NCQA
Measuring quality.
Improving health care.

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. It's a model that puts patients at the forefront of care by building better relationships between patients and the teams who care for them. PCMHs directly address the fragmentation[1] that plagues our health care system by:

- Ensuring Helping patients receive the treatment they need, when they need it.
- Preventing costly, avoidable hospitalizations and emergency department visits – particularly for those with complex chronic conditions.
- Reducing health care disparities for important services like preventive screenings.
- Coordinating the type of personalized, comprehensive, integrated care that patients want.
- Improving staff satisfaction by ensuring practices have the systems and structures to work efficiently.
- Leveraging health information technology (HIT) to enhance access and coordinate and manage care.

PCMH practices meet a set of clear, specific criteria that show clinicians how to organize care around patients and work in teams to coordinate, track and improve care:

Team-Based Care and Practice Organization

Helps structure practice leadership, care team responsibilities and how practices partner with patients, families and caregivers.

Know and Manage Patients

Sets standards for things like data collection, medication reconciliation and evidence-based clinical decision support.

Patient-Centered Access and Continuity

Guides practices to provide patients with convenient access to clinical advice and helps ensure continuity of care.

Care Management and Support

Helps clinicians set up care management protocols to better identify patients who need more closely-managed care.

Care Coordination and Care Transitions

Makes sure primary and specialty care clinicians are effectively sharing information and managing patient referrals. Cost, confusion and inappropriate care is minimized.

Performance Measurement and Quality Improvement

Helps practices develop ways to measure their performance to set goals and to develop activities that will improve performance.

This year, NCQA is launching a PCMH Redesign to help clinicians through the recognition process. We are aligning recognition activities with other reporting requirements, leveraging investment HIT to support transformation, and strengthening the link between recognition and practice performance on quality, cost, and patient experience. The Redesign also focuses on helping providers develop relationships with social, community and other non-medical providers to fully integrate care delivery.

[1] Frandsen, B.R., Joynt, K.E., Rebitzer, J.B. & Jha, A.K. (2015). Care Fragmentation, Quality, and Costs Among Chronically Ill Patients. *American Journal of Managed care.*

A growing body of evidence documents PCMHs' many benefits, including better quality, continuity, prevention, disease management and patient engagement. Studies also show lower costs from inpatient admissions, especially for patients with complex chronic conditions. [i] [ii] [iii] [iv] [v] [vi] [vii]

Practice & Clinician Benefits

- Align with national health care trends away from volume and toward value-based care.
- Earn auto-credit and perform better in the Merit-Based Incentive Payment System.
- Improve patient care by implementing processes that drive practice efficiency.
- Earn enhanced reimbursements through federal, state and commercial payers for your NCQA recognition.

Patient Benefits

- Trust their PCMH to deliver the right preventive services to stay healthy.
- Enhanced access and better communication to get needed clinical advice or information.
- Care teams have helpful staff to coordinate care both inside and outside the practice.
- Complex chronic conditions are better managed, preventing acute incidents and costly hospital visits.

PCMH & MACRA. Medicare recognized these benefits by offering financial incentives for NCQA PCMH Recognition under the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA). That's because NCQA PCMH provides a roadmap for making this powerful change to how clinicians provide care.

PCMHs also are a fundamental building block for participating in public and private APMs. APMs are proliferating under the nationwide transition from volume to value-based care, and NCQA's rigorous standards provide a roadmap for practices to implement the infrastructure necessary to flourish in this new environment. Together with our Patient-Centered Specialty Practice (PCSP) and Patient-Centered Connected Care (PCCC) Recognition, NCQA offers a full suite of programs to recognize an entire medical neighborhood that could potentially form its own APM.

NCQA's PCMH standards are available free of charge at https://store.ncqa.org/. NCQA also offers are variety of educational programs about how the program works. For more information, please contact Paul Cotton, NCQA's Director of Federal Affairs at (202) 955-5162 or cotton@ncqa.org.

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[i] Pines J.M., Martijn van Hasselt & Nancy McCall (2015). Emergency Department and Inpatient Hospital Use by Medicare Beneficiaries in Patient-Centered Medical Homes. *Annals of Emergency Medicine*. http://www.annemergmed.com/article/S0196-0644(15)00003-7/pdf.

[ii] Van Hasselt, M., McCall, N., Keyes, V., Wensky, S. G., & Smith, K. W. (2014). Total Cost of Care Lower among Medicare Fee-for-Service Beneficiaries Receiving Care from Patient-Centered Medical Homes. *Health Services Research.*

[iii] Friedberg MW, Rosenthal MB, Werner RM, Volpp KG, Schneider EC. (2015). Effects of a Medical Home and Shared Savings Intervention on Quality and Utilization of Care. *JAMA Internal Medicine.* http://archinte.jamanetwork.com/article.aspx?articleid=2296117

[iv] Markovitz AR, Alexander JA, Lantz PM, Paustian ML (2015). Patient-Centered Medical Home Implementation and Use of Preventive Services: The Role of Practice Socioeconomic Context. *JAMA Internal Medicine*.

[v] Department of Vermont Health Access / Vermont Blueprint for Health http://blueprintforhealth.vermont.gov/sites/blueprint/files/BlueprintPDF/AnnualReports/Vermont-Blueprint-for-Health-2015-Annual-Report-FINAL-1-27-16.pdf

[vi] M. B. Rosenthal, M. W. Friedberg, S. J. Singer et al. (2013). Effect of a Multipayer Patient-Centered Medical Home on Health Care Utilization and Quality: The Rhode Island Chronic Care Sustainability Initiative Pilot Program. *JAMA Internal Medicine.*

[vii] Reid et al (2013). Spreading a Medical Home Redesign: Effects on Emergency Department Use and Hospital Admissions. *Annals of Fam Med.*