



NCQA's Physician Practice Connection® Patient-Centered Medical Home™ (PPC®-PCMH™) Program

The Patient-Centered Medical Home (PCMH) is a promising model of health care delivery that aims to improve the quality and efficiency of care. Across the country, practitioners, patients, health plans, employers, public purchasers and others are actively testing the concept to learn how to transform and assess medical home practices. Early evaluations of the PCMH have shown promising results in improving care quality and lowering costs by increasing access to more efficient, more coordinated care. By avoiding unnecessary hospitalizations and emergency room visits, these early results are producing savings for payers, purchasers and patients. ⁱ, ⁱⁱ, ⁱⁱⁱ, ^{iv}.

NCQA worked with the four national organizations representing primary care physicians – the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association – to develop a set of standards known as the Physician Practice Connections® – Patient-Centered Medical Home™ (PPC-PCMH). We have also sought the input of patient advocates, employers and other purchasers, state and federal officials and many others to help refine and improve the model. Organizations and policymakers using the standards can shorten the development process for new pilots and initiatives and make sure that their programs can compare to others.

How can NCQA's standards be used in new medical home programs?

NCQA's PPC-PCMH standards are in use in the public and private sectors. NCQA has worked with state leaders in Colorado, Florida, Louisiana, Maryland, New York, Pennsylvania, Vermont and elsewhere. We also are working with the U.S. Centers for Medicare & Medicaid Services (CMS) to adapt this tool for Medicare.

What are the NCQA standards and how does the program work?

Practices apply to NCQA to become recognized as patient-centered medical homes by submitting detailed information about the care they deliver. Independent reviewers score the practice based on how well they meet NCQA standards.

"The Physician Practice Connections® - Patient-Centered Medical Home (PPC-PCMH) standards have emerged at the center of a national move to improve primary care and prevention. Providers and insurers, groups that often have difficulty finding common ground, have adapted these standards as basis for evaluating the quality of care that practices deliver, planning improvements, and guiding payment reforms. This is true in states across the nation and in Vermont." - Vermont Governor Jim Douglas, March 23, 2010

NCQA has nine standards for medical homes. The standards and scores for each recognition level are available at www.ncqa.org. NCQA offers three levels of PPC-PCMH recognition. More than half of NCQA Recognized practices have achieved Level 3 status.

Level	Overall Points Required	“Must Pass” Requirements (at least 50% performance)
Level 1	25-49	5 of 10
Level 2	50-74	10 of 10
Level 3	75-100	10 of 10

PPC-PCMH Standards:

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| <ol style="list-style-type: none"> 1. Access and communication 2. Patient tracking and registry functions 3. Care management 4. Self-management support 5. Electronic prescribing | <ol style="list-style-type: none"> 6. Test tracking 7. Referral tracking 8. Performance reporting and improvement 9. Advanced electronic communications |
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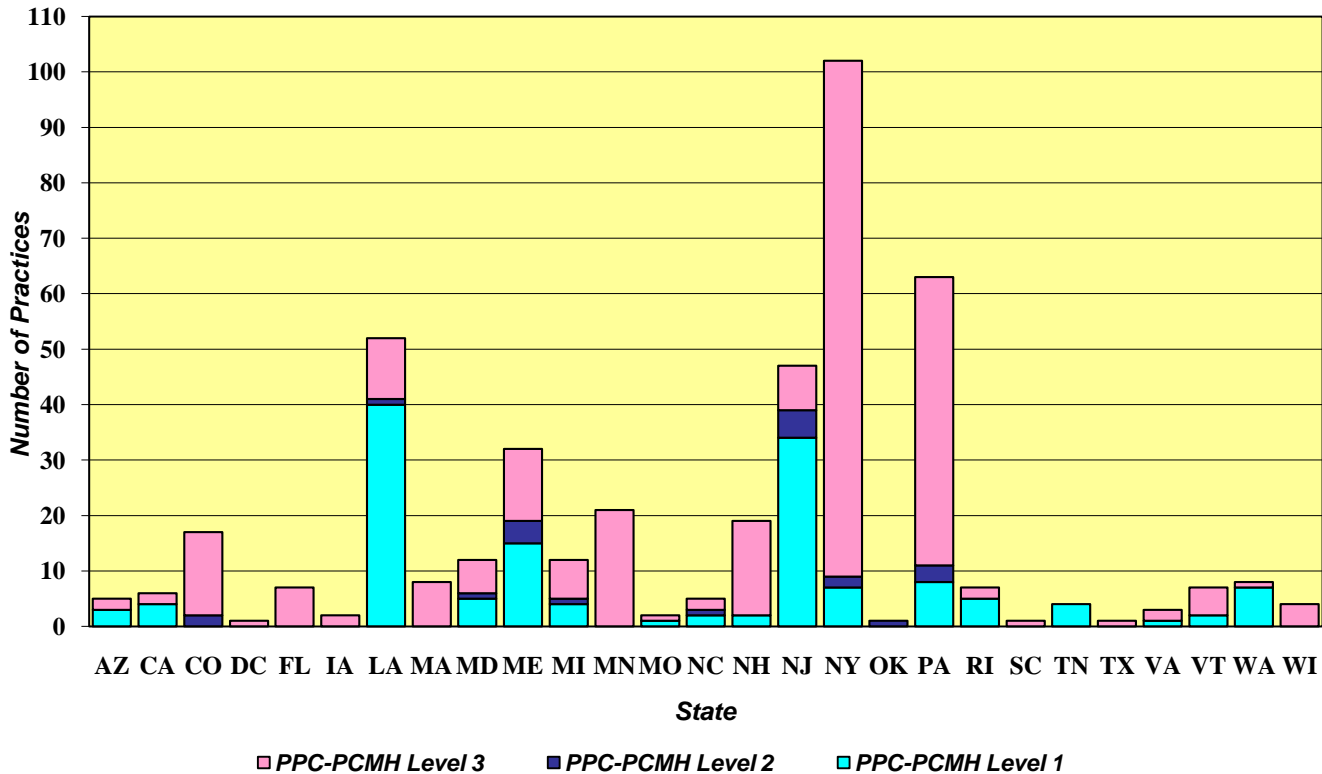
Health Information Technology (HIT) that supports high quality patient care, electronic record keeping, online disease registries, Internet communication with patients and electronic prescribing are crucial to a fully functioning medical home. Practices in the early stages of transformation do not need electronic medical records to be recognized as Level 1 medical homes. However, to achieve scores enabling Level 2 or 3 recognition, e-prescribing, advanced electronic communications with members and electronic care management support are recommended and rewarded.

Where are medical homes and how is the program growing?

Medical home programs are growing rapidly, fueled by interest from both the private and public sectors. As of March 1, 2010, nearly 450 practices in 24 states and the District of Columbia have been reviewed and recognized by NCQA as medical homes. More than 400 applications are pending, and we are receiving an average of 100 applications per month.

Medical home programs are being initiated in many parts of the U.S. Although these pilots have different payment models and designs, they use the NCQA Recognition tool to designate practices as eligible to receive higher payments for providing PCMH services. For example, the Colorado Patient-Centered Medical Home Pilot in Denver, is convened by the Colorado Clinical Guidelines Collaborative, and involves several private sector payers. The Rhode Island Chronic Care Sustainability Initiative is a multi-stakeholder program organized by the state health insurance commissioner. More information on medical home pilots is at <http://www.pcpcc.net/files/PilotGuidePip.pdf>.

**PPC-PCMH RECOGNIZED PRACTICES BY STATE
(As of 2/28/10)**



About NCQA

NCQA is a private, non-profit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of health care organizations and recognizes physicians in key clinical areas. NCQA’s Healthcare Effectiveness Data and Information Set (HEDIS®) is the most widely used performance measurement tool in health care. NCQA is committed to providing health care quality information through the Web, media and data licensing agreements in order to help consumers, employers and others make more informed health care choices.

For more information, please contact either Sarah Thomas, Vice President of Public Policy & Communications, at Thomas@ncqa.org, or Mina Harkins, Assistant Vice President, Physician Recognition Programs, at Harkins@ncqa.org.

ⁱ Paulus RA, Davis K, Steele GD. Continuous Innovation in Health Care: Implications Of The Geisinger Experience. Health Affairs. 2008 Sept-Oct; 27(5):1235-43.
ⁱⁱ Reid, R. J., P. A. Fishman, et al. Patient-Centered Medical Home Demonstration: A Prospective, Quasi-Experimental, Before and After Evaluation. Am J Managed Care. 2009; 15(9): 71-87.
ⁱⁱⁱ Wilhide S, Henderson T. Community Care of North Carolina: A Provider-Led Strategy for Delivering Cost-Effective Primary Care to Medicaid Beneficiaries. Washington, DC: American Academy of Family Physicians; 2006 Jun.
^{iv} Grumbach K, Bodenheimer T, Grundy P. The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies, August 2009. Available from : http://pcpcc.net/files/evidenceWEB%20FINAL%2010.16.09_1.pdf