MINNESOTA
HEALTH CARE HOMES

Health Care Homes Self-Audit Tool

TO BE COMPLETED BY CLINIC STAFF

Organization Name:____ **Date of Audit:**____________________

Directions: Clinics applying for certification or recertification confirm they have processes in place to provide coordinated care and that these processes are regularly evaluated to ensure they are working as intended. If desired, clinics may use the HCH Self-Audit Tool to validate this. It is suggested that an organization randomly selects enough clinics and patients to provide a sample size from which they can evaluate their findings and identify areas of opportunities. NOTE: The use of the HCH Self-Audit Tool is optional; organizations may choose to use other information or data to evaluate these processes (i.e., internally developed self-audit tool or assessment, policy/procedure/workflow, quality improvement plan, patient survey, and others).

For each patient and question please indicate Yes, No, or Not Applicable (N/A)

Access and Communication Standard

Description	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	Patient 7	Patient 8	Patient 9	Patient 10
1. Patient sought access to care during business hours or after hours. *If Yes: answer 2 – 5 below*										
2. Clinic staff (including the patient's personal clinician or backup if needed) was available to respond to the patient										
3. Identified needs were addressed appropriately (i.e., telephonic instructions, virtual visit, clinic appointment, or sent on for urgent/emergent care)										
4. If needed, a same-day or next-day appointment was available for the patient										
5. Response time to patient request met guidelines outlined in protocol										

Care Coordination Standard: System of care coordination and collaboration within the care team

Description	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	Patient 7	Patient 8	Patient 9	Patient 10
1. The patient has consistent visits and access to their dedicated primary care clinician										
2. If receiving intensive care coordination, frequency of patient contact with the care coordination team is determined and the patient has regular contact according to those plans.										

Care Coordination Standard: Documentation of care coordination elements

Confirm that the following elements are completed and documented in the patient's chart or care plan:

Description	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	Patient 7	Patient 8	Patient 9	Patient 10
1. referral tracking and follow up that includes information about the referral made, results of the referral, and updates to patient plan of care, if indicated										
2. tests ordered, results tracked, and timely notification to patients										
3. admissions to facilities are tracked and result of the admission										
4. timely discharge planning from health care facilities										
5. communication with patient's pharmacy and medication reconciliation										
6. links to external team members and care plans, as appropriate										

Care Planning Strategies Standard

The health care home must establish and implement policies and procedures to guide the health care home in the identification and use of care plan strategies to engage patients in their care and to support self-management. NOTE: 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.

Description	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	Patient 7	Patient 8	Patient 9	Patient 10
1. If applicable, the patient is provided with information from their personal clinician visit that includes relevant clinical details, health maintenance and preventative care instructions, and chronic condition monitoring instructions, including any indicated early intervention steps and plans for managing exacerbations.										
2. If applicable, patient sets goals and identifies action steps/resources to achieve those goals in collaboration with the care team and is offered documentation of their goals/action steps. (Pertinent information related to whole person care needs or other determinants of health are included.)										
3. If applicable, advance care planning processes are included (i.e., palliative care, end-of-life care, health care directives, etc.). The care team is provided with information about the presence of a health care directive and the patient/family has a copy.										

Health Care Homes Self-Audit and Action Plan

Organization Name:______________________________________ **Date of Audit:**_________________**Number of Clinics/Records Reviewed:**______

Access and Communication Standard:

Evaluation/Findings:

Areas of Opportunity:

Care Coordination Standard: System of care coordination and collaboration within the care team:

Evaluation/Findings:

Areas of Opportunity:

Care Coordination Standard: Documentation of care coordination elements:

Evaluation/Findings:

Areas of Opportunity:

Care Planning Strategies Standard:

Evaluation/Findings:

Areas of Opportunity:

Additional Information

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