



NCQA Patient-Centered Medical Home 2011

Health care that revolves around you

An Established Model
of Care Coordination





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In the search for higher quality, more affordable health care, the patient-centered medical home has rapidly gained momentum. Building on decades of innovation, this model of adult and pediatric primary care continues to generate attention. Clinicians, professional societies, employers and purchasers, insurers, government and consumer organizations recognize the patient-centered medical home as a promising alternative to the nation's costly, fragmented delivery system.

NCQA's Patient-Centered Medical Home (PCMH) 2011 program provides a roadmap for practices to improve delivery and the experience of care for both clinicians and patients. The program

helps develop relationships between primary care providers, their patients and patients' families (when appropriate). It uses technology to assist in managing care. Ultimately, patients receive care when and where they need it, in a culturally and linguistically appropriate manner. This increasingly popular delivery system innovation leads to safer, higher quality of care, more empowered patients and a renewal of the patient-provider relationship. PCMH encourages patient access and coordination of care, supported by information technology.

In keeping with NCQA's mission to improve the quality of health care, the revised PCMH standards reflect a commitment to access, affordability and accountability. The standards emphasize a practice's dedication to continuous quality improvement. They are more patient centered, they incorporate behavioral health care and they emphasize patient access, coordinated care and evaluating performance and patient experience.

NCQA's redesigned Patient-Centered Medical Home Recognition Program promotes these goals: improving the patient experience, recognizing clinicians for their efforts and providing confidence for purchasers that their dollars are spent on quality care.

What is a "patient-centered medical home"?

A patient-centered medical home is a model of care that strengthens the clinician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship. Each patient has a relationship with a primary care clinician who leads a team that takes collective responsibility for patient care, providing for the patient's health care needs and arranging for appropriate care with other qualified clinicians. The medical home is intended to result in more personalized, coordinated, effective and efficient care.

A medical home achieves these goals through a high level of accessibility, providing excellent communication among patients, clinicians and staff and taking full advantage of the latest information technology to prescribe, communicate, track test results, obtain clinical support information and monitor performance.

¹ Also referred to as the "advanced primary care" model.

Helping Primary Care Practices Transform Health Care

NCQA's PCMH 2011 Recognition Program emphasizes the systematic use of patient-centered care management processes. It is an expansion of NCQA's highly regarded Physician Practice Connections® (PPC®) Recognition Program, an evaluation of practice systems. PPC was initiated in 2003 with support from The Robert Wood Johnson Foundation, The Commonwealth Fund and Bridges to Excellence and evolved into the Physician Practice Connections®-Patient-Centered Medical Home™ (PPC®-PCMH™) 2008 Recognition program. The PPC-PCMH 2008 program was developed with input from the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP) and the American Osteopathic Association (AOA) and their published 2007 Joint Principles of the Patient-Centered Medical Home.² Thanks in part to the efforts of these organizations, today, patients are living longer, healthier lives.

PCMH standards assess many of the ways in which practices function as medical homes. Our standards are the first and most widely-used formal evaluation program from a national quality oversight organization that results in a designation. We have given thousands of clinicians a method for achieving better quality through a systematic approach to care management. The PCMH 2011 standards offer guidance on developing better chronic care management programs, enhancing patient engagement and improving patient outreach. **Our updated standards are aligned with new health IT "meaningful use" criteria.**

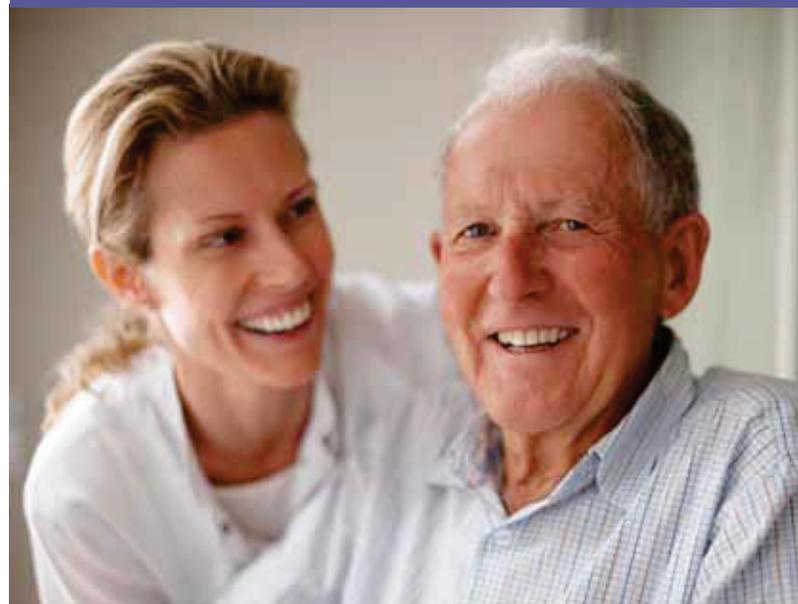
Across the country, clinicians, patients, health plans, employers, public entities and others are actively testing the model to learn how to transform and reward medical home practices. The evidence shows promising results in improving care quality and lowering costs by increasing access to more efficient, coordinated and responsive care.

More than 1,500 NCQA-Recognized medical homes offer superior value to purchasers and consumers because they clearly demonstrate that systems and processes are in place to meet nationally recognized standards for delivering high-quality care. These standards focus on evidence-based requirements to improve quality and reduce costs, and encourage practices to adopt proven systems for improving care.

Achieving NCQA's PCMH Recognition prepares practices to take advantage of financial incentives offered by health plans and employers, and by federal and state-sponsored pilot programs. Practices earning NCQA Recognition may qualify for additional bonuses or payments.

"The Patient-Centered Medical Home is a model of 21st century primary care that combines access, teamwork and technology to deliver quality care and improve health."

Margaret E. O'Kane, President, National Committee for Quality Assurance



² The full text is available at <http://pcpcc.net/content/joint-principles-patient-centered-medical-home>

Revised PCMH Standards

PCMH Recognition is based on meeting specific elements included in six standard categories.

- 1. Enhance Access and Continuity:** Accommodate patients' needs with access and advice during and after hours, give patients and their families information about their medical home and provide patients with team-based care
- 2. Identify and Manage Patient Populations:** Collect and use data for population management
- 3. Plan and Manage Care:** Use evidence-based guidelines for preventive, acute and chronic care management, including medication management
- 4. Provide Self-Care Support and Community Resources:** Assist patients and their families in self-care management with information, tools and resources
- 5. Track and Coordinate Care:** Track and coordinate tests, referrals and transitions of care
- 6. Measure and Improve Performance:** Use performance and patient experience data for continuous quality improvement

Practices must successfully meet the following "must-pass" elements to achieve recognition at any level.

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



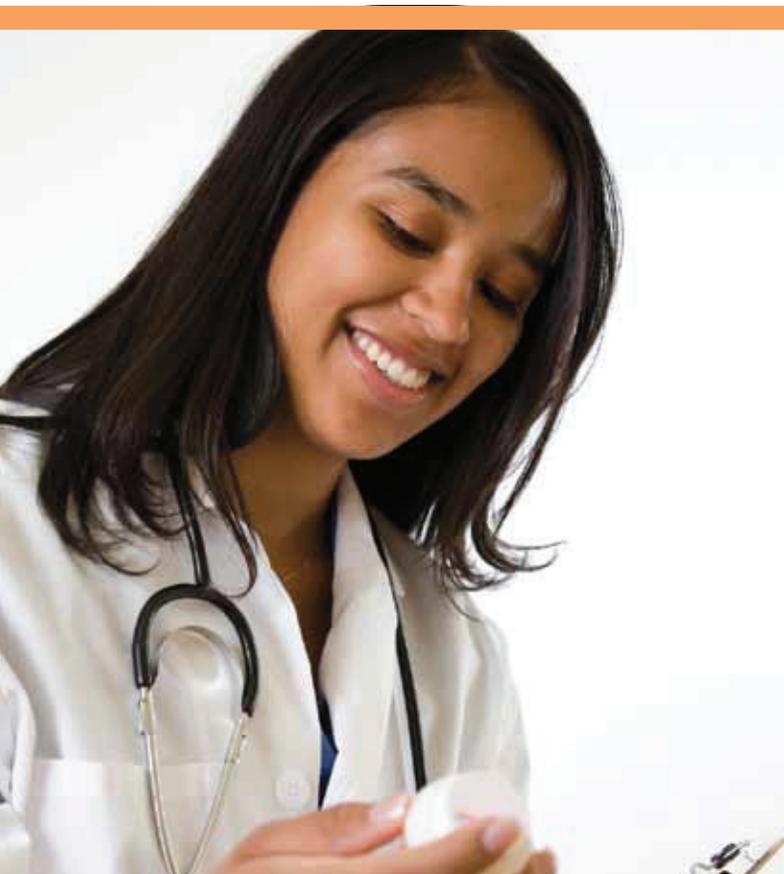
"The patient-centered medical home model transforms the way we practice and deliver health care, and focuses the primary care team on delivering comprehensive and integrated care to their entire patient population. The outcome is a patient whose health is enhanced and whose experience with their medical home is outstanding. Everyone in the practice, including the patient, has an essential role in the medical home."

Marc Rivo, MD, MPH, Chief Medical Officer,
Prestige Health Choice, Vice President of
Managed Care, Health Choice Network Inc.

Applying for PCMH 2011 Recognition

Primary care practices and clinicians interested in seeking the latest version of NCQA's PCMH Recognition should request a free copy of the PCMH 2011 *Standards and Guidelines* (available at www.ncqa.org/pcmh) to help determine their readiness to meet the standards. The document contains technical requirements, explanations and examples.

Free application materials are also available and include eligibility criteria and pricing information.



“PCMH is a win-win for clinicians and patients. Patients and families really like being engaged in their care, and they value having an ongoing relationship with their clinician. As a physician who works in a medical home, it is extremely satisfying to work with a practice team that anticipates patients’ needs and works collaboratively with patients and families.”

Xavier Sevilla, MD, FAAP, Chair, Steering Committee of Quality Improvement and Management (AAP), Whole Child Pediatrics

Pricing is based on practice size. Before beginning the application process, applicants are encouraged to participate in an audio conference (offered on a monthly basis) or in an educational workshop (held quarterly) to learn more about the survey process and requirements.

Practices that meet specific elements among the six standards can achieve one of three levels of NCQA Recognition. The Web-based data collection tool records responses. WebEx demonstrations support use of the PCMH Recognition Survey Tool and NCQA customer support is available Monday–Friday at 888-275-7585 to help with the survey, document preparation and the online submission system.

The actual Survey Tool can be purchased online. It includes data collection guidelines needed for electronic submission of responses and supporting documents to NCQA. Practices can also use the Survey Tool to assess their readiness before submitting their survey for NCQA review. Application for recognition applies to a single practice location.

NCQA reviews and scores the completed application and survey. We perform a random audit of 5 percent of the practices that submit an application, through onsite review, teleconference and e-mail. We will contact you if your practice is selected for audit.

Recognized practices receive:

- A letter and Certificate of Recognition
- Posting in the NCQA Recognition Directory
- A media kit that includes NCQA Marketing and Advertising Guidelines
- A press release announcement of Recognition to their choice of five publications

NCQA PCMH Recognition is valid for three years.



Distinction in Patient Experience Reporting



NCQA Patient-Centered Medical Home

The patient-centered medical home continues to gain momentum as a model for improving delivery of primary care. In many states, practices are eligible for financial incentives for adopting the medical home model, and the federal government has joined multi-payer demonstrations and supports efforts to deploy the model in community health centers. NCQA's Patient-Centered Medical Home (PCMH) Recognition program is the most widely used method for qualifying practices for rewards in multi-payer demonstrations.

NCQA developed the optional Distinction in Patient Experience Reporting to help practices capture patient and family feedback. Because consumer experience is a critical component of quality of care, giving more prominence to patient engagement is a crucial change to the PMCH program. Recognized practices, or practices applying for recognition, could earn distinction in collecting and reporting patient experience data by submitting results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) PCMH Survey to NCQA.

The CAHPS PCMH Survey assesses several domains of care: access, information, communication, coordination of care, comprehensiveness, self-management support and shared decision making. The survey lays the groundwork for measuring and improving a practice's delivery of care and assessing how well the practice is achieving the goals of the patient-centered medical home.

Submitted data will be used to develop a benchmarking database that will allow comparison across practices. In addition to earning distinction and being listed in directories as having distinction, practices will receive credit in PCMH 2011 *Standard 6: Measure and Improve Performance*, Element B (Patient/Family Feedback).

NCQA worked with a research team sponsored by the federal Agency for Healthcare Research and Quality (AHRQ) to develop and field-test a new version of the CAHPS Clinician & Group Survey. This project was funded in part by the Commonwealth Fund.





How to Apply

NCQA uses an online application to collect information about practices that intend to report CAHPS PCMH Survey data. Practices can obtain the CAHPS PCMH publication that includes the survey, information on how to apply, and the data submission process at <http://www.ncqa.org/Communications/Publications/index.htm> or by contacting NCQA Customer Support at 888-275-7585.

Practices with current NCQA PCMH Recognition are eligible for the optional distinction. Practices without NCQA Recognition may submit PCMH CAHPS results, but may earn optional distinction only after achieving NCQA PCMH Recognition. Practices may pursue NCQA PCMH Recognition and Distinction in Patient Experience Reporting at the same time.

Practices must use an NCQA Certified Survey Vendor to ensure standardization of data collection and reporting. The vendor must meet four requirements to help practices obtain NCQA Distinction.

- **Capture patient experiences data via the CAHPS PCMH Survey.** The CAHPS PCMH Survey captures patients' experiences of care in the last 12 months.¹ It includes all core items in the CAHPS Clinician & Group Survey and incorporates new items to address domains of care identified through multi-stakeholder input as critical for evaluating functioning of PCMH practices.
- **Use a standardized sampling process and attain the minimum number of completed surveys,** based on number of clinicians and patients at the practice site.
- **Use an approved data collection process.** For flexibility, the CAHPS PCMH Survey can be implemented in five modes of data collection: mail, telephone, Interactive Voice Response [IVR], Internet or mixed communication channels.
- **Submit survey data to NCQA using a specified file layout and data submission method.** Recognized practices that report CAHPS PCMH Survey data will receive notification of distinction soon after data submission. There are two data submission periods each year: spring and fall. Practices may retain distinction by collecting and reporting CAHPS PCMH data annually.

For more information about NCQA's Distinction in Patient Experience Reporting, PCMH and other NCQA Recognition programs, visit www.ncqa.org or contact NCQA Customer Support at 888-275-7585.

¹ Versions of the survey are available for adults to report on their own care and for adults to report on their child's care. Surveys are available in English and Spanish.



Patient-Centered Medical Homes Improve Care and Efficiency

Diverse studies have demonstrated that medical homes improve access and reduce unnecessary medical costs.

- Patient access to care through available visits outside of regular practice hours and same-day access has been shown to reduce emergency department use (Bodenheimer and Pham 2010³).
- Another study evaluating a PCMH demonstration project in an integrated group practice showed significant improvement in patients' and providers' experiences and in the quality of clinical care (Reid 2009⁴).

Champion Sponsor



The PCMH 2011 Recognition Program is further expression of NCQA's commitment to improving health care quality. The program builds on earlier NCQA programs (PPC and PPC-PCMH Recognition) that support outstanding, innovative primary care. Other NCQA performance measurement programs recognize excellence in caring for patients with diabetes, back pain, cardiovascular disease and stroke.

For more information about PCMH and other NCQA Recognition Programs, visit www.ncqa.org or contact NCQA Customer Support at 888-275-7585.



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³ Bodenheimer T, Pham H. Primary Care: Current Problems and Proposed Solutions. *Health Affairs*. 2010;29(5):799-805

⁴ Reid R., Fishman P., Yu O., Ross T., Tufano J.T. (2009). Patient-Centered Medical Home Demonstration: A prospective, quasi-experimental, before and after evaluation. *American Journal of Managed Care*. 15(9), e71-e87.