MINNESOTA
HEALTH CARE HOMES

Minnesota Health Care Homes

Redefining Health, Redesigning Care

Overview

Minnesota's Health Care Homes (HCH) advanced model of primary care delivery, known nationally as a patient centered medical home (PCMH), is redefining health and redesigning care across the state. The model promotes coordinated, comprehensive, patient centered, team based, primary care delivery to ensure patients get care when and where they need it in a way they understand.

The HCH model of care acknowledges a shift from a purely medical model of health care to a focus on linking primary care with wellness, prevention, self-management, and community services. The HCH approach proactively engages patients with a focus on the patient's health goals, needs, and abilities to achieve desired health outcomes. Transformation to a HCH results in a practice that can benefit all patients, whether they have chronic or complex conditions or are relatively healthy.

Background

The HCH program began in 2008 as part of a broad, bipartisan health reform initiative to transform clinical care to coordinated, patient-centered, team-based, care. HCH supports improvement in quality, patient experience, staff satisfaction, and cost effectiveness. The model is a principal driver for focusing primary care on prevention, management of chronic disease, and population health.

MDH certified the first Health Care Home in 2010. A list of certified HCH is on the program's website.

Most Minnesota clinics are HCH certified at the Foundational Level. In October 2022, The Minnesota Department of Health (MDH) amended the HCH rule adding two progression certification levels to address health equity, social determinants, and population health.

Certification

HCH certification is free of charge for primary care clinicians, clinics, and organizations. Program nursing staff are available to support the process.

The certification process confirms the coordinated, patient centered, team-based care approach is a partnership between primary care providers and patients and their families.

Voluntary certification assesses clinic performance on five HCH standards.

- Access and Communication
- Patient Tracking and Registry
- Care Coordination
- Care Planning
- Performance Reporting and Quality Improvement

Healthcare providers and organizations may certify at the Foundational Level, Level 2, or Level 3. The progression framework recognizes clinics that are advancing primary care models to reduce disparities, improve value, and address population health. The framework provides a foundation that can drive integration of health care with behavioral, community, social service, and public health system.

Incentives & Payments

HCH certification has benefits that can help sustain your practice. This includes care coordination services reimbursement, alignment with value-based payment and other alternative payment arrangements, and advantages for participants in the Centers for Medicare & Medicaid (CMS) Merit-based Incentive Payment System (MIPS).

Learning Collaborative

The HCH Learning Collaborative supports primary care clinic transformation and offers a variety of free learning opportunities related to the delivery of patient centered health care that qualify for continuing education credits.

Offerings include: annual Learning Days conference; regional meetings; peer to peer networking; e-learning; and webinars.

Outcomes Measurement

HCH benchmarking performance measurements are based on the standardized quality measure set called the Minnesota Statewide Quality Reporting and Measurement System (SQRMS) that clinics and hospitals have been reporting to SQRMS since 2010.

Resources

For more information about HCH:

- Visit the HCH website at https://www.health.state.mn.us/facilities/hchomes/index.html
- Email health.healthcarehomes@state.mn.us
- Read COMPASS for HCH requirements and standards https://www.health.state.mn.us/facilities/hchomes/documents/compass.pdf

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