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 supports, as needed.
- Medical homes offer enhanced access through expanded hours and online communication.
- They promote shared decisions, so patients make informed choices and 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. NCQA updated the PCMH standards in 2011 to be clearer and more specific. The new standards are more challenging than our 2008 criteria because they "raise the bar" in several important respects:

- They emphasize language and culturally sensitive facets of care.
- They align with federal requirements for "meaningful use" of health IT.
- They have a stronger focus on integrating care management and behavioral healthcare.
- They address pediatric topics like parental decision-making, immunizations and teen privacy.
- They incorporate surveys to engage patients and families in quality improvement.

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 and 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 IT and clinician-patient partnerships, these new standards raise the bar in defining high-quality care."

Research demonstrates that PCMHs achieve powerful results. Patients in PCMHs report having increased access to care.[1] PCMHs reduce disparities in care for people with lower incomes.[2] Empire Blue Cross of New York showed that NCQA PCMHs have higher quality and lower cost than non-PCMHs.[3] Colorado found $2-4 in savings for every $1 spent,[4] and other states are seeing similar benefits.[5]

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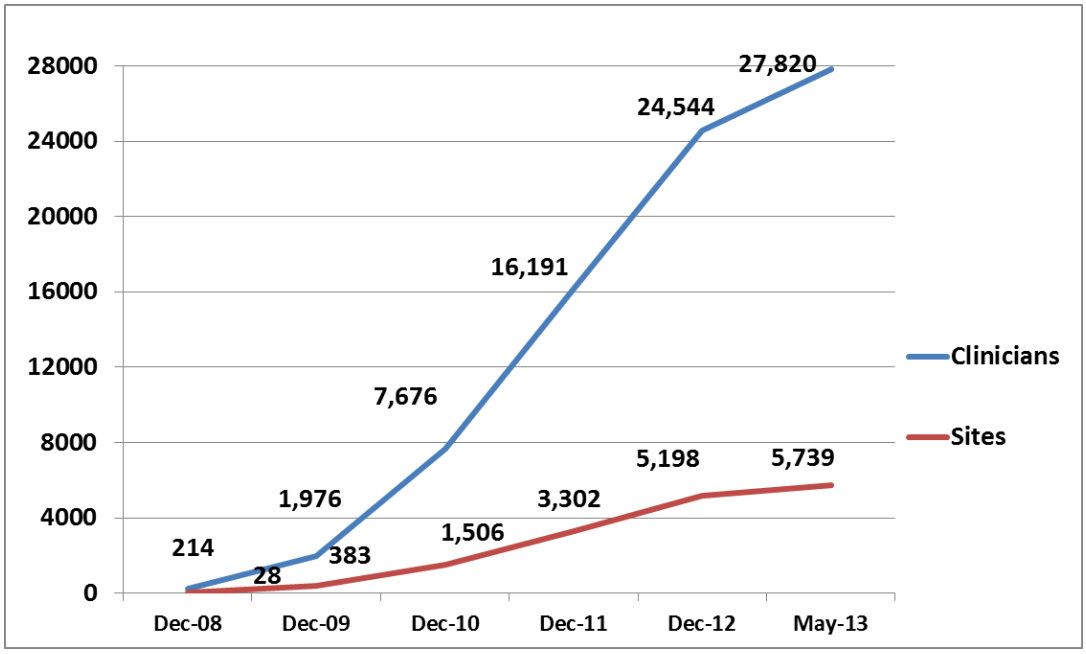
[1] *Patient Experience Over Time in PCMHs*, Kern, American Journal of Managed Care, May 2013

[2] *Achieving Better Quality of Care for Low-Income Populations: The Role of Health Insurance and the Medical Home for Reducing Health Inequities,* Berenson, Commonwealth Fund, May 2012

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.

- More than 27,500 clinicians and 5,700 sites across the country have earned NCQA 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 PCMHs.
- 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.

NCQA PCMH Growth 2008-2013



PCMH & Accountable Care Organizations. PCMHs are the fundamental building block for meeting NCQA's rigorous Accountable Care Organizations (ACO) standards. ACOs can expand the PCMH principles of patient-centered care to the entire health care system. TO NCQA's rigorous standards, ACOs will need to start with a strong PCMH foundation.

NCQA's PCMH 2011 standards 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 probinson@ncqa.org.

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

[4] *Colorado's Patient-Centered Medical Home Pilot Met Numerous Obstacles, Yet Saw Results Such As Reduced Hospital Admissions,* Harbrecht, Health Affairs, September 2012

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