DEPARTMENT OF HEALTH

Health Care Homes: The Choice for Primary Care

A BUSINESS CASE FOR CLINICS

The Health Care Homes (HCH) program is the Minnesota Department of Health's (MDH) nationally recognized Patient Centered Medical Home (PCMH). Certified primary care clinics 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. With redesign of care delivery and meaningful engagement of patients through a team-based approach, certified HCH clinics are transforming care across Minnesota.

Benefits of MDH HCH Certification

- **Provides infrastructure** to deliver organized and coordinated care.
- **Encourages flexibility** in implementation, allowing clinics to take an approach that aligns with existing processes, organizational culture and the needs of the individuals served.
- **Delivers personalized support** from HCH experts for model implementation, certification, program sustainability, connection to resources and on-going technical assistance.
- **Grants access** to an array of learning opportunities, free CEUs and peer networking.
- **Positions organizations for success** in integrating behavioral health, substance abuse programs, palliative care and other programs into this model.
- **Qualifies organizations**:
  - to bill for care coordination services through the Minnesota Department of Human Services HCH Care Coordination Billing methodology.
  - to receive full credit for the Improvement Activities performance category under the Centers for Medicare & Medicaid Services Merit-based Incentive Payment System.
  - that are Community Health Centers to earn a PCMH badge from the Health Resources and Services Administration.
- **Aligns with and prepares organizations** to successfully participate in value-based reimbursement models such as Accountable Care Organizations and Integrated Health Partnerships.
- **Offers recognition** through advances levels of certification to clinics addressing social determinants of health and working to advance health equity and community health.

Outcomes

Patient Centered Medical Home (PCMH) Model[1]

- Increased utilization of primary care and increased revenue.
- Improved quality, effectiveness of care and patient outcomes.
- Demonstrated readiness to be successful in value-based contracts.

Minnesota's HCH Model 5-Year Evaluation[2]

- HCH certified clinics were associated with higher quality of care for diabetes, vascular disease, asthma, depression and colorectal cancer screening than non-HCH clinics.
- For Medicaid enrollees, hospitalization rates and emergency department visits were lower.

Clinical Improvement in Diabetes Care[3]

- HCHs had significantly better performance in Optimal Diabetes Care when compared to uncertified clinics, which were due to improved statin rates and higher tobacco-free rates.

Minnesota Care Coordination Effectiveness Study (MNCARES)[4]

- Care coordination received strong support from clinicians and clinic leaders who viewed it as a valuable component of successful care delivery.

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To obtain this information in a different format, call: 651-201-5421.

[1] Patient-Centered Medical Home; Developing the business case from a practice perspective (PDF), (https://www.ncqa.org/wp-content/uploads/2019/06/06142019_WhitePaper_Milliman_BusinessCasePCMH_Final.pdf)

[2] Minnesota Department of Health (MDH), Evaluation of the State of Minnesota Health Care Homes Initiative – Evaluation Report for Years 2010-2014 (PDF), (https://www.health.state.mn.us/facilities/hchomes/legreport/docs/hch2016report.pdf)

[3] Minnesota Department of Health (MDH), Comparing Diabetes Care at Health Care Homes and non-Health Care Home clinics (PDF) (https://www.health.state.mn.us/facilities/hchomes/collaborative/documents/ld2019cahoon.pdf)

[4] Care Coordination in Primary Care: Views of Clinicians and Clinic Leaders, Journal of Nursing Care Quality, 2024, www.jncqjournal.com