NCQA's Patient-Centered Medical Home (PCMH) 2011
January 31, 2011

NCQA's Patient-Centered Medical Home (PCMH) 2011 is an innovative program for improving primary care. In a set of standards that describe clear and specific criteria, the program gives practices information about organizing care around patients, working in teams and coordinating and tracking care over time. The new PCMH 2011 standards build on the success of earlier standards and make the program even more responsive to patients' needs. Although the standards have always pointed practices toward using systems—including electronic health records—to support tracking care, the new program aligns closely with many specific elements of the federal program that rewards clinicians for using health information technology to improve quality (Centers for Medicare & Medicaid Services [CMS] Meaningful Use [MU] Requirements).

Improving quality of care by organizing care around patients

Primary care is a foundation of the health care system. The NCQA PCMH standards reflect elements that make primary care successful. Primary care clinicians are often the first point of contact for an individual; thus, patient access to care is an important issue. Clinicians must have a broad knowledge of many health care conditions and often follow their patients over years; thus, the quality of the clinician/patient relationship and the clinician's ability to track care over time are also important. Many primary care clinicians need to refer patients to specialists; thus, communication among providers is important—and often challenging.

Although the earlier PCMH program addressed many of these issues, PCMH 2011 strengthens and adds to existing elements. We revised the standards to be clearer and more specific, and some practices may find the program more challenging. Through a comprehensive review of new evidence on effective care practices, NCQA PCMH 2011 Advisory Committee discussions, feedback on our earlier programs and a public comment period, we have taken the program to a new level.

Robust patient centeredness is an important program goal:

- There is a stronger focus on integrating behavioral healthcare and care management
- Patient survey results help drive quality improvement
- Patients and their families are involved in quality improvement.

We have added a new, standardized patient experience survey and an accompanying standardized methodology. Practices that use this survey will receive extra credit for doing so. Although this is not required, the survey lays the groundwork for broader reporting and benchmarking and makes data available to PCMH program sponsors across the country. This new survey is a tool to track patients' ratings of the care they get in the PCMH.

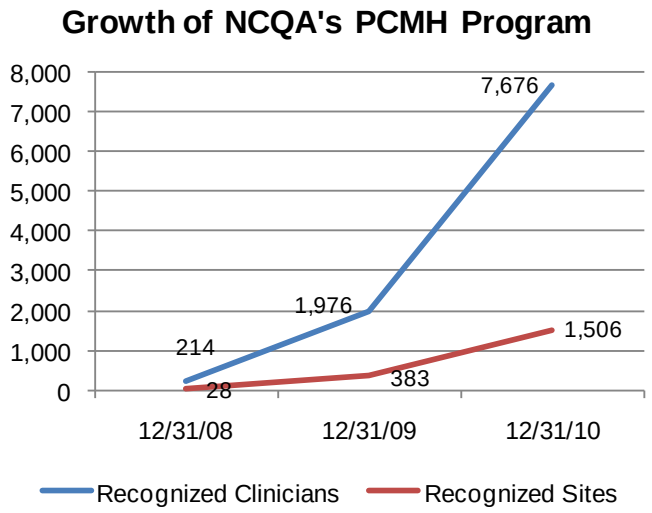
Coordinating care and managing information

Just as patient-centeredness is an integral part of the program, so too is a practice's ability to track care over time and across settings. The amount of clinical information for some patients—particularly those with chronic illnesses—and the fragmented nature of the U.S. health system make this aspect of primary care challenging. Experts agree that health information technology can help clinicians coordinate patient care, but merely having an electronic health record system in a practice is not enough. The health information system itself must be useful, and practices must use it to achieve the goals of coordination and high quality of care.

We recognize that the federal government is making a major investment in encouraging clinicians to use health information technology to improve the quality of care, and where possible we have aligned the PCMH 2011 standards with government laws and regulations. We want to reinforce incentives for clinicians to invest in improving quality.

NCQA's PCMH program makes sense

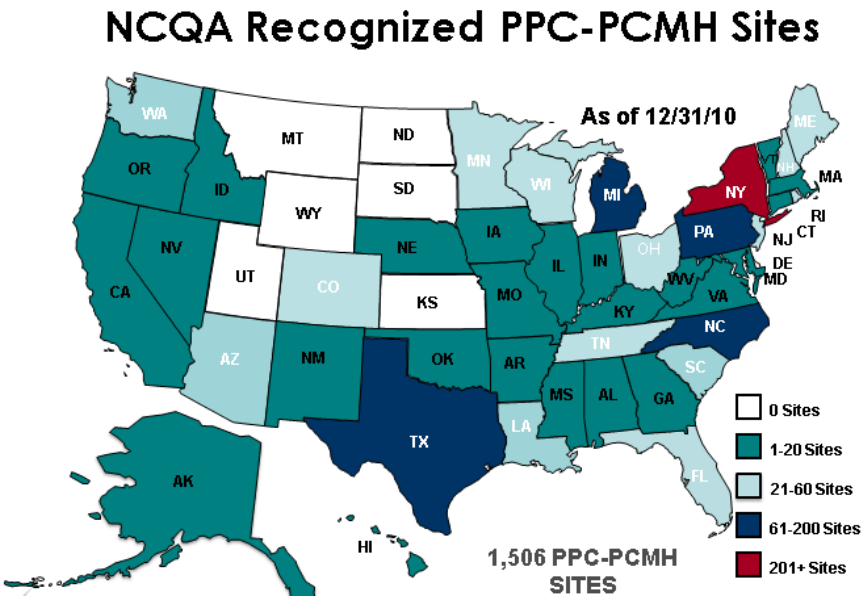
Another of the PCMH program's strengths is that it clearly communicates an action plan for becoming a patient-centered medical home. The PCMH standards are available on the NCQA Web site at no cost, and we conduct educational programs around the country that discuss the program and how it works. By the end of 2010, participation in one of the two earlier versions of the PCMH program had skyrocketed: more than 7,600 clinicians at more than 1,500 practices across the country had earned PCMH Recognition.



NCQA's PPC-PCMH program is acknowledged as the primary standardized method for evaluating a practice's capability of performing as a patient-centered medical home. Across the country, public and private payers, purchasers and clinicians have created pilot and demonstration programs. Many programs provide financial incentives, such as pay for performance and reimbursement for services beyond the patient visit, which have motivated primary care practices to engage in the transformation that leads to NCQA PPC-PCMH Recognition.

As practices work on system redesign to meet the PPC-PCMH standards, many have noted the effect—both on their practice and on their patients. A few comments from practices:

- "The medical home design will revitalize primary care by improving the efficacy of our efforts while more fairly rewarding its inherent value."
- "The medical home allows physicians to do reliably and consistently the things they want to do anyway."
- "The medical home….[is] just better care, helping patients and staff."



Early evidence suggests that PCMH improves quality and returns savings

The Patient-Centered Primary Care Collaborative recently released a report that summarized findings from PCMH demonstrations (http://www.pcpcc.net/content/pcmh-outcome-evidence-quality) and concluded that findings from PCMH demonstrations show success in increasing the quality of care and in reducing cost of care on some measures. In the academic literature, a recent article also found reduced use of hospitalization and emergency room visits and overall savings (Fields, Leshen, Patel, 2010). Another study evaluating a PCMH demonstration project in an integrated group practice showed significant improvement in patient and provider experiences and in the quality of clinical care (Reid, 2009). A study of the impact of the PCMH model on costs of care indicated a relationship between practices with established systems/processes and a decreased use of inpatient and emergency care by diabetic patients (Flottemesch, under review).

PCMH 2011

Development

NCQA's goal is for the PCMH standards to move transformation of primary care practices forward but to ensure that the standards are reasonably within reach of a range of primary care practice sizes, configurations (e.g., solo, multi-site, community health center), electronic capabilities, populations served and locations (e.g., urban, rural) .

Standard development was a rigorous process that included significant research; input from an engaged, multi-stakeholder advisory committee and from many others; results of an open public comment period; and extensive interviews with NCQA Recognized practices.

The Consumer Perspective

In developing the PCMH 2011 standards, we were guided by a strong consensus that we must expand the patient-centered perspective. To ensure that we captured this vantage point, the advisory committee included representatives of consumer organizations and researchers working on related patient-centered areas, and we encouraged consumer participation during the public comment process.

Public Comment

We posted the draft standards on the NCQA Web site and solicited comments from a wide group of stakeholders. We received more than 200 responses from health care providers, health plans, consumer groups and government agencies. There was a high degree of support for the proposed standards, especially the increased emphasis on patient-centered, team-based care coordinated across the health care system.

We also received useful suggestions for further revisions and changes, which we incorporated into the final version of the standards after review by our stakeholder advisory committee and the NCQA Board of Directors. Many organizations expressed interest in using the new standards, including primary care associations, community health centers, the Health Resources and Services Administration (HRSA)/Bureau of Primary Health Care (BPHC), the Veterans Administration, the Department of Defense Tri-Care Services, state-led demonstration projects and multi-payer demonstration projects.

Recognition Levels and Point Requirements

There are three levels of NCQA PCMH Recognition; each level reflects the degree to which a practice meets the requirements of the elements and factors that compose the standards. For each element's requirements, NCQA provides examples and requires specific documentation.

The NCQA Recognition levels allow practices with a range of capabilities and sophistication to meet the standards' requirements successfully. The point allocation for the three levels is as follows.

- **Level 1:** 35–59 points and all 6 must-pass elements
- **Level 2:** 60–84 points and all 6 must-pass elements
- **Level 3**: 85–100 points and all 6 must-pass elements

Initial Recognition vs. Renewal

To acknowledge that practices with current NCQA Level 2 or Level 3 Recognition have taken steps toward practice redesign and have systems in place that enabled their recognition level, NCQA offers a streamlined process for renewal through reduced documentation requirements. Practices that satisfactorily demonstrated basic medical home transformation can focus on more advanced aspects of redesign for their renewal applications.

Note: *Even though some elements do not require a practice to submit documentation, the practice must be able to produce documentation if it is selected for audit.*

The Standards

The PCMH 2011 program's six standards align with the core components of primary care.

PCMH 1: Enhance Access and Continuity

PCMH 2: Identify and Manage Patient Populations

PCMH 3: Plan and Manage Care

PCMH 4: Provide Self-Care and Community Support

PCMH 5: Track and Coordinate Care

PCMH 6: Measure and Improve Performance

The Must-Pass Elements

Six must-pass elements are considered essential to the patient-centered medical home, and are required for practices at all recognition levels. Practices must achieve a score of 50% or higher on must-pass elements:

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

Optional Recognition for Use of Standardized Patient Experience Survey

Beginning in January 2012, NCQA will offer additional points based on reporting results from a standardized patient experience survey. This option will require practices to use the Medical Home version of the CAHPS Clinician and Group Survey (currently in development by the research team sponsored by the federal Agency for Healthcare Quality and Research [AHRQ], with collaboration from NCQA). Practices can earn NCQA Distinction for collecting data using the survey and methods and reporting the results to NCQA. Because there are no national data sources for benchmarking performance on patient-experience results using this new tool, results will not initially be publicly reported or used to score practices.

In a future version of this optional distinction program, NCQA intends to score practices based on the results. Benchmarks for national performance and scoring will be based on data reported through the optional patient experience survey.

Table 1: Summary of NCQA PCMH 2011 Standards

Standard	Content Summary
Enhance Access/Continuity	• Patients have access to culturally and linguistically appropriate routine/urgent care and clinical advice during and after office hours • The practice provides electronic access • Patients may select a clinician • The focus is on team-based care with trained staff
Identify/Manage Patient Populations	• The practice collects demographic and clinical data for population management • The practice assesses and documents patient risk factors • The practice identifies patients for proactive and point-of-care reminders
Plan/Manage Care	• The practice identifies patients with specific conditions, including high-risk or complex care needs and conditions related to health behaviors, mental health or substance abuse problems • Care management emphasizes: – Pre-visit planning – Assessing patient progress toward treatment goals – Addressing patient barriers to treatment goals • The practice reconciles patient medications at visits and post-hospitalization • The practice uses e-prescribing
Provide Self-Care Support/ Community Resources	• The practice assesses patient/family self-management abilities • The practice works with patient/family to develop a self-care plan and provide tools and resources, including community resources • Practice clinicians counsel patients on healthy behaviors • The practice assesses and provides or arranges for mental health/substance abuse treatment
Track/Coordinate Care	• The practice tracks, follows-up on and coordinates tests, referrals and care at other facilities (e.g., hospitals) • The practice follows up with discharged patients
Measure/Improve Performance	• The practice uses performance and patient experience data to continuously improve • The practice tracks utilization measures such as rates of hospitalizations and ER visits • The practice identifies vulnerable patient populations • The practice demonstrates improved performance

Table 2: Integration of PCMH 2011 Development Goals Into Standards

PCMH 2011 Goals	Goal Integration in the Standards
Increase patient-centeredness	**PCMH 1: Enhance Access and Continuity** • Provide continuity of care with the same provider • Provide information to patients about the medical home • Provide access to care during and after office hours • Provide patient materials and services that meet the language needs of patients
	PCMH 3: Plan and Manage Care • Collaborate with the patient/family to develop and manage a plan of care • Reconcile medication with the patient/family
	PCMH 4: Provide Self-Care and Community Support • Provide resources to support patient/family self-management
	PCMH 6: Measure and Improve Performance • Involve patients/families in quality improvement • Obtain performance data for key vulnerable populations

Table 2 ***continued***

PCMH 2011 Goals	Goal Integration in the Standards
Align the requirements with processes that improve quality and eliminate waste	**PCMH 3: Plan and Manage Care** • Conduct medication reconciliation and management Use electronic prescribing **PCMH 5: Track and Coordinate Care** • Identify patients with hospital admission or emergency department visits
Increase the emphasis on patient feedback	**PCMH 6: Measure and Improve Performance** • Expand the survey categories (access, communication, coordination, self-management support, whole person orientation, comprehensiveness, shared decision-making) and practice requirements • Use patient survey results for quality improvement • Involve patients/families in quality improvement ***Note:*** *Optional Recognition for reporting results using a standardized patient experience survey and methodology*.
Enhance the use of clinical performance measure results	**PCMH 6: Measure and Improve Performance** • Increase the number of performance measures • Add a requirement to monitor utilization/overuse data • Add a requirement for practices to demonstrate improved PCMH status.
Integrate behaviors affecting health, mental health and substance abuse	**PCMH 1: Enhance Access and Continuity** • Comprehensive assessment includes depression screening for adolescents and adults
	PCMH 3: Plan and Manage Care • One of three clinically important conditions identified by the practice must be a condition related to unhealthy behaviors (e.g., obesity) or a mental health or substance abuse condition.
	PCMH 5: Track and Coordinate Care • Track referrals and coordinate care with mental health and substance abuse services
Enhance coordination of care	**PCMH 5: Track and Coordinate Care** • Arrange for information exchange with facilities, including after-hours care providers • Coordinate referrals • Coordinate with community service agencies
Enhance applicability to pediatric practices	**Throughout the standards** • Incorporate “family” where appropriate • Use “NA for pediatric practices” where appropriate • Use pediatric examples and explanations • Reference Bright Futures
	PCMH 1: Enhance Access and Continuity • Explanation addresses unique pediatric issues, such as teen privacy and guardianship
	PCMH 2: Identify and Manage Patient Populations • Include pediatric clinical data, health assessment requirements and age appropriate immunizations and screenings • Include age-appropriate screenings (e.g., developmental, adolescent depression)
	PCMH 3: Plan and Manage Care • Explanation specifies relevant pediatric clinical conditions, including well-child care and children/youth with special health care needs
	PCMH 4: Provide Self-Care and Community Resources • Population specific referrals includes parenting and respite care
	PCMH 5: Track and Coordinate Care

	• Communicate with facilities for newborn lab test results • Collaborate to develop a written care plan for patients transitioning from pediatric care to adult care
	PCMH 6: Measure and Improve Performance • Preventive measures include developmental screening, immunizations and depression screening

The PCMH 2011 Advisory Committee

NCQA began planning for the next version of the PPC-PCMH standards shortly after the original standards were released in January 2008. From the release date, we solicited, received and catalogued suggestions for future modifications. In the latter half of 2009, we created the PCMH Advisory Committee, a diverse, 22-member committee composed of practice, medical association, physician group, health plan and consumer and employer group representatives. The committee met throughout 2010 to discuss and analyze draft standards, PPC-PCMH data analysis and public comment results.

The committee was charged with "raising the bar" by emphasizing continuity and coordination of care, making standards and explanations more inclusive of pediatric practices and streamlining the documentation requirements.

The importance of this committee cannot be overstated. Its members gave their time, energy, enthusiasm and a willingness to hear and compromise on opposing perspectives. The PCMH 2011 standards are a reflection of their hard work and collaboration.

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Resources

Barr, M. The Patient-Centered Medical Home: Aligning Payment to Accelerate Construction. *Med Care Res Rev OnlineFirst.* May 6, 2010: XX(X)1–8.

Berwick, D.M., T.W. Nolan, J. Whittington. 2008. The Triple Aim: Care, Health, And Cost *Health Affairs*, 27, no. 3:759–69.

Bitton, A., C. Martin, B. Landon. 2010. A Nationwide Survey of Patient Centered Medical Home Demonstration Projects. *J Gen Intern Med.* 25(6):584–92.

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

Centers for Medicare and Medicaid Services (CMS). Electronic Health Records and Meaningful Use. http://healthit.hhs.gov/portal/server.pt?open=512&objID=2996&mode=2 (January 12, 2011)

Diedhiou, A., J. Probst, J. Hardin, et al. Relationship Between Presence of a Reported Medical Home and Emergency Department Use Among Children With Asthma. *Med Care Res Rev OnlineFirst.* May 4, 2010:XX(X)1–26.

Fields, D., E. Leshen, K. Patel. 2010. Driving Quality Gains and Cost Savings Through Adoption of Medical Homes. *Health Affairs*. 29(5):819–26.

Grumbach, K., P. Grundy. *Outcomes of Implementing Patient Centered Medical Home Interventions: A Review of the Evidence from Prospective Evaluation Studies in the United States.* November 16, 2010. http://www.pcpcc.net/files/evidence_outcomes_in_pcmh.pdf (January 12, 2011)

Grundy, P., K. Hagan, J.C. Hansen, et al. 2010. The Multi-Stakeholder Movement For Primary Care Renewal and Reform. *Health Aff*. 29(5):791–8.

Holmboe, E., G. Arnold, W. Weng, et al. 2010. Current Yardsticks May Be Inadequate For Measuring Quality Improvements From The Medical Home. *Health Affairs.* 29(5):859–66.

Homer, C., R. Baron. 2010. How to Scale Up Primary Care Transformation: What We Know and What We Need to Know? *J Gen Intern Med.* 25(6):625–9.

Howell, J. 2010. Reflections on the Past and Future of Primary Care. *Health Affairs.* 29(5):760–5.

Institute of Medicine. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century.* National Academies Press, Washington, DC.

Institute of Medicine. 2005. *Building a Better Delivery System: A New Engineering/Health Care Partnership.* National Academies Press, Washington, DC.

Landon, B., J. Gill, R. Antonelli, et al. 2010. Prospects for Rebuilding Primary Care Using the Patient-Centered Medical Home. *Health Affairs.* 29(5):827–34.

Merrell, K., R. Berenson. 2010. Structuring Payment for Medical Homes. *Health Affairs.* 29(5):852–8.

Margolius, D., T. Bodenheimer. 2010. Transforming Primary Care: From Past Practice to The Practice of The Future. *Health Aff.* 29(5):779–84.

McClellan, M., A. McKethan, J. Lewis, et al. 2010. A National Strategy to Put Accountable Care Into Practice. *Health Aff.* 29(5):982–90.

Naylor, M., E. Kurtzman. 2010. The Role of Nurse Practitioners in Reinventing Primary Care. *Health Affairs.* 29(5):893–9.

Pham, H. 2010. Good Neighbors: How Will the Patient-Centered Medical Home Relate to the Rest of the Health-Care Delivery System? *J Gen Intern Med.* 25(6):630–4.

Rittenhouse, D., S. Shortell, E. Fisher. 2009. Primary Care and Accountable Care—Two Essential Elements of Delivery-System Reform. *N Engl J Med.* 361(24):2301–3.

Rittenhouse, D., D. Thom, J. Schmittdiel. 2010. Developing a Policy-Relevant Research Agenda for the Patient-Centered Medical Home: A Focus on Outcomes. *J Gen Intern Med.* 25(6):593–600.

Roby, D.H., N. Pourat, M.J. Pirritano, et al. Impact of Patient-Centered Medical Home Assignment on Emergency Room Visits Among Uninsured Patients in a County Health System. *Med Care Res Rev OnlineFirst.* June 2, 2010:XX(X)1–19.

Shortell, S., L. Casalino. 2010. Implementing Qualifications Criteria and Technical Assistance for Accountable Care Organizations. *J Amer Med Assoc.* 303(17):1747–8.

Stange, K., P. Nutting, W. Miller, et al. 2010. Defining and Measuring the Patient-Centered Medical Home. *J Gen Intern Med.* 25(6):601–12.

Wagner, E.H., B.T. Austin, C. Davis, M. Hindmarsh, J. Schaefer, A. Bonomi. 2001. Improving chronic illness care: translating evidence into action. *Health Aff (Millwood).* 20:64–78.

Wagner, E.H. 1998. Chronic disease management: what will it take to improve care for chronic illness? *Eff Clin Pract.* 1:2–4.