

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. PCMHs are improving quality, mitigating health disparities, and cutting costs of care by focusing on these principles:

- 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.

The Recognition Program provides 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'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.

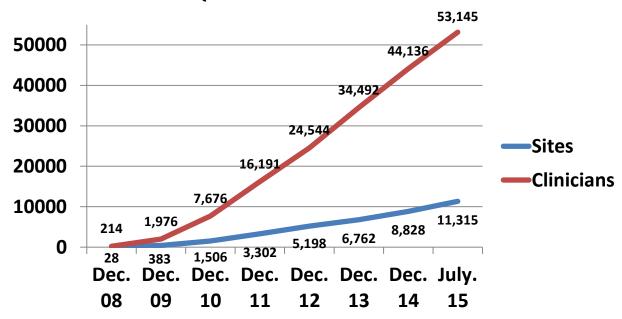
We have updated the program twice since 2008 to focus more on integrating care management and behavioral healthcare, address high-needs populations and further incorporate patient and family engagement. NCQA is now planning a program redesign to align recognition activities with other reporting requirements, leverage investment in health information technology to support transformation, and strengthen the link between recognition and practice performance on quality, cost, and patient experience.

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 viii

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

- More than 53,000 clinicians and 11,300 sites across all 50 states have earned NCQA PCMH recognition.
- PCMHs receive full credit for "Clinical Practice Improvement Activities" that provide 15% of scoring in Medicare's new Merit-Based Incentive Payment System.
- NCQA has worked with the Departments of Defense and Health and Human Services to help transform primary care facilities into PCMHs.
- Dozens of states are using NCQA's PCMH standards as part of their Medicaid programs, Health Home initiatives and State Innovation Model Grants.

NCQA PCMH Growth 2008-2015



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 meet NCQA's rigorous standards, ACOs will need to start with a strong PCMH foundation.

NCQA's PCMH standards are available free of charge at https://store.ncqa.org/. NCQA offers educational programs about how the program works. For more information, please contact Leah Kaufman, NCQA Physician Recognition Programs Manager, at (202) 735-3689 or kaufman@ncqa.org/.

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^v Department of Vermont Health Access / Vermont Blueprint for Health http://hcr.vermont.gov/sites/hcr/files/pdfs/VTBlueprintforHealthAnnualReport2013.pdf

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viii Reid et al (2013). Spreading a Medical Home Redesign: Effects on Emergency Department Use and Hospital Admissions. *Annals of Family Medicine*.