

## Health Care Home Certification – Minnesota Rural Palliative Care Collaborative Crosswalk

Health Care Home Certification Requirement	Minnesota Rural Palliative Care Initiative
<p><b>Access and communication standard.</b> The applicant for certification must have a system in place to actively recruit the applicant's patients into the health care home and support effective communication among the members of the health care home team, the participant, and other providers.</p>	<p>Communities participating in the Initiative have experience with identifying people who may benefit from palliative care services. Many of these would be likely choices for participation in a health care home.</p>
<p><b>Participant registry and tracking participant care activity standard.</b> The applicant for certification must use a searchable, electronic registry to record participant information and track participant care.</p>	<p>Although communities participating in the Initiative may not have a focused electronic tracking system, some are developing processes to link patients to multiple community services and to track use of these resources.</p>
<p><b>Care coordination standard.</b> The applicant for certification must adopt a system of care coordination that promotes patient and family-centered care</p>	<p>The criteria focus on the communication and coordination of care between team members such as the patient, care coordinator, personal clinician. This team would work with the patient to set goals of care and identify needed community resources. Many participants in the Initiative are working on this type of care coordination as part of their palliative care services.</p>
<p><b>Care plan standard; certification requirements.</b> This includes creation of a care plan for appropriate patients. This should be done with active patient engagement as well as the involvement of all appropriate members of the health care team and community resources.</p>	<p>The care plan is a key element to the health care home. It is meant to serve as a guide to that patients care and should include goals of care as well and advance care planning and advance directives. The work done by communities in the Initiative to create a plan of care for patients that involved a variety of community resources will help in meeting this criterion.</p>
<p><b>Performance reporting and quality improvement standard</b> The applicant for certification must create a performance improvement team and demonstrate experience with measuring, analyzing and tracking a quality improvement measure over time.</p>	<p>The measure to be tracked to meet this criterion would be identified through participation in the health care home learning collaborative. Participants in the Initiative have identified performance measures to measure, analyze, and track as well as provide the measures requested by Stratis Health, so participation may help prepare them to meet this standard.</p>

