collaborative activities with other HCH care team members and staff: (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *Routine team meetings*
- ☐ *Email or intranet*
- ☐ *Other (describe below)* _____

Optional Narrative _____

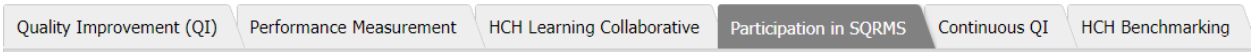
Level 2 Requirements – None

This area of the HCH standards does not have any Level 2 requirements.

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Tab: Participation in SQRMS



Foundational Level Requirements – Recertification

Foundational Level – Recertification Requirement: by the first recertification or if certifying at Level 2 or Level 3, the certified health care home must meet the following additional requirement:

Participate in the Statewide Quality Reporting and Measurement System (SQRMS) as required by MDH.

Our clinic(s) participates in the Statewide Quality Reporting and Measurement System (SQRMS) and submits data as prescribed by the Commissioner of Health.

- ☐ *Yes*
- ☐ *No*

*If not, provide a brief description as to why _____

*If no, Has your organization requested and been granted a variance from the Minnesota Department of Health (MDH) Statewide Quality Reporting and Measurement System (SQRMS) for those aspects in which your clinic(s) did not participate?

- ☐ *Yes*
- ☐ *No*

Optional to upload supporting documentation (i.e., verification letter) from MDH SQRMS:

Level 2 Requirements – None

This area of the HCH standards does not have any Level 2 requirements.

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Tab: Continuous QI

Quality Improvement (QI) | Performance Measurement | HCH Learning Collaborative | Participation in SQRMS | Continuous QI | HCH Benchmarking

Foundational Level Requirements

Foundational Level – Recertification Requirement: by the first recertification or if certifying at Level 2 or Level 3, the certified health care home must meet the following additional requirement:

Measure, analyze, and track at least one quality indicator in each of the following categories during the previous year:

- Improvement in patient health
- Quality of patient experience
- Measures related to cost effectiveness of services

The quality team measures, analyzes, and tracks changes and progress in at least one quality indicator in each of the triple aim components during the previous year and will provide an overview of the HCH's quality improvement work to demonstrate this at the team meeting. (Please see the guide in Appendix E of COMPASS for expectations in leading a quality improvement and performance benchmarking presentation and discussion at the team meeting. A quality report template is available on the HCH website for use as desired)

1) Improvement in patient/population health

- ☐ *Yes*
- ☐ *No*

  If yes, What are your patient/population health (or quality) goals or priorities? _____

2) Quality of patient experience

- ☐ *Yes*
- ☐ *No*

  If yes, What are your patient experience goals or priorities? _____

3) Measures related to cost effectiveness of services

- ☐ *Yes*
- ☐ *No*

If yes, What are your cost effectiveness (or finance) goals or priorities? _____

QI Work - File Upload

Do you use a standardized tool to capture patient experience?

- ☐ *Yes*
- ☐ *No*

*If yes, which one?

Level 2 Requirements

Progression to Level 2 also requires:

1) Uses information and population health data about the community served to inform organizational strategies and quality improvement plans

2) Measures, analyzes, tracks, and addresses health disparities within the clinic population through continuous improvement processes.

What sources of community and population health data does your organization/clinic(s) use to inform its strategic planning, HCH operations, or quality improvement initiatives. (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *hospital and health system community health needs assessment*
- ☐ *Health Resources and Services Administration (HRSA) health center needs assessment*
- ☐ *local public health community health assessment*
- ☐ *health plan data*
- ☐ *school district data*
- ☐ *health equity data analysis*
- ☐ *Certified Community Behavioral Health Clinic (CCBHCs) community needs assessment*
- ☐ *County Health Rankings*
- ☐ *Other (describe below)* _____

Optional Narrative _____

Briefly describe at least one example of how community and population health data has impacted or contributed to organizational strategies and quality improvement. How does this data inform care, target interventions, track population health or induce community partnerships? _____

Optional upload

The quality team measures, analyzes, and tracks changes and progress in at least one quality indicator that addresses health disparities during the previous year and will provide an overview of the HCH's quality improvement work to demonstrate this at the team meeting (Please see the guide in Appendix E of COMPASS for expectations in leading a quality improvement and performance benchmarking presentation and discussion at the team meeting).

- ☐ *Yes*
- ☐ *No*

  If yes, What health disparities have you identified and what are your goals? _____

Optional: upload supporting documentation that demonstrates quality improvement work to advance health equity and address a health disparity

Level 3 Requirements

Progression to Level 3 also requires:

Contribute to a coordinated community health needs assessment and population health improvement planning process by:

- sharing aggregated information or de-identified data that describes health issues and inequities;
- prioritizing population health issues in the community and planning for population health improvement in collaboration with community partners;
- implementing and monitoring progress of the population health improvement plan using shared goals and responsibility.

Which partners and/or community-based assessment processes has your organization/clinics(s) shared aggregated information or de-identified data with? (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *hospital and health system community health needs assessment process*
- ☐ *Health Resources and Services Administration (HRSA) health center needs assessment process*
- ☐ *local public health community health assessment process*
- ☐ *Other (describe below)* _____

Optional Narrative _____

What types of information or data is being shared? (check all that apply and provide additional details as needed in the narrative box below)

- ☐ *demographic information about patient population*
- ☐ *disease or risk factor prevalence*
- ☐ *receipt of preventative care/recommended services*
- ☐ *health disparities in patient population*
- ☐ *prevalence of social determinants of health factors in patient population*
- ☐ *information about unmet referral needs/access to community-based resources to meet the whole person care needs of the patient population*
- ☐ *Other (describe below)* _____

Optional Narrative _____

Do you have a formal agreement in place, such as a data sharing agreement or memorandum of understanding, to share information and/or data with partners? (NOT REQUIRED, but requested for our informational/learning purposes)

- ☐ *Yes*
- ☐ *No*

The organization/clinic(s) collaborates with community partners to measure and prioritize population health issues and plan for population health improvement and will provide an overview to demonstrate this at the team meeting (Please see the guide in Appendix E of COMPASS for expectations in leading a quality improvement and performance benchmarking presentation and discussion at the team meeting).

- ☐ *Yes*
- ☐ *No*

  If yes, What are the population health issues that you and your partners have identified and what are your goals? _____

The organization/clinic(s) has shared responsibility in implementing and monitoring progress of the population health improvement plan and will provide an overview to demonstrate this at the team meeting (Please see the guide in Appendix E of COMPASS for expectations in leading a quality improvement and performance benchmarking presentation and discussion at the team meeting).

- ☐ *Yes*
- ☐ *No*

Optional: upload supporting documentation that demonstrates population health improvement planning and implementation.

Tab: HCH Benchmarking

Quality Improvement (QI) | Performance Measurement | HCH Learning Collaborative | Participation in SQRMS | Continuous QI | HCH Benchmarking

Foundational Level Requirements – Recertification

Foundational Level – Recertification Requirement: by the first recertification or if certifying at Level 2 or Level 3, the certified health care home must meet the following additional requirement:

Use benchmarks to demonstrate accountability for outcomes in patient health, patient experience, and cost-effectiveness in the primary care services patient population and engage in process improvement to impact these outcomes. For more information, review the guide in Appendix E of COMPASS.

Reviewed the guide in Appendix E of COMPASS for expectations in leading a quality improvement and performance benchmarking presentation and discussion and will be prepared with this for the team meeting.

- ☐ *Yes*
- ☐ *No*

What measure set(s) does your organization use to assess its performance? Check all that apply.

- ☐ *Minnesota Statewide Quality Reporting and Measurement System (SQRMS)*
- ☐ *Health Resources and Services Administration (HRSA) Uniform Data System (UDS)*
- ☐ *Government Performance and Results Act (GPRA)*
- ☐ *Other (describe below)* _____

Which benchmarks does your organization use to assess its performance? Check all that apply. (Benchmarks are measurement targets used to assess or compare performance in order to identify opportunities for improving quality, cost-effectiveness, and patient experience)

- ☐ *Statewide averages/rates*
- ☐ *Expected rates*
- ☐ *Percentage of improvement from a previous point of measurement*

- ☐ *Highest performing clinic*
- ☐ *Highest performing clinician/provider*
- ☐ *Targets set by an ACO or payer group (list the specific group/s) _____*
- ☐ *Other (describe below) _____*

Optional: Upload supporting documentation that demonstrates your organizations use of benchmarks, such as reports, screenshots of dashboards, or other tools used.

Level 2 Requirements – None

This area of the HCH standards does not have any Level 2 requirements.

Level 3 Requirements – None

This area of the HCH standards does not have any Level 3 requirements.

Portal Form: Attestation and submission

Tab: Page 1

Attestation

Is there anything else that you would like to share with the HCH program that was not previously asked? _____

The eligible provider seeking health care homes certification or recertification has read and agrees to voluntarily:

- Meet all health care homes standards and criteria, and processes for certification and recertification.
- Accept the responsibility to orient new clinicians and staff to the health care home's care delivery approach
- Maintain policies and procedures that establish privacy and security protections of health information and comply with applicable privacy and confidentiality laws.
- Notify the Commissioner of the Minnesota Department of Health and the Health Care Homes program by written notice if he or she wishes to voluntarily surrender health care home certification.

All information provided in this application is complete, true, and accurate to the best of my knowledge.

Under the eligible provider's articles of incorporation, bylaws, or resolution of the board of directors, I am authorized to submit this application on behalf of the organization and bind it.

*Authorize

- ☐ *Agree*
- ☐ *Disagree*

*Name _____

*Title _____

*eSignature (Enter password used to log into HCH portal)

Username: _____

Password: _____

*Date _____

Certification/Recertification Levels

*Which of the following best describes your organization?

- ☐ *All of our clinics are certifying/recertifying at the Foundational level*
- ☐ *At least one of our clinics is certifying/recertifying at Level 2*

  If this is checked, Are all clinics in your organization certifying/recertifying at Level 2?

  - ☐ *Yes*
  - ☐ *No*

    If No is checked, Would you prefer to list which clinics will be remaining Foundational and which will be progressing to Level 2, **OR** upload a document containing this information?

  - ☐ *List* _____

- ☐ *Upload*

- ☐ *At least one of our clinics is certifying/recertifying at Level 3*

  If this is checked, Would you prefer to list which clinics are remaining Foundational, which will be progressing to Level 2, and which to Level 3? **Or** would you rather upload a document containing this information?

  - ☐ *List* _____
  - ☐ *Upload*

*We are certifying more than one clinic.

- ☐ *Yes*
- ☐ *No*

  If yes, How do you ensure these clinics are meeting all HCH certification/recertification requirements? _____