Fact Sheet

Patient-Centered Medical Homes

NCQA's Patient-Centered Medical Home (PCMH) Recognition program is a powerful tool for transforming primary care into what patients want it to be. That means:

- Patients have long-term partnerships with clinicians, not a series of sporadic, hurried visits.
- Clinician-led teams coordinate care, especially for prevention and chronic conditions.
- Medical homes coordinate other clinicians' care and community resources, as needed.
- Patients have enhanced access through expanded hours and electronic communication.
- They help patients participate in decisions about their care to get better results.
- Medical homes coordinate care and improve quality but do not deny care; even so, many insurers pay modest fees for these benefits because they save more than they cost.

NCQA PCMH Recognition standards provide a roadmap for making this powerful change in how clinicians provide care. Clear, specific criteria show clinicians how to organize care around patients and work in teams to coordinate, track and improve care. We updated our PCMH standards in 2011 to be clearer, more specific and more challenging than our 2008 criteria. The new standards "raise the bar" in several important respects:

- They make medical homes more responsive to patients' needs by incorporating surveys and other information to engage patients and families in quality improvement.
- They align with federal requirements for "meaningful use" of health IT.
- They emphasize language and culturally sensitive facets of care.
- They have a stronger focus on integrating care management and behavioral healthcare.
- They help pediatric practices by addressing such topics as parental decision-making, age-appropriate immunizations and teen privacy.

Different kinds of primary care practices can meet the standards, regardless of their size, configuration, electronic capabilities, populations served or location. NCQA's three levels of PCMH recognition reflect how extensively practices meet our criteria. The different levels allow diverse practices to meet requirements and become what their patients want them to be.

"PCMH 2011 advances the patient-centered medical home as a paragon of 21st-century primary care," said NCQA President, Margaret E. O'Kane. "By emphasizing access, health information technology and partnerships between clinicians and patients to improve health, these new standards raise the bar in defining high-quality care."

Research demonstrates that PCMHs achieve powerful results. They provide better preventive health, disease management, and resource use than other practices.[1]

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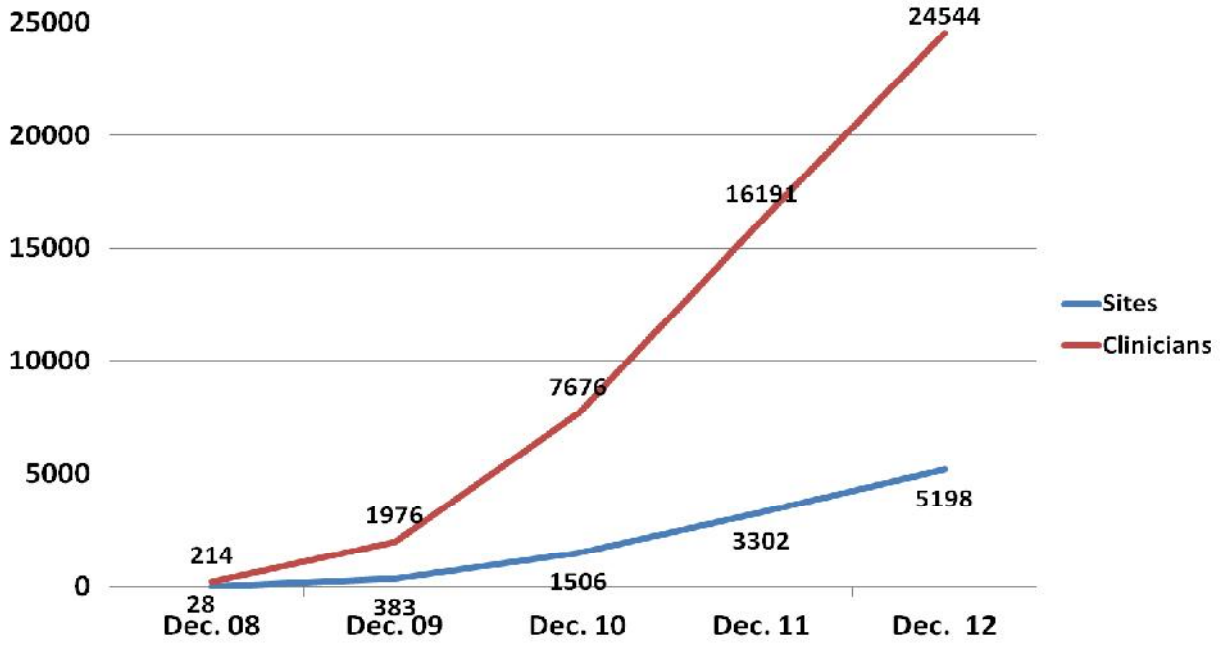
[1] *Impact of Medical Homes on Quality, Healthcare Utilization, and Costs,* DeVries et al, American Journal of Managed Care, September 2012

They reduce hospital and emergency department admissions and provide a solid return on investment.[2] They reduce income-related disparities in care.[3] They also improve patient and satisfaction while reducing provider burn-out.[4] North Carolina Medicaid saved $1 billion, primarily through reduced hospital and emergency department visits.[5] Other states are seeing similar benefits.[6]

NCQA PCMH: "The Gold Standard" for Primary Care Transformation. NCQA's PCMH Recognition program is by far the most widely used method for transforming primary care practices into medical homes—and it is NCQA's fastest growing service.

- Between 2008 and the end of 2012, more than 24,500 clinicians at nearly 5,200 practice sites across the country earned PCMH recognition.
- Each month, more than 150 practices apply for recognition.
- The Department of Defense is working with NCQA to help its primary care practices become medical homes.
- The Department of Health & Human Services is working with NCQA to help community health centers transform into medical homes.
- Dozens of state programs and insurance companies are helping practices make the transition to PCMH because the benefits are clear.



[2] *Colorado PCMH Multi-Payer Pilot Reduced Inpatient Admissions, ER Visits & Demonstrated Plan ROI* Harbrecht, Health Affairs, September 2012

[3] *PCMH Improves Low-income Access, Reduces Inequities*, Berenson, Commonwealth Fund, May 2012

[4] *The Group Health Medical Home At Year Two: Cost Savings, Higher Patient Satisfaction and Less Burnout For Providers*, Soman et al, Health Affairs, May 2010

[5] Milliman. January 2012. *Analysis of Community Care of North Carolina Cost Savings*.

[6] *Reinventing Medicaid: State Innovations To Qualify And Pay For Patient-Centered Medical Homes Show Promising Results* Takach, Health Affairs, July 2011

How NCQA PCMH 2011 Standards Work. The PCMH 2011 program's six standards align with the core components of primary care. NCQA scores practices on six areas that define patient-centered medical homes:

- PCMH 1: Enhance Access and Continuity.
- PCMH 2: Identify and Manage Patient Populations.
- PCMH 3: Plan and Manage Care.
- PCMH 4: Provide Self-Care Support and Community Resources.
- PCMH 5: Track and Coordinate Care.
- PCMH 6: Measure and Improve Performance.

Six "must pass" elements are essential for PCMHs at all three recognition levels. Practices must score at least 50 percent on these elements:

- PCMH 1, Element A: Access During Office Hours.
- PCMH 2, Element D: Use Data for Population Management.
- PCMH 3, Element C: Care Management.
- PCMH 4, Element A: Support Self-Care Process.
- PCMH 5, Element B: Referral Tracking and Follow-Up.
- PCMH 6, Element C: Implement Continuous Quality Improvement.

These scores result in a recognition level of 1, 2 or 3, and states and other payers often tie payment to the level of PCMH recognition practices achieve.

There is also a new, optional NCQA Distinction for using a standardized patient experience survey. As of January 2012, PCMHs can earn additional distinction for reporting results from the Patient-Centered Medical Home version of the CAHPS Clinician and Group Survey (developed by the Agency for Healthcare Quality and Research, in collaboration with NCQA). However, NCQA will not publicly report results until we establish national benchmarks for gauging performance using this new tool.

PCMH and Accountable Care Organizations. PCMHs are the fundamental building block for meeting NCQA's rigorous standards for accrediting accountable care organizations (ACO). ACOs have the potential to expand the PCMH principles of patient-centered care to the entire health care system. Not all organizations calling themselves ACOs will be able to meet NCQA's standards; those that do will start with a strong PCMH foundation, which is essential for expanding PCMH success beyond the primary care practice.

NCQA's PCMH 2011 standards—including examples of how to comply and provide documentation—are available free of charge at www.ncqa.org/view-pcmh2011. NCQA offers educational programs about how the program works. For more information, please contact Paige Robinson, NCQA Physician Recognition Programs Manager, at 202-955-5122 or at probinson@ncqa.org.