DEPARTMENT OF HEALTH

Health Care Homes

2025 YEAR END REPORT

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2025 Health Care Homes Year End Report

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Health Care Homes Certification

The Minnesota Department of Health (MDH) Health Care Homes (HCH) program certifies, guides, and supports primary care organizations to advance and sustain patient-centered, whole person care. Through a focus on high-quality, coordinated, and accessible care, the program aims to advance health equity and improve the overall well-being of all Minnesotans.

Capacity Building

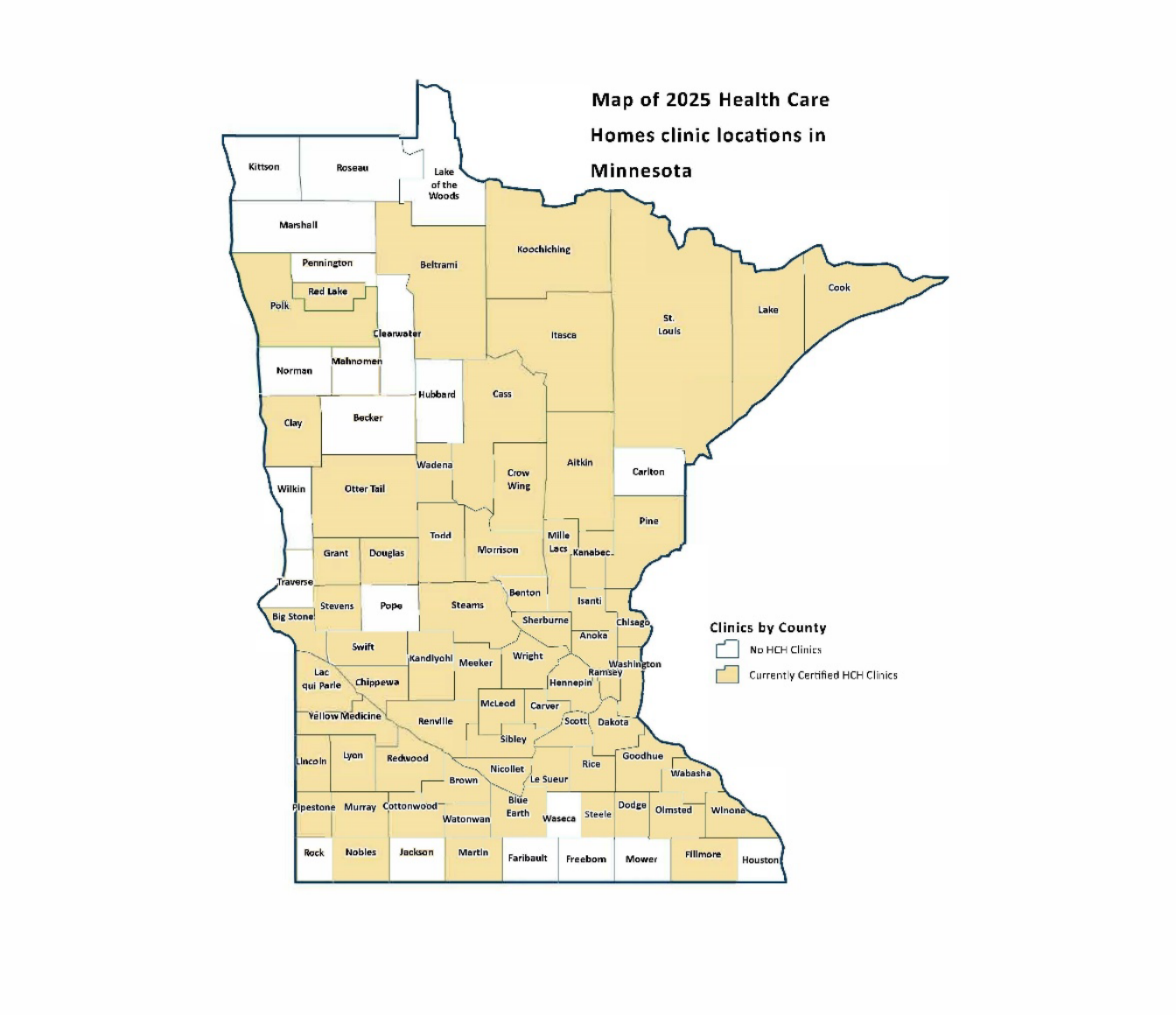
The HCH program offers its services to all Minnesota primary care clinics but prioritizes and focuses on the needs of currently certified clinics and those seeking initial certification. This includes technical assistance, connections to resources and peers, and various training methods to enhance organizational skills and address their specific needs.

- Initial Certification: three organizations.
- Recertification: 26 organizations.
- Spread: 14 clinics.
- Check-in: 15 contacts with certified organizations.
- Technical Assistance: 286 contacts with certified primary care organizations.
- Outreach to uncertified organizations: 261 contacts with primary care organizations for general help and guidance.

Minnesota Counties with Certified HCH

Certified HCH are key contributors to improving population health and health equity in all regions of Minnesota.

- 383 Minnesota primary care clinics and seven additional border state clinics are certified for a total of 390 certified HCH clinics. Of these, 84 are certified at the Foundational Level, 61 at Level 2, and 245 at Level 3.
- 66 of 87 Minnesota counties (76%) have at least one certified HCH clinic. They are: Aitkin, Anoka, Beltrami, Benton, Big Stone, Blue Earth, Brown, Carver, Cass, Chippewa, Chisago, Clay, Cook, Cottonwood, Crow Wing, Dakota, Dodge, Douglas, Fillmore, Goodhue, Grant, Hennepin, Isanti, Itasca, Kanabec, Kandiyohi, Koochiching, Lac qui Parle, Lake, Le Sueur, Lincoln, Lyon, McLeod, Martin, Meeker, Mille Lacs, Morrison, Murray, Nicollet, Nobles, Olmsted, Otter Tail, Pine, Pipestone, Polk, Ramsey, Red Lake, Redwood, Renville, Rice, St. Louis, Scott, Sherburne, Sibley, Stearns, Steele, Stevens, Swift, Todd, Wabasha, Wadena, Washington, Watonwan, Winona, Wright, Yellow Medicine.
- 21 of 87 Minnesota counties (24%) do not have at least one certified HCH clinic. They are: Becker, Carlton, Clearwater, Faribault, Freeborn, Houston, Hubbard, Jackson, Kittson, Lake of the Woods, Mahnomen, Marshall, Mower, Norman, Pennington, Pope, Rock, Roseau, Traverse, Waseca, Wilkin.



Level Progression

The HCH progression model builds on the original HCH certification and includes the following levels: Foundational Level, Level 2 and Level 3. The purpose of the HCH progression model framework is to recognize and support clinics that are advancing primary care models to

identify and address health-related social needs, reduce disparities, improve value, and work with their communities to impact population health.

Level Progression by Clinic

- 47 certified clinics advanced to Level 2.
- 147 certified clinics advanced to Level 3.

Certification Features

- Certification remains voluntary and free.
- Encourages flexibility in implementation, allowing clinics to take an approach that aligns with existing processes, organizational culture, and needs of the individuals served.
- Delivers personalized support from HCH experts for model implementation, certification, program sustainability, connection to resources, and ongoing technical assistance.
- Grants access to an array of learning opportunities, free continuing education units, and peer networking.
- Provides infrastructure to deliver organized and coordinated care, and positions organizations for success in integrating behavioral health, substance abuse programs, palliative care, and other programs into this model.
- Offers recognition through advanced levels of certification to clinics addressing social determinants of health and working to advance health equity and community health.
- Aligns with and prepares organizations to successfully participate in value-based reimbursement models such as Accountable Care Organizations and Integrated Health Partnerships.
- Many physicians can receive board maintenance of certification credits for practicing in a certified HCH.
- Qualifies organizations:
  - to bill for care coordination services through the Minnesota Department of Human Services (DHS) 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 Patient Centered Medical Home badge from the Health Resources and Services Administration.

Health Equity

Health Care Homes has leveraged the HCH progression model and its relationships with certified organizations to support primary care systems in advancing health equity. Levels 2 and 3 certifications signify working directly to advance health equity and achieve equitable outcomes within the clinic. Level 2, for example, requires clinics to have a process for screening, identifying, and addressing the social determinants of health and to have strengthened their

care coordination systems and partnerships across community supports. Clinics who reach Level 3 demonstrate an even stronger focus on community health through efforts such as working with community partners to plan for population health improvements and sharing aggregated, de-identified data that describes community health needs and inequities.

HCHs are Identifying and Addressing Health-Related Social Needs:

- Regardless of certification level, ~73% of organizations (n=48), are using non-medical criteria or factors, such as social determinants of health, to identify needs and determine risk across their patient population.
- Most utilize embedded EMR tools to routinely assess for factors related to food insecurity, socio-economic concerns, personal safety, transportation barriers, housing instability, and more. PRAPARE and CMS's Health-Related Social Needs Screening Tool are also somewhat utilized.
- Once needs are identified, there are processes for referrals and connection to appropriate resources. Some highlights include:
  - Multi-disciplinary, team-based care that uses dedicated staff with expertise to address needs and facilitate a connection to community resources, including care coordinators and community health workers.
  - Providing food boxes or stocking on-site food pantries fills immediate needs.
  - Enhancing community-clinical linkages through strengthened partnerships with community-based organizations, making it easier to connect patients and families to needed resources.

HCHs are Advancing Health Equity by:

- Enhancing Access: Approximately 30% of clinics (n=20) are providing some care or services off-site, meeting patients where they are (such as in school-based clinics, in community settings, in assisted living or other long-term care settings, and even in a patient's home)
- Identifying Disparities: Currently about 50% (n=33) of systems can stratify data for at least one measure/indicator. Clinics need additional resources to stratify their data across race, ethnicity, age, payor, residence (zip code), the presence of health-related social needs, or other factors. Health Care Homes partnered with Minnesota Community Measurement (MNCM) to develop a series of on-demand eLearning modules that provides technical support in using Excel to stratify data.

Minnesota Care Coordination Effectiveness Study

The HCH program collaborated with HealthPartners Institute, payers, certified clinics, and MN Community Measurement on a Patient-Centered Outcomes Research Institute (PCORI) comparative study—the Minnesota Care Coordination Effectiveness Study (MNCARES). This four-year study, which concluded in 2024, examined the effectiveness of medical versus

medical-social models of care coordination. Publication summaries, links, and additional study findings are available on the HCH MNCARES webpage.

A primary objective of MNCARES was to understand how primary care clinics coordinate services for patients with complex needs and whether the integration of a social worker influences that process. The January 2025 publication, "*Care Coordination: How Is It Implemented and Is It Different If a Social Worker Is on the Team?*" explored variations in care coordination models and activities. Findings indicated that clinics with an integrated social worker differ in both the frequency and approach to care coordination, particularly in how social needs are addressed, while providing medical and nursing services at similar or higher rates compared to clinics using a nurse only model.

Learning Collaborative

The HCH Learning Collaborative was established in legislative statute to provide certified HCH clinics and their partners with opportunities to share quality improvement strategies and best practices. Certified clinics must demonstrate ongoing learning and advancement of their care delivery model through participation in the Collaborative and other approved activities. The HCH program supports this requirement by offering a wide range of learning experiences across multiple modalities.

In 2025, educational programming centered on strengthening communication, enhancing care coordination, and advancing culturally responsive, patient centered care. Strategic partnerships further expanded the Collaborative's impact. Collaborations with the Diabetes Program and the Community Health Worker Program made it possible to bring in expert presenters, including nationally known speakers in diabetes care and speakers from the Community Health Worker Alliance. These partnerships broadened the reach and diversity of learning opportunities for clinics across the state.

A major focus this year was the expansion of health coaching training. The program brought in a subject matter expert who delivered an introductory series on foundational coaching skills. Building on its success, a second advanced series was offered for participants who attended the initial training. These returning participants were invited to attend at no cost to reinforce and deepen their practice. The program also partnered with CentraCare Health System to deliver customized health coaching training for their care coordination teams, which strengthened alignment and skill building across clinical settings.

Learning Days continued to serve as the signature event, bringing together certified HCH clinics from across Minnesota. This year's conference included 193 attendees, 33 speakers, and 16 breakout sessions, providing a rich environment for knowledge exchange, networking, and the sharing of best practices.

The conference opened with an engaging keynote from Dr. David Satin, who guided participants through evidence informed strategies for empowering patients in chronic disease prevention and management. He encouraged attendees to reflect on how many of the top ten empowerment methods they use in their work and personal lives and to commit to adding one more to their routine. Through practical examples and comparisons to high reliability industries, he highlighted tools such as shared decision making and motivational interviewing.

Participants left with clear take away resources and renewed motivation to support patient engagement.

Additional webinars throughout the year addressed a wide range of clinical and operational topics, including chronic disease management, physical activity engagement, adolescent communication, opioid use disorder treatment, transitions from pediatric to adult care, health literacy, refugee health, and trust building in diverse clinical environments. These sessions reinforced the program's ongoing emphasis on equity, high quality care delivery, and continuous improvement within the HCH model.

HCH Learning

Month	Topic	Webinar	In Person Learning
February	Coaching Skills for Health Care Providers (3-part series)	x	
March	Improving Prediabetes and Diabetes Health Outcome: Evidence, Challenges, Opportunities and Resources	x	
March	Exercise is Medicine: Engaging Patients in Physical Activity	x	
April	Adolescent Healthcare Communication Strategies and Resources	x	
May	Learning Days		x
June	Building Trust in Culturally Diverse Clinic Environments	x	
July	Refugee Health in Minnesota	x	
September	The Critical Role of Health Care Homes in Treating Opioid Use Disorder	x	
September	Coaching Skills for Health Care Professionals: Deepening Practice and Integration	x	
October	Health Literacy Foundations	x	
December	Building a Sustainable, Empowering Pediatric to Adult Healthcare Transition Program	x	

Strategic Planning

In response to the many changes in the health care landscape and the HCH program itself over the last several years, Health Care Homes undertook an inclusive strategic planning process that was completed in late 2025. An updated vision, mission, long-term goals, and key strategies and actions were developed using input from a diverse range of stakeholders including members of the HCH Advisory Committee and its work groups, clinicians and care team members from HCH certified clinics, key collaborators, internal staff, patients, and other experts.

The HCH program identified the following engagement objectives and values for the strategic planning process:

- Sought to engage stakeholders with a broad range of perspectives to ensure we were hearing from clinics of all sizes, from across all geographical regions, with varying experiences, varying resources, and varying patient populations.

- Worked to share and be transparent about the strategic planning process, bringing updates to key meetings and by using the HCH Strategic Planning webpage to share progress and results from the various phases of input.

Health Care Homes Strategic Plan

The strategic plan will be implemented as a living document, with updates and adjustments made to meet evolving needs, opportunities, and expectations. Continuous monitoring mechanisms will be incorporated to evaluate progress and will include expanding the type of feedback that is gathered by the HCH program. Continuous improvement to date has focused on the feedback the HCH program receives regarding certification processes and operations as well as training content and format, while in the future it will also include feedback on strategic priorities.

Vision

High-quality, integrated, and accessible care that improves health and wellness for all Minnesotans.

Mission

Certify, train, and support primary care organizations and partners to advance and sustain equitable, patient-centered care.

Goals and Key Strategies

Goals: 10-15 years; Key Strategies: 3-5 years.

***GOAL*:** Health Care Homes is Minnesota's preferred model of care.

- **Key Strategy**: Establish HCH model as a key element of high-value primary care.
  - Develop a compelling value statement and expand partnerships to cultivate advocates for the HCH model.
  - Increase visibility and relevance of HCH among healthcare and public health leaders, including payers.
- **Key Strategy:** Expand reach and scope of HCH.
  - Use the compelling value statement and work with a broader range of partners to expand the HCH model in other health care settings.
- **Key Strategy:** Support clinics to attain highest level of certification.
  - Improve and increase value of, awareness of, and support for the HCH model and certification.
  - Streamline and better support the certification / recertification process.

***GOAL*:** Health Care Homes clinics are sustainable and equipped to deliver high-quality care.

- **Key Strategy:** Connect clinics to robust reimbursement and financial incentives.

- Help clinics optimize reimbursements, advocate for increased funding incentives for certification, and support sustainability of the HCH model.

- **Key Strategy:** Deliver training, technical assistance, and supports that meet evolving needs, priorities.
  - Work with key stakeholders to understand and meet their learning needs with expanded content and formats.

***GOAL*:** The Health Care Homes program is thriving and sustainable.

- **Key Strategy:** Ensure effective, efficient programs and services.
  - Build a culture of trust, openness, collaboration, and rigorous evaluation that supports continuous improvement and excellence.
- **Key Strategy:** Sustain diverse and stable program funding and support.
  - Deepen understanding and support for our program and actively broaden our funding base.

Partners

Minnesota Department of Health

Health Promotion Chronic Disease

In April 2025, HCH program staff collaborated with the MDH Asthma Program and the MDH Diabetes Unit to conduct program check-ins at Cass Lake Indian Health Services (IHS) and Red Lake IHS. Both organizations welcomed the MDH team to discuss their HCH programs and share updates on emerging approaches to asthma and diabetes care.

The visits provided an opportunity for meaningful exchange among clinic leaders, staff, and MDH representatives. Participants shared experiences, best practices, and resources to strengthen chronic disease management within their communities. Following the visit, the MDH Diabetes Unit facilitated a connection between the Leech Lake Band of Ojibwe and Cass Lake IHS with the National Kidney Foundation (NKF). The NKF subsequently delivered an educational session on chronic kidney disease (CKD) screening, diagnosis, and management for clinic providers and staff. A second session, scheduled for December, will expand participation to include pharmacists and ancillary staff.

Reflecting on the collaboration, a Diabetes Unit staff member noted, “I had made attempts to connect with them prior, but it happened more organically after the in-person visit.”

During the April site visits, Asthma Education Resources for American Indian Communities were distributed. A Red Lake leader shared, “The resources were a fantastic addition to our patient education materials.” Similarly, staff from the Leech Lake Band and Cass Lake IHS expressed appreciation for the culturally responsive materials that reflect the communities they serve. To further enhance patient engagement and education, both certified HCH clinics received a lung model following the visit. One clinic leader remarked, “It is being put to use in patient education today.”

Community Health Workers Initiatives

The HCH program recognizes the essential role Community Health Workers (CHWs) play in improving care coordination, bridging cultural and language barriers, strengthening access to care, and advancing health equity. Through ongoing partnership with the Minnesota Community Health Worker Alliance and MDH's CHW Initiatives, the HCH program continues to champion the CHW workforce, elevate upcoming learning and development opportunities, and contribute to statewide workforce-development efforts.

In March 2025, more than 100 stakeholders convened to develop a sustainable plan for strengthening the CHW field in Minnesota, including the creation of a Statewide CHW Measurement Plan. The work group reconvened in October and will continue meeting monthly through June 2026 to:

- Review and analyze data from statewide surveys of CHWs and CHW employers.
- Identify gaps and opportunities in current data-collection practices.
- Provide guidance on the design of a statewide visual data-sharing tool.
- Inform the development of a CHW implementation toolkit to support employers.

These collaborative efforts aim to build a more robust, data-informed, and sustainable CHW workforce across Minnesota.

MN Healthy Aging Framework

With a growing national and state-level focus on healthy aging, MDH has prioritized this work in 2025 through the establishment of an agency-wide Healthy Aging Core Team and Work Group dedicated to identifying shared vision, practices, and priorities. The HCH program is involved in the effort, with staff serving on both the Core Team and the Work Group. The vision guiding this effort is to make Minnesota the best state in which to grow up and age well.

Key work resulting from these groups' efforts include the development of the Healthy Aging Framework, which outlines strategic network supports, core practices, and focus priorities designed to position MDH and Minnesota to realize this vision. The HCH program and model of whole person, patient-centered care aligns closely with the Healthy Aging Framework's focus priorities, which include planning and preparing for safety and resilience; strengthening care systems to support Healthy Aging; and promoting physical activity to enhance mental, physical, and social health.

Office of Statewide Health Improvement Initiatives

The HCH team continues its collaboration with the Office of Statewide Health Improvement Initiatives to strengthen partnerships between certified clinics and local public health (LPH). This joint effort supports the implementation of a new Statewide Health Improvement Program project designed to enhance integration across sectors. Through this work, HCH fosters stronger linkages between primary care and local public health while LPH expands its role in supporting clinics to address health-related social needs and advance community health improvement efforts.

Statewide Quality Reporting and Measurement System

HCH continues its partnership with Statewide Quality Reporting and Measurement System (SQRMS) staff to pilot the Measurement Framework, which was developed by a broad group of stakeholders in response to a 2017 legislative directive. This pilot project brings together HCH certified clinics, local public health, and community partners to apply innovative measurement strategies for a selected health and equity improvement topic, providing a comprehensive picture of the conditions and factors that influence health. HCH staff have continued to have a leadership role in the Measurement Framework pilot project, although the work overall is a true intra-agency effort, with various MDH programs providing support and expertise, including Public Health Practice and Infectious Disease Epidemiology, Prevention and Control.

Minnesota Department of Human Services

Integrated Health Partnerships

The HCH program continued a longstanding collaboration with the Integrated Health Partnerships (IHP) program throughout 2025. This included regular meetings with discussions focused on how to better align the two initiatives. The need for joint communication strategies was agreed upon, with outreach to clinics that could benefit from participation in the two programs. Talks continued as to how incentives could be included for IHP participants who reach Level 2 or Level 3 HCH certification. Discussion around joint learning opportunities was also begun. To this end, HCH staff attended IHP's inaugural learning summit, an opportunity to learn about new developments in IHP as well as a chance to network and dialogue with clinic participants.

Minnesota Management and Budget

State Employee Group Insurance Program

The HCH partnership with the Minnesota Management and Budget (MMB) State Employee Group Insurance Program (SEGIP) continued to strengthen throughout 2025. Two SEGIP leaders serve on the HCH Sustainability Work group and meet periodically with HCH staff to address questions from certified clinics and explore opportunities for collaboration.

In early 2025, the teams met to discuss clinic concerns regarding overall costs, reimbursement challenges, and the impacts of assigned tiering levels. SEGIP responded with a detailed explanation of the tiering process, including the steering committee's approach, consideration of total cost of care, and accommodations for smaller or rural practices where primary care access may fall outside the ideal 30-mile radius. HCH also learned about SEGIP's contract negotiations, access adjustments, and a pilot program offering risk-sharing agreements, all of which provide additional options for certified clinics.

In fall 2025, the teams reconvened to review how HCH certification designations appear within the clinic directory used during open enrollment. New this year, state employees can filter primary care clinics by HCH certification status. Each clinic listing now includes its certification designation, with the option to hover for a brief program description or click through to the public-facing HCH website for more information.

These efforts reflect the HCH program's ongoing commitment to collaboration, transparency, and support for certified clinics, ensuring that state employees have clear information to make informed choices about their primary care.

Minnesota Primary Care Stakeholders Group

Health Care Homes continued its partnership with the Minnesota Academy of Family Physicians (MAFP) as co-facilitator of the Minnesota Primary Care Stakeholder Group (MPCSG). The Stakeholder Group was formed in 2020 in order to address the many challenges facing primary care in Minnesota. Its membership includes representatives from all corners of the healthcare sector including clinicians, insurers, non-profits, government, and professional organizations.

MPCSG met several times in 2025, inviting speakers to present to the group and engage with members in discussion. Topics this past year included:

- The strategic partnership analysis on transitions from pediatric to adult care being conducted by Gillette Children's and the National Alliance to Advance Adolescent Health.
- The Minnesota Department of Health's vision for primary care in Minnesota.
- Legislative agendas and proposals of MPCSG members.
- The Massachusetts Primary Care Dashboard and how it is being used to drive investment in primary care.

Planning is underway for the next round of meetings, set to begin in early 2026, as MPSCG continues its mission to promote and strengthen Minnesota's primary care system through collaborative partnerships.

Pediatrics

Health Care Transition: Pediatric to Adult

The Minnesota Health Care Transition Learning Collaborative (HCT LC) is a pioneering initiative launched in 2023 to improve the transition from pediatric to adult health care for children and youth with special health needs (CYSHN). In Minnesota, 17.5% of children under 18 have special health care needs, underscoring the urgency of this work. Led by Gillette Children's Health Services Research Program in partnership with The National Alliance to Advance Adolescent Health, Got Transition®, and the MDH CYSHN section—which also funds the work—the collaborative addresses the critical gap in transition support through education, quality improvement, and systems change efforts. The HCT LC offers a series of learning sessions, multidisciplinary discussions, and an ECHO Series, which engages a multidisciplinary audience to support clinical practice through the sharing of evidence-informed transition practices and case presentations. The work is further informed by the Minnesota Health Care Transition Steering Work group, with HCH staff serving as advisory members.

Pediatric Care Coordination: Community of Practice

The Minnesota statewide Pediatric Care Coordination: Community of Practice (PCP CoP) serves as an important platform for care coordinators from diverse sectors to connect, collaborate, and learn from one another. Led by the MDH CYSHN program and supported by HCH staff, this

initiative enhances system capacity to support families of children and youth with special health needs, fosters cross sector connections, and strengthens pediatric care coordination across the state. Through this partnership, HCH contributes to building a robust continuum of collaborative pediatric care by fostering education, networking, and shared learning.

HCH Statewide Promotion

The Choice for Primary Care

The HCH program promotes the value and benefit of HCH certification to all primary care clinics and other partners wherever possible. Many of these benefits are outlined in the recently updated Business Case for Clinics. One such benefit that has come to our attention this year—and which has already proved to be highly valuable to physicians and certified clinics—is the ability for physicians to use HCH certification to meet maintenance of certification credits (specifically, the Performance Improvement requirement) for the American Board of Family Medicine (PDF) and the American Board of Pediatrics. The HCH program is currently exploring how this benefit may be extended to other credentialing bodies, including for Advanced Practice Registered Nurses and Physician Assistants (PAs).

Sustainability Roadmap

On October 16, 2025, the HCH Sustainability Roadmap marked its second anniversary. Originally developed to provide clinics and primary care teams with concrete actions and resources to support implementation and ongoing use of the HCH model, the Roadmap has become a widely referenced and valued tool among certified HCH programs, averaging about 50 webpage visits per month.

While the Roadmap acknowledges that funding and reimbursement are critical to sustaining primary care practices, its scope extends beyond financial considerations to include other essential components of sustainability. These elements—Care Coordination, Finance, Learning, Partnerships, and Workforce—offer guidance for policy development, process improvement, and innovative action steps tailored to the unique needs of each certified organization.

Patient-Family Advisory Councils

Early in 2025, MDH HCH had the opportunity to engage directly with patients through some of our certified HCHs Patient-Advisory Councils. Staff traveled across the state to attend Patient and Family Advisory Council meetings to explain/remind them of what a certified HCH is and does and to gather input on ways to improve the dissemination of information about HCH to patients and the public. Certified organizations also expressed appreciation for the MDH HCH program's interest and willingness to engage directly with their patients. It was a great example of the partnership between MDH HCH and its certified clinics!

Outreach Activities

MDH HCH program staff participate in various events and conferences to promote HCH and connect with primary care providers and partners. In 2025, these included: The Primary Care Collaborative Conference, MN Rural Health Conference, Advances in Learning Health System

Sciences Conference, Many Faces of Community Health Conference, and PrimeWest Health's Providers & Partners Fall Conference.

Tagline development

The HCH program is excited to announce that we are adopting a new tagline, "Primary Care Clinics That Put You First."

The new tagline directly addresses a challenging misconception—too many people confuse Health Care Homes with traditional home healthcare services or nursing home facilities. We want to clarify that Health Care Homes is a clinic-based model for coordinated health care. Health Care Homes are primary care clinics that have met our state's patient-centered requirements for certification.

The old tagline spoke to the work but had more of a systems-change message. Developed with input from a diverse range of stakeholder, the new tagline specifically calls out our clinic-based model and emphasizes our patient-centered approach. We are enthusiastic that this shift in our tagline will help people more clearly understand what HCH are and the valuable work that HCH clinics do all across our state.

References

American Board of Family Medicine https://www.theabfm.org/app/uploads/2024/03/24-03_PerformanceImprovement.pdf

American Board of Pediatrics https://www.abp.org/content/patient-centered-medical-home-pcmh

Business Case for Clinics
https://www.health.state.mn.us/facilities/hchomes/documents/bizcaseclinics.pdf

Care Coordination: How Is It Implemented and Is It Different If a Social Worker is on the Team? https://www.jabfm.org/content/jabfp/early/2025/01/30/jabfm.2024.240010R1.full.pdf

Gather input *[through Strategic Planning Round 1]*
https://www.health.state.mn.us/facilities/hchomes/documents/stratplanrnd1.pdf

Health Care Transition Learning Collaborative https://www.gillettechildrens.org/get-involved/health-care-transition-collaborative/get-involved-hctlc

MNCARES https:/www.health.state.mn.us/facilities/hchomes/mncares.html

Strategic Planning
https://www.health.state.mn.us/facilities/hchomes/about/strategicplan.html