DEPARTMENT OF HEALTH

Introducing: Health Care Homes New Progression Model and Portal

October 19, 2022

Noon – 1:00 p.m.

Via Webex

MINNESOTA HEALTH CARE HOMES

Please turn off your mic and video

Enter your name and organization in the chat/conversation

Welcome and Agenda Review

- Greetings!
- Our Big News – Rule Amendment, Progression Model and New Portal
- What It Means to You
- Questions/Comments/Discussion

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The Rule and HCH Progression Model

Tina Peters | Integration Specialist

Health Care Home Model

A care delivery approach in which primary care providers, patients, families, and community partners work together to improve…

- Health Outcomes
- Patient Experience
- Value of Care

HCH certification is Minnesota's version of what is nationally known as a Primary Care Medical Home (PCMH) or advanced primary care model.

HCH Progression Model

- In 2016, the Health Care Homes program began the process of proposing a new framework for its care delivery model, building on foundational Health Care Homes standards to add two additional levels of certification.
- The purpose of the HCH progression model framework is to recognize clinics that are advancing primary care models to **reduce disparities**, **improve value**, and **address population health** to advance primary care.

HCH Progression Model

The HCH rule amendments were effective 10/8/2022. HCH statutes and rule links can be found on our MDH HCH website.

HCH Progression Model

Current standards

Foundational

- Focus on team-based patient-centered care

Progression level 2

Accountable Care for Populations

- Screening and addressing for social needs
- Enhanced access to care
- Integrated care teams
- Addresses health disparities and advances equity
- Strengthened community partnerships

Progression level 3

Community Integrated Health Care

- Contribute to a community health needs assessment and population health improvement planning process
- Share responsibility in implementing and monitoring the progress of community health improvement efforts

Health Care Home Standards

- Standard 1: Access and Communication
- Standard 2: Patient Registry and Tracking
- Standard 3: Care Coordination
- Standard 4: Care Plan
- Standard 5: Performance Reporting and Quality Improvement

Standard 1: Access and Communication

Foundational	Level 2	Level 3
Requires clinics to have strategies for population and care management, deliver services that facilitate ongoing communication with the patient and the patient's family and provide care when patients need it.	Directs the HCH to use information about SDOH in population and care management, offer more flexible options to access care, and promote patient engagement.	No Level 3 requirement

Standard 2: Patient Registry and Tracking

Foundational	Level 2	Level 3
Requires clinics to maintain a patient registry, enabling the HCH to readily access clinically useful information that can be used to manage health care services, provide appropriate follow-up, and identify gaps in care for their patient population.	Adds data elements to a patient registry that incorporate social determinants of health, enabling the clinic to consider non-medical factors that affect the health risks and outcomes for their patient population.	No Level 3 requirement

Standard 3: Care Coordination

Foundational	Level 2	Level 3
Directs HCHs to have a system of care coordination focused on the patient and their family's needs.	Advance coordinated care systems, requiring a multidisciplinary care team to meet patient and family needs, ensuring information exchange, and implementing processes aimed at improving safety, reducing readmissions, and unnecessary ED utilization.	No Level 3 requirement

Standard 4: Care Plan

Foundational	Level 2	Level 3
Requires clinics to establish and implement policies and procedures to guide the identification and use of care plan strategies to engage patients in their care and to support self-management.	No Level 2 requirement	No Level 3 requirement

Standard 5: Performance Reporting & Quality Improvement

Foundational	Level 2	Level 3
Directs the HCH to engage in continuous improvement processes that focus on patient population health, patient experience, and the cost-effectiveness of services.	Advances continuous improvement processes to use community health data, address health disparities, and ensure that patient feedback reflects the diversity of the patient population and includes underrepresented voices.	Broadens the focus from the clinic population to include community health through requirements to participate and share responsibility in community-based health improvement efforts.

Questions

Questions?

Comments?

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The New Portal and Application Process

Jennifer Strickland | Practice Improvement Specialist

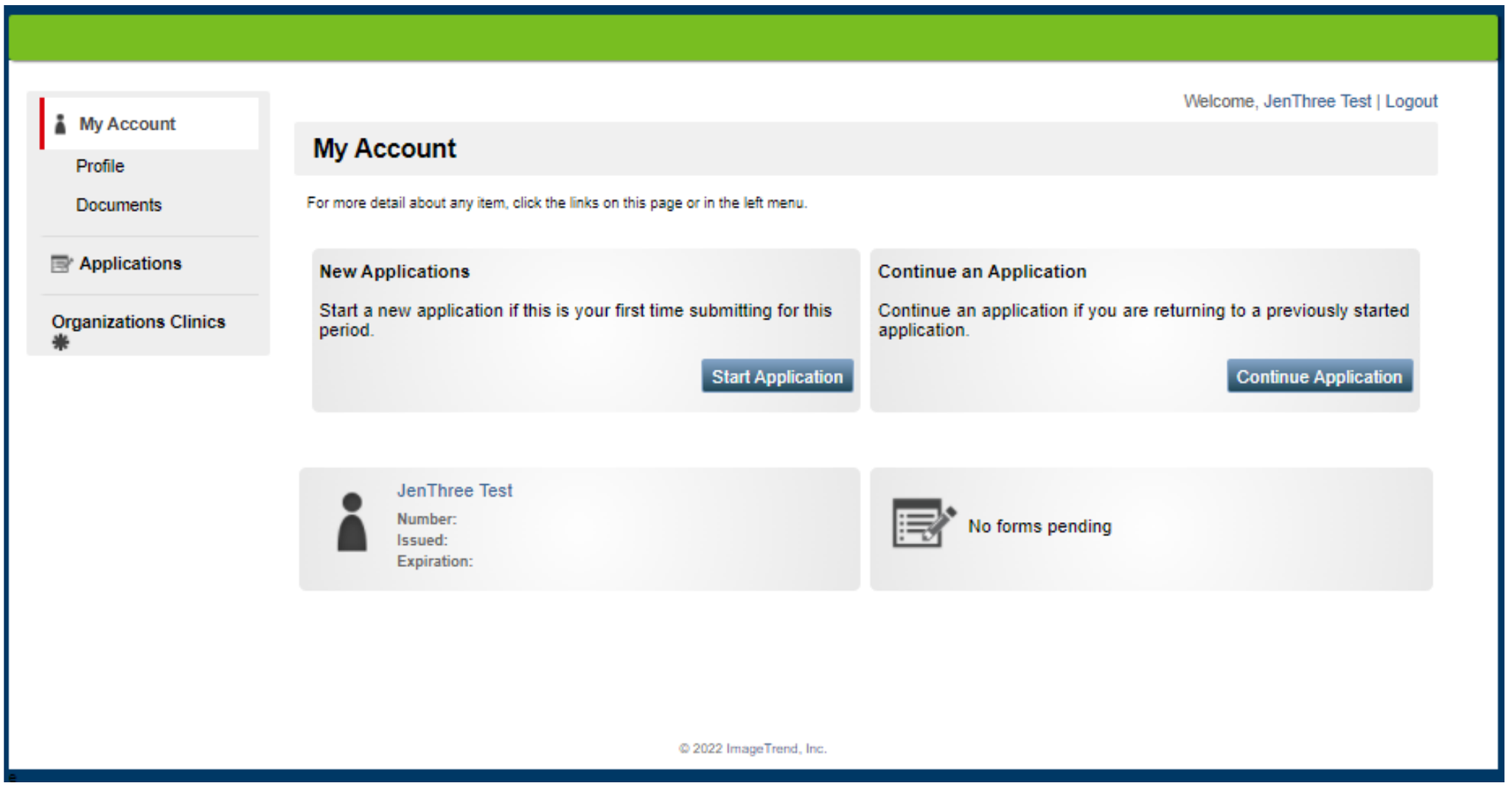
Stakeholder Feedback

- More stream-lined
- Less duplication
- Use of plain language
- Less narrative, more check boxes
- Less time to complete
- Easy to navigate
- Valuable resources

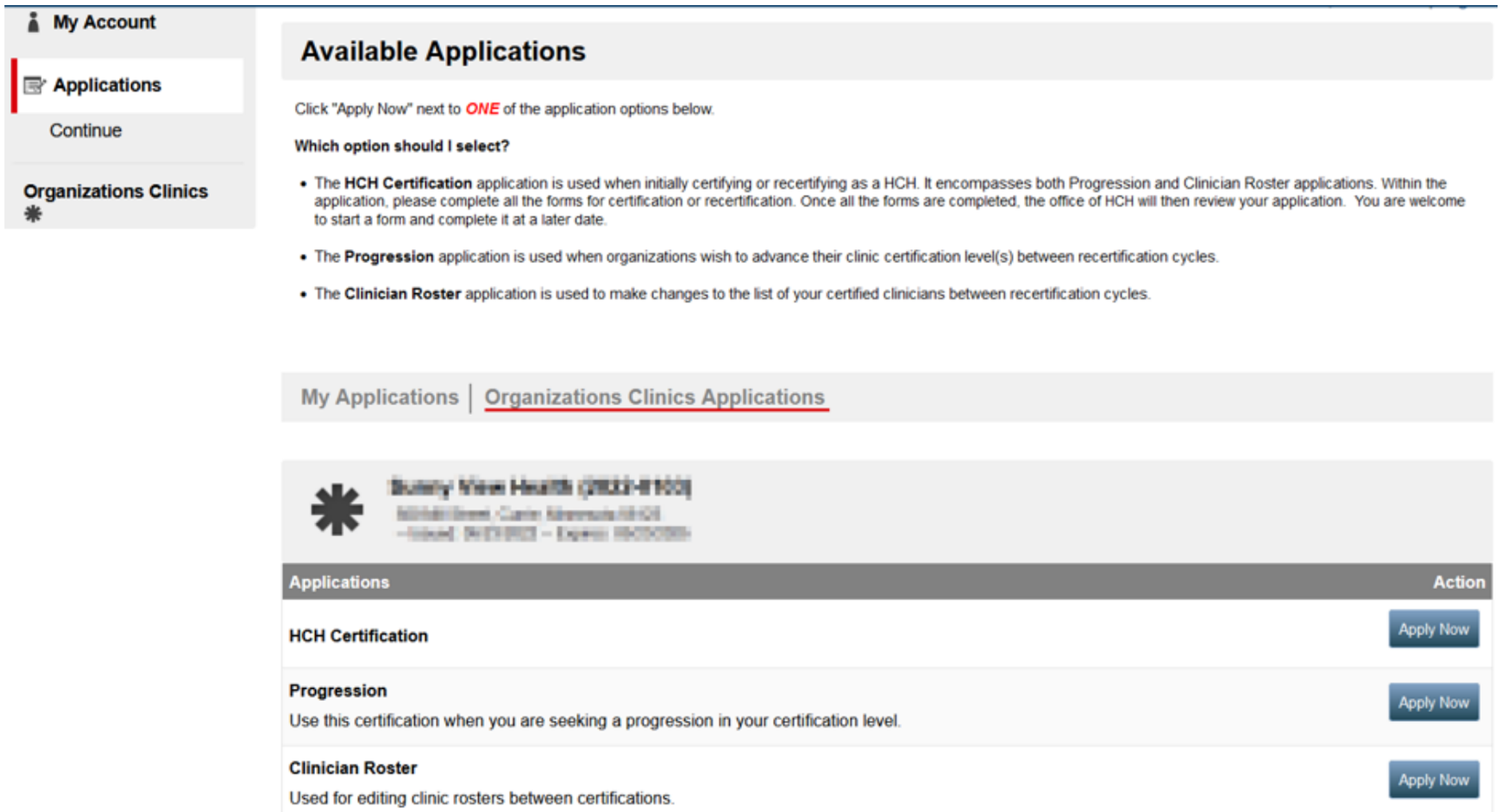
HCH Applications

- HCH Certification
- Progression
- Clinician Roster

HCH Portal Landing Page



Selecting an Application



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Selecting an Application

Available Applications

Click "Apply Now" next to ***ONE*** of the application options below.

Which option should I select?

- The **HCH Certification** application is used when initially certifying or recertifying as a HCH. It encompasses both Progression and Clinician Roster applications. Within the application, please complete all the forms for certification or recertification. Once all the forms are completed, the office of HCH will then review your application. You are welcome to start a form and complete it at a later date.
- The **Progression** application is used when organizations wish to advance their clinic certification level(s) between recertification cycles.
- The **Clinician Roster** application is used to make changes to the list of your certified clinicians between recertification cycles.

HCH Application Options

Applications	Action
HCH Certification	Apply Now
Progression Use this certification when you are seeking a progression in your certification level.	Apply Now
Clinician Roster Used for editing clinic rosters between certifications.	Apply Now

HCH Certification Application

HCH - Standard			
Form	**Requested**	**Completed**	**Action**
Standard One - Access and Communication	Jan 13, 2022		Start
Standard Two - Patient Registries and Tracking Patient Care	Jan 13, 2022		Start
Standard Three - Care coordination	Jan 13, 2022		Start
Standard Four - Care plan	Jan 13, 2022		Start
Standard Five - Performance reporting and quality improvement	Jan 13, 2022		Start
Attestation and submission	Jan 13, 2022		Start
Additional Forms			
Form	**Requested**	**Completed**	**Action**
Organization Demographics	Jan 13, 2022	Jan 13, 2022	View PDF

Standards and Requirements

Standard One - Access and Communication

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

Sample Question

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

- [x] 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
- [x] Hospital staff assumes after-hours access
- [ ] On-call staff assume after-hours coverage
- [ ] Other (describe below)

Optional Narrative

Options

*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

Upload deidentified screenshot

Upload File

Name

Screenshot

Document Type

Supporting Documents

Level Progression within a Certification Application

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

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

Level 3 Requirements

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

Progression Application Forms

Progression			
Form	**Requested**	**Completed**	**Action**
Clinic Progression	May 12, 2022	May 12, 2022	View PDF
Standard One: Levels 2 & 3 - Access and Communication	May 12, 2022		Continue
Standard Two: Levels 2 & 3 - Patient Registries and Tracking Patient Care	May 12, 2022		Start
Standard Three: Levels 2 & 3 - Care coordination	May 12, 2022		Start
Standard Five: Levels 2 & 3 - Performance reporting and quality improvement	May 12, 2022		Start
Attestation and submission: Progression	May 12, 2022		Start

Clinician Roster

Roster

Organization Clinicians Roster

Edit Organization Clinician Roster

I. Click the "Download Clinicians Roster" button (below) 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 auto-filled by MDH based on your certification cycle

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

Download Clinicians Roster | Import Clinicians Roster

Submit

Recommended Next Steps

- Review the updated HCH requirements
- Identify when you are due for Recertification
- Discuss as an organization if you would like to apply for Level Progression
- Reach out to your Practice Improvement Specialist or Integration Specialist with any questions, or for a portal demonstration.

QUESTIONS?

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RESOURCES

Joan Kindt | Practice Improvement Specialist

Guides and Tools

- **COMPASS** (Certification/recertification Operations Manual Providing Application Submission Support)
- **PUG** (Portal User Guide)
- **Application** tool

COMPASS Objectives

- Background
- Explanation
- Definitions
- Step by step process
- Resources

COMPASS Characteristics

- Ease of use
- Plain language
- Chronological progression
- Consistent visual cues
- Comprehensive support

COMPASS Contents

- Introduction
- How to use the guide
- Standards and Requirements
- Certification/Recertification Process
- Check-Ins
- Level Progression
- Variances and Recommendations
- Appendices

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Health Care Homes (HCH) COMPASS:

Certification/recertification Operations Manual Providing Application Submission Support

Contents

Introduction

Thank you for your interest in Health Care Homes (HCH) certification. HCH certification is a free and voluntary program that the Minnesota Department of Health (MDH) provides to primary care clinicians, clinics, and organizations committed to providing high quality, **patient and family centered care**. Health Care Homes is not a prescriptive framework. Each practice implements the standards based on its own unique characteristics, such as the size of the practice, location, and the patient population it serves.

Patient and family-centered care: planning, delivering, and evaluating health care through patient-driven, shared decision-making that is based on participation, cooperation, trust, and respect of patient perspectives and choices. It also incorporates the patient's knowledge, values, beliefs, and cultural background into care planning and delivery. Patient and family-centered care applies to patients of all ages.

How to Use the Guide

How to use this guide

Please reference this guide when preparing for HCH certification and recertification and when completing the HCH application which can be found online at the Public Portal (mn.gov).

The information provided in this guide is not intended as an all-inclusive list of the strategies clinics could employ to meet each standard. It offers guidance in making gradual and lasting changes and provides a structure around which to base primary care transformation efforts.

Navigation Notes – What this guide provides

- Narrative descriptions of each HCH standard
- Important definitions included in text boxes
- Overview of each of the requirements for Foundational Level, Level 2, and Level 3 certifications
- Actions to consider as your team works to transform care and practice
- Quick links to appendices that provide helpful information as you navigate the HCH certification and recertification process
- How to get help

Standards

The standards for certification cover five key areas to qualify as a patient-centered medical home. The standards align with the shared principles of primary care adopted by the national Primary Care Collaborative (Primary Care Collaborative, 2020).

1. Access and communication
2. Patient registry and tracking patient care activity
3. Care coordination
4. Care planning
5. Performance reporting and quality improvement

What Needs to be in Place

Requirement: Inform patients of choice in specialty care

Providing information about optimal treatment and care options shows support of patients' decisions, even when they choose care outside of the HCH delivery system.

What needs to be in place:

Foundational Level
Inform all patients of choice in specialty care and treatment options ✓ Referral processes at the clinic must support patient choice and allow for shared decision making to occur around specialty care options when needed ✓ Referral processes at the clinic should make the effort to provide patients with the information they need to make an informed choice, which often include financial implications
Level 2 Progression also requires
This area of the HCH standards does not have a Level 2 requirement
Level 3 Progression also requires
This area of the HCH standards does not have a Level 3 requirement

What needs to be in place: Recertification

What needs to be in place:

Recertification: Foundational Level - 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 participants. ✓ Such as: social services, transportation services, school-based services, and home health care services
Level 2 Progression also requires
Support ongoing coordination of care and follow-up with partners by sharing information. ✓ There can be various challenges and barriers to sharing information among external partners, including technical limitations, concerns with patient data privacy and security, and lack of organizational processes. ✓ Clinics progressing to Level 2 are required to be working to improve information sharing processes, while also considering what is within the HCH clinic scope and control.
Level 3 Progression also requires
This area of the HCH standards does not have a Level 3 requirement

COMPASS Appendices

- **Appendix A:** Levels of HCH Certification with requirements
- **Appendix B:** First Recertification Reporting Requirements
- **Appendix C:** On-going Recertification Reporting Requirements
- **Appendix D:** What to expect during an initial site visit
- **Appendix E:** What to expect during a recertification team meeting

Appendix A

Standard 1: Access and Communication

The health care home must have systems in place to support effective communication among members of the health care home team, the patient and family, and other providers by meeting the following requirements:

FOUNDATIONAL LEVEL	LEVEL 2	LEVEL 3
Offer health care home services to all the primary care services population that includes doing the following: (1) identify patients who have or are at risk of developing complex or chronic conditions (2) offer varying levels of coordinated care to meet the needs of the patient (3) offer more intensive care coordination for patients with complex medical and social needs	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.	No Level 3 requirement
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	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.	No Level 3 requirement

Portal User Guide (PUG)

Portal User Guide

Minnesota Department of Health (MDH) Health Care Homes (HCH) Certification and Recertification

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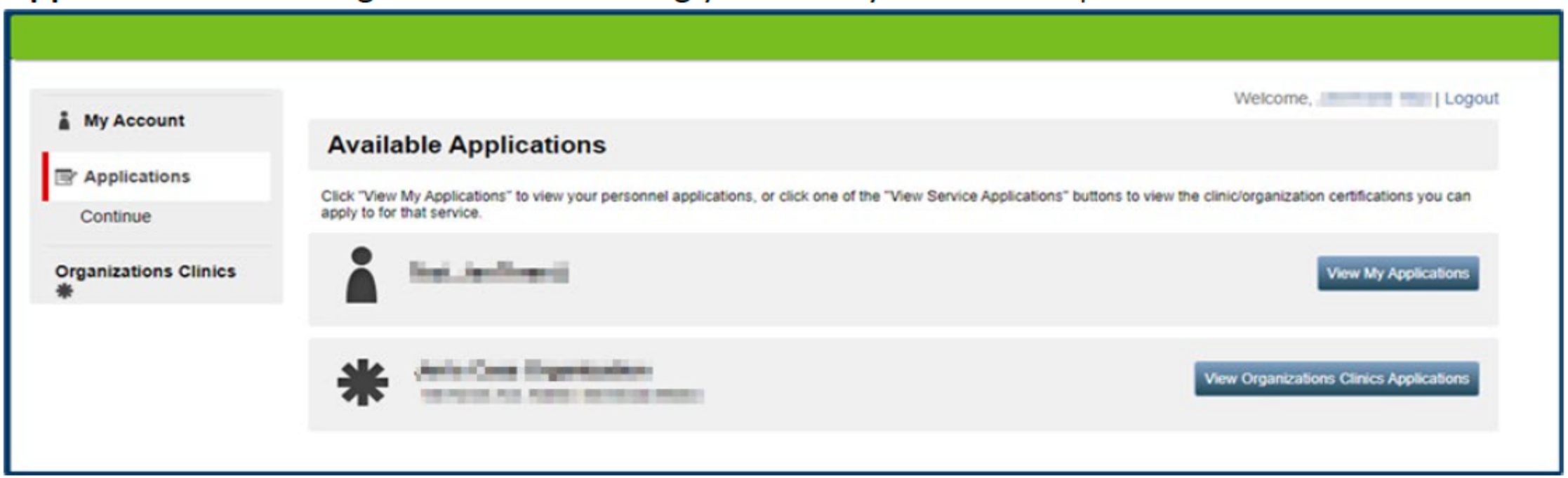
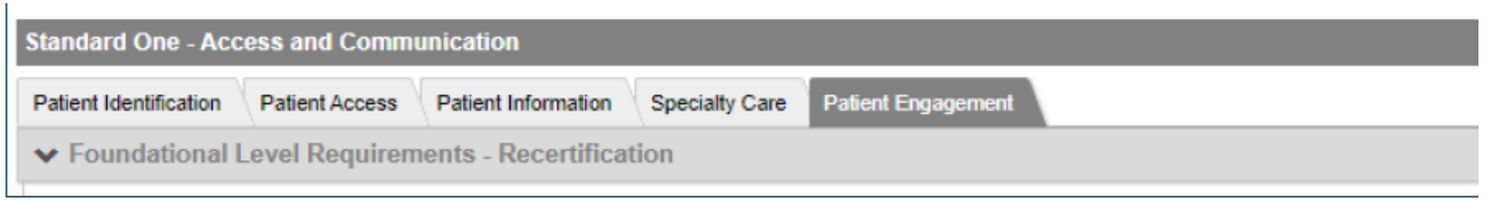
PUG Screen shot example

Applications

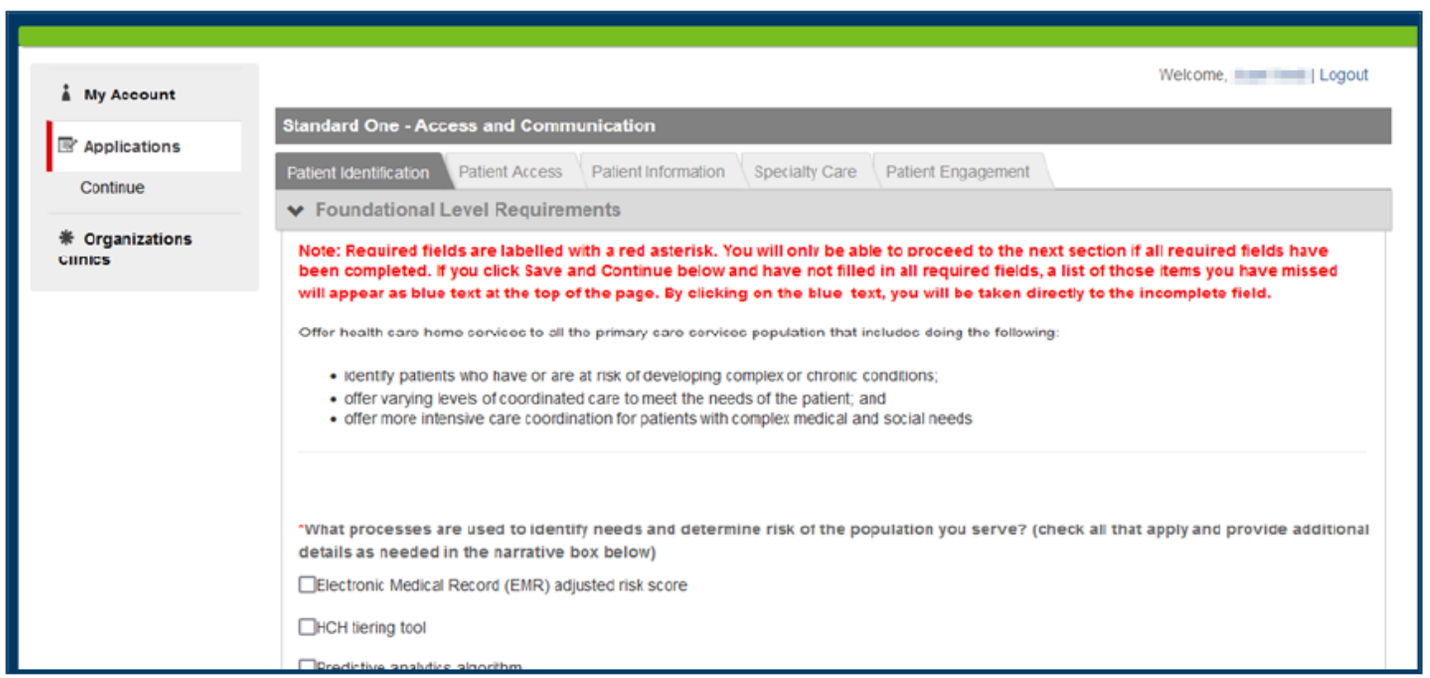
Applications is for viewing applications in progress or starting new ones. Notice the red line next to **Applications** in the navigational tools is telling you where you are in the portal.



On this page, there are two blue buttons on the right side of the screen. **View My Applications** is where *your* applications will be accessible to you in the future. If you have not yet completed an application, this will simply state **No Records** under the **Applications** heading, like this:



While you are answering the questions in each tab, note that important information will be in **red** throughout the application. Please read it carefully as it will provide direction and clarification.



The portal will guide you throughout. Here is another example in the Performance Measurement tab where instructions in **red** alert users to a unique instance in this requirement:

Health Care Homes (HCH) Application

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Application example

Tab: Care Coordinators

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

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 _____

Where?

Minnesota Care Coordination Effectiveness Study

Learning

News & Announcements

About Health Care Homes

Related Topics

DHS Behavioral Health Home Service

MDH Health Care Facilities, Providers and Insurance

MDH Health Equity

Redefining Health | Redesigning Care

WHAT IS A HEALTH CARE HOME?

A primary care clinic or clinician certified by the Minnesota Department of Health to coordinate care among the primary care team, specialists and community partners to ensure patient-centered whole person care and improve total health and well-being.

Certification & Recertification

Online HCH Application Portal

Certification

Recertification

Level Progression

Certified HCH Performance Measurement

Minnesota Care Coordination Effectiveness Study

MNCARES

News

News & Announcements

HCH Newsletter: *The Connection*

Subscribe to HCH Newsletter

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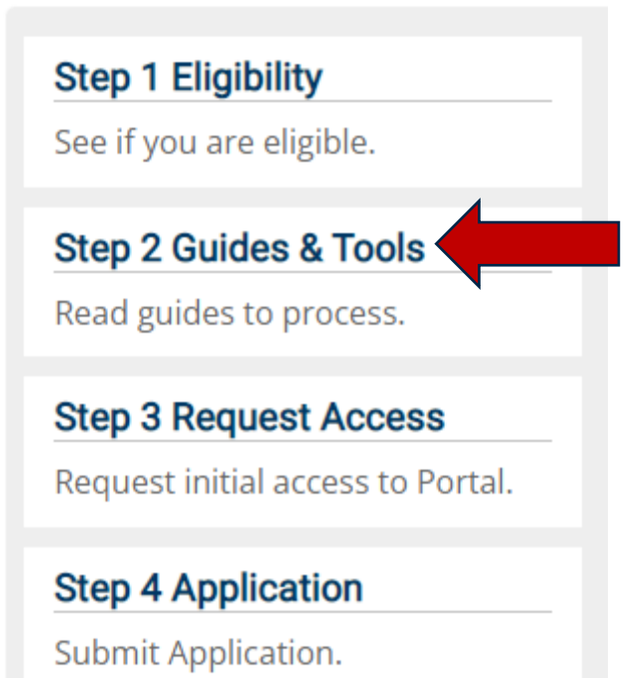
YouTube HCH Playlist

MINNESOTA HEALTH CARE HOMES

Questions?

Contact Health Care Homes at: Health.healthcarehomes@state.mn.us.

Guides and Tools



Step 2 Guides & Tools

Utilize the following resources as needed to assist you in preparing for the certification process. Your assigned Practice Improvement Specialist/Integration Specialist is also available to answer questions and provide ongoing support. If you are not aware of your assigned HCH staff, please email the HCH program at health.healthcarehomes@state.mn.us.

•COMPASS (PDF) outlines the requirements and standards for being a certified Health Care Home.

•

The Portal User Guide (PDF) provides step by step instructions for online documentation.

•

The HCH Application (PDF) may be downloaded for planning purposes.

•

The HCH Self-Audit Tool (PDF) may be used for internal process assessment.

•

Access the MDH Learning Center "Foundations of HCH Certification" course that takes organizations through the HCH certification and recertification process. Visit the **Health Care Homes Learning Collaborative MDH Learning Center webpage** for more information.

Learning

Minnesota Care Coordination Effectiveness Study

Learning

News & Announcements

About Health Care Homes

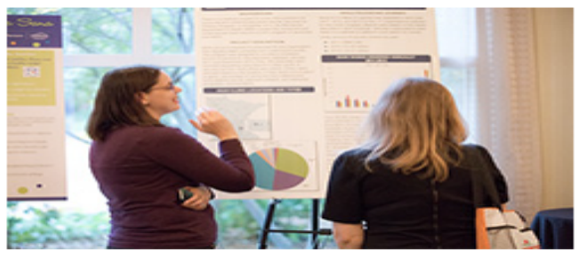
Related Topics

DHS Behavioral Health Home Service

MDH Health Care Facilities, Providers and Insurance

MDH Health Equity

Learning Collaborative



The Health Care Homes Learning Collaborative was established in 2008 as a part of Minnesota Health Reform Legislation to support primary care clinics seeking Health Care Homes certification and recertification.

The Learning Collaborative continues to provide learning opportunities to primary care clinics and their staff through a variety of modalities. Click on the link below to explore the options.

Learning Days

Conference based learning for certified Health Care Homes and community partners.

MDH Learning Center

Gateway to online courses, conferences, webinars and other resources.

LEARN Bulletin

Collaborative Learning for the Future of Health

Peer to Peer Events

Networking opportunities to actively engage in learning and implement transformation

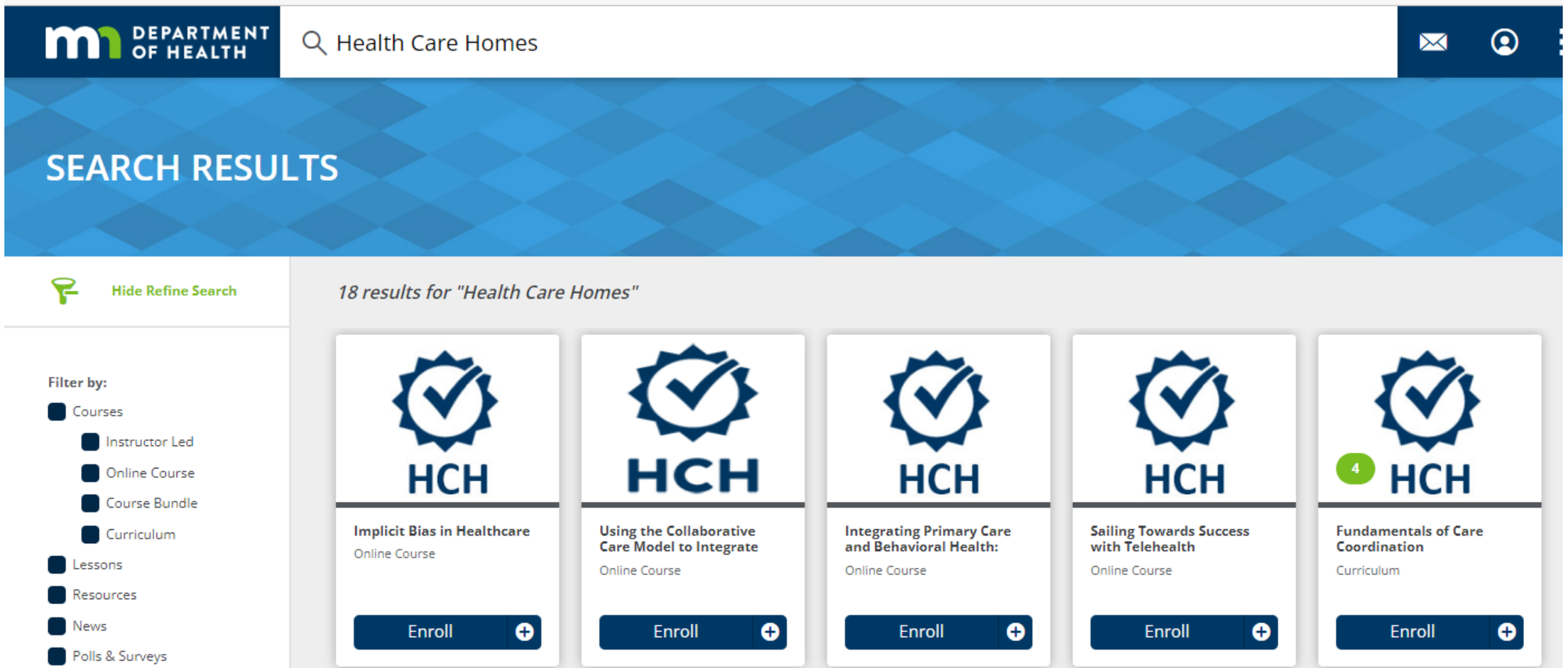
Webinar Series

Online learning for certified Health Care Homes and community partners

YouTube HCH Playlist

Short videos to learn more about the HCH program

MDH Learning Center



Technical Assistance

General email: health.healthcarehomes@state.mn.us

Or your assigned HCH nurse:

Tina Peters tina.peters@state.mn.us

Jen Strickland jennifer.strickland@state.mn.us

Joan Kindt joan.m.kindt@state.mn.us

Questions

Questions?

Comments?

Thank You!

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HCH mailbox	health.healthcarehomes@state.mn.us
HCH website:	Health Care Homes - Home Page (state.mn.us)
HCH telephone number:	651-201-5421