

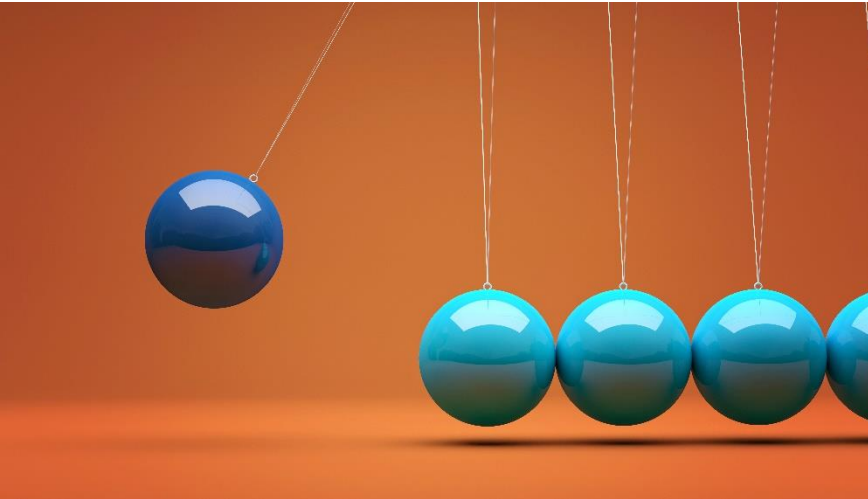


# HEALTH CARE HOME PROGRAM OVERVIEW

May 28, 2026

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

# 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 Patient Centered Medical Home (PCMH) or advanced primary care model.



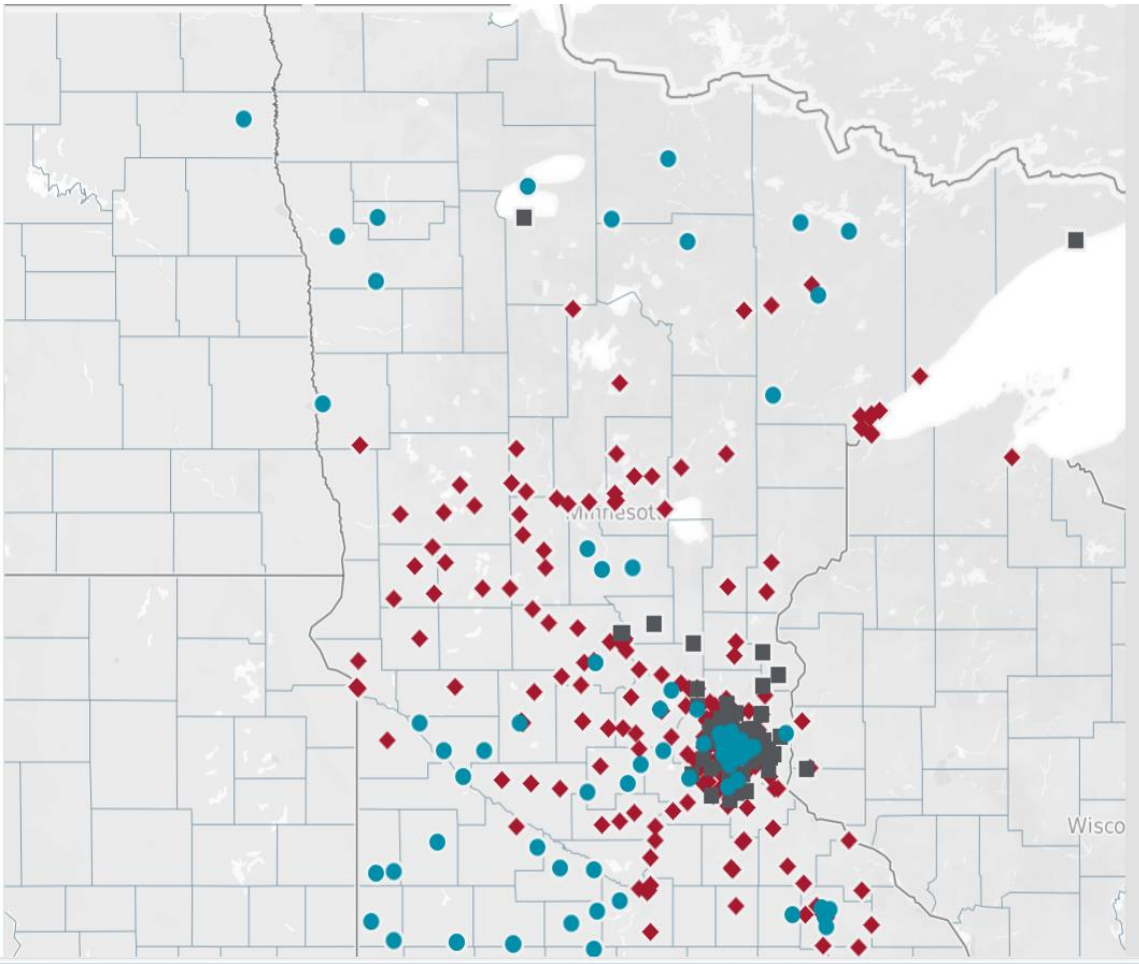
- Continue building a strong primary care foundation
- Increase care coordination and collaboration
- Improve population health and advance health equity
- Improve the Quadruple Aim

# Better Health, Better Care, & Lower Costs

- Research confirms that Health Care Homes improve all elements of the quadruple aim:
  - Quality: diabetes, asthma, depression and colorectal cancer screening
  - Patient experience
  - Cost effectiveness: ED utilization, inpatient hospital stays
  - Staff satisfaction



# By The Numbers



- Roughly fifty-nine percent of Minnesota primary care clinics are certified as a Health Care Home (HCH)
  - **390** certified Health Care Homes
    - **80** at the Foundational Level
    - **61** at Level 2
    - **249** at Level 3
- Healthcare landscape is continually shifting
- Unprecedented challenges since 2020

# Eligibility



- An eligible clinic is one that takes responsibility for the patient's care and provides full range of primary care services.
- An individual clinician or primary care clinic may be certified as a Health Care Home (HCH).
- To maintain their status as a HCH certified, clinicians or clinics must renew their certification every 3 years.

# Certification Standards

- Standard 1: Access and Communication
  - Examples: Provide 24-7-365 access, identify complex patients
- Standard 2: Patient Registry and Tracking
  - Examples: Use a patient registry to track care activity and identify gaps
- Standard 3: Care Coordination
  - Examples: Designated care coordinator, coordinating with external providers
- Standard 4: Care Planning
  - Examples: Develop plan that includes patient-centered goals, managing chronic illness
- Standard 5: Performance Reporting and Quality Improvement
  - Examples: Establish quality improvement team, submit data, participate in learning collaborative

# Incentives & Reimbursement

- HCH Care Coordination Billing
  - [MHCP Provider Manual](#) – Physician and Professional Services - HCH
- Alternative Payment Arrangements/Value Based Programs
  - MN Integrated Health Partnerships (IHPs)
  - HCHs are structured to support value based care arrangements
- CMS Merit-based Incentive Payment System (MIPS)
  - HCHs receive full credit for the Improvement Activities performance category under MIPS
- Benefit to board certification for family practice physicians and pediatricians
- Access to learning

# HCH Model Progression

## 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

# HCH Learning Collaborative

- Key element of the HCH program
- Numerous learning opportunities for certified providers:
  - Over 30 e-learning modules
  - Monthly webinars
  - In-person trainings
  - Peer-to-peer networking
  - Annual conference

# HCH Partnerships and Collaboration

- Clinics: staff, patient-family advisory councils
- HCH Advisory Committee
- Sustainability Workgroup
- Data and program evaluation
- DHS

# Primary Care Stakeholder Group

**Purpose:** *Increase investment in primary care services that are equitable, person centered, team based and community aligned, and will help achieve the goals of better health, better care, and lower costs.*

**Objectives:** **To support the goal of investing in primary care for better health, better care and lower costs, the coalition will:**

- Engage stakeholders that represent all parts of the community and healthcare delivery system.
- Work to strengthen the ability of primary care to improve population health.
- Promote primary care workforce to ensure access to all.
- Keep the patient at the center of care.
- Implement primary care through value-based models that promote and align incentives across participants, including consumers.

Thank you!

Stay connected by subscribing to the HCH Newsletter and LEARN Bulletin by using the subscribe buttons in the upper right-hand corner of the [HCH website](#)

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# Study References

- All data, estimates and calculations used to derive this information comes from the University of Minnesota's Five-Year Evaluation of the Health Care Homes program. This evaluation can be viewed at:  
<http://www.health.umn.edu/sites/default/files/UM%202015%20HCH%20Evaluation%20Final%2007Feb2016.pdf>
- Sinsky, C.A., Willard-Grace R., Schutzbank, A.M., Sinsky, T.A., Margolis, D., & Bodenheimer, T. (2013). In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices. *Annals of Family Medicine*, 11(3), 272-278.
- Rachel Willard-Grace, Danielle Hessler, Elizabeth Rogers, Kate Dubé, Thomas Bodenheimer, Kevin Grumbach (2014). Team Structure and Culture Are Associated With Lower Burnout in Primary Care. *The Journal of the American Board of Family Medicine*, 27(2), 229-238.
- Link to full PCPCC Report, "The Patient-Centered Medical Home's Impact on Cost & Quality," found at: <https://www.pcpcc.org/resource/medical-homes-impact-cost-quality>