



NCQA Patient-Centered Medical Home

PPC®-PCMH™

A New Model of
Care Delivery

Patient-Centered
Medical Homes
Enhance Primary
Care Practices



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Patient-Centered Medical Homes Enhance Primary Care Practices

What is a “patient-centered medical home”?

A patient-centered medical home is a model of care that strengthens the physician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship.

Each patient has an ongoing relationship with a personal physician who leads a team at a single location that takes collective responsibility for patient care, providing for the patient’s health care needs and arranging for appropriate care with other qualified clinicians. The medical home is intended to result in more personalized, coordinated, effective and efficient care.

A medical home achieves these goals through a high level of accessibility, providing excellent communication among patients, physicians and staff and taking full advantage of the latest information technology to prescribe, communicate, track test results, obtain clinical support information and monitor performance.

In the search for a higher quality, more affordable health care system, the patient-centered medical home¹ is rapidly gaining momentum and attention as an innovative approach to primary care.

Among primary care physicians and their professional societies, employers and purchasing coalitions, insurers, government agencies and consumer organizations, the patient-centered medical home has emerged as a promising alternative to the nation’s costly and fragmented health care delivery system.

In today’s value-driven health care environment, physicians are often overwhelmed because they are asked to deliver consistently high-quality care more efficiently, implement new information technology and improve care coordination and patient communication—all while empowering patients to take more responsibility for their health. Many physicians are not fully compensated for these additional responsibilities, which adds to the challenge.

NCQA’s nationally acclaimed Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) Recognition Program has helped hundreds of medical practices and thousands of physicians adopt this evolving delivery model and navigate emerging expectations while positioning themselves to benefit from payment and performance initiatives sponsored by private and public payers.

¹ Also referred to as the “advanced primary care” model.



“The patient-centered medical home has the potential to change the interaction between patients and physicians. Patients can no longer be silent partners in their care—they are active participants in managing their health with a shared goal of staying as healthy as possible.”

Margaret E. O’Kane, NCQA President

Helping Primary Care Practices Transform Health Care

NCQA Patient-Centered Medical Home (PPC-PCMH) Recognition Program

NCQA’s PPC-PCMH Recognition Program emphasizes systematic use of patient-centered, coordinated care management processes. It is an extension of NCQA’s highly regarded Physician Practice Connections (PPC) Recognition Program, initiated in 2003 with support from such prestigious organizations as The Robert Wood Johnson Foundation, The Commonwealth Fund and Bridges to Excellence.

Based on the well-known and empirically validated Wagner Chronic Care Model, the PPC-PCMH Recognition Program recognizes practices that successfully use systematic processes and information technology to enhance the quality of patient care.

NCQA launched PPC-PCMH with guidance from the American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics and the American Osteopathic Association, and based the program on the Medical Home Joint Principles² developed by these organizations:

- **Personal physician.** Each patient has an ongoing relationship with a personal physician who is trained to provide first contact, continuous and comprehensive care.
- **Physician-directed medical practice.** The personal physician leads a team of individuals at the practice level who collectively take responsibility for ongoing patient care.
- **Whole-person orientation.** The personal physician is responsible for providing all of the patient’s health care needs or for arranging care with other qualified professionals.

- **Care is coordinated and integrated** across all elements of the complex health care system and the patient’s community.
- **Quality and safety** are hallmarks of the medical home.
- **Enhanced access** to care is available through open scheduling, expanded hours and other innovative options for communication between patients, their personal physician and practice staff.
- **Payment** appropriately recognizes the added value provided to patients who have a patient-centered medical home.

Practices that achieve NCQA’s PCMH Recognition are positioned to take advantage of financial incentives offered by health plans and employers, as well as of federal and state-sponsored pilot programs.

Practices earning NCQA Recognition may qualify for additional bonuses or payments. For example, Bridges to Excellence ([www. bridgestoexcellence.org](http://www.bridgestoexcellence.org)) accepts NCQA Recognition to qualify for “Physician Office Link” financial rewards, which can range from \$50 to several hundred dollars per patient per year.

NCQA-Recognized medical homes—hundreds of practices, involving thousands of physicians—offer superior value to purchasers and consumers because they clearly demonstrate that systems and processes are in place to meet nationally recognized standards for delivering high-quality care.

² This list summarizes the Joint Principles. The full text is available at: <http://pcpcc.net/content/joint-principles-patient-centered-medical-home>.

PPC-PCMH Standards

PPC-PCMH Recognition is based on meeting specific elements included in nine standard categories:

1. Access and Communication
2. Patient Tracking and Registry Functions
3. Care Management
4. Patient Self-Management and Support
5. Electronic Prescribing
6. Test Tracking
7. Referral Tracking
8. Performance Reporting and Improvement
9. Advanced Electronic Communication

Included in the standards are 10 “must-pass” elements. To achieve Level 1 Recognition, practices must successfully comply with *at least 5 of these elements*. Achieving Level 2 or Level 3 depends on overall scoring and compliance *with all 10 must-pass elements*:

- PPC-1A: Written standards for patient access and patient communication
- PPC-1B: Use of data to show standards for patient access and communication are met
- PPC-2D: Use of paper or electronic charting tools to organize clinical information
- PPC-2E: Use of data to identify important diagnoses and conditions in practice
- PPC-3A: Adoption and implementation of evidence-based guidelines for three chronic or important conditions
- PPC-4B: Active support of patient self-management
- PPC-6A: Systematic tracking of tests and follow up on test results
- PPC-7A: Systematic tracking of critical referrals
- PPC-8A: Measurement of clinical and/or service performance
- PPC-8C: Performance reporting by physician or across the practice



“PPC-PCMH Recognition provides an independent evaluation of a practice’s application of technology and team approach to improve access to and the coordination of care. Supporting our network practices through this transformation has been immensely rewarding, and as demonstrated by improvement in quality performance measures, has allowed the involved practices to provide leading edge quality care for our members.”

Richard L. Snyder, MD, Chief Medical Officer, Independence Blue Cross

Apply for NCQA PPC-PCMH Recognition

Practices interested in seeking NCQA PPC-PCMH Recognition should request a free copy of the *PPC-PCMH Standards and Guidelines* (available at www.ncqa.org/ppcpcmh) and use them to help determine the readiness of their practice before proceeding. The document contains technical requirements, explanations and examples.

Free application materials are also available and include eligibility criteria and pricing information. Pricing is based on practice size. Prior to beginning the application process, applicants can choose to participate in a monthly audio conference or in-depth educational workshops (held quarterly) to find out more about the survey process and requirements.

Practices that meet specific elements among nine standard areas achieve one of three levels of NCQA Recognition. The Web-based data collection tool records responses. WebEx demonstrations support use of the PPC-PCMH Recognition Survey Tool and NCQA customer support is available Monday–Friday to help with the survey, document preparation and the online submission system.

The actual Survey Tool can be purchased online. It includes data collection guidelines needed for electronic submission of responses and supporting documents to NCQA. Practices can also use the Survey Tool to assess their readiness before submitting their survey for evaluation.

- NCQA reviews and scores the completed application and survey. We perform a random onsite audit of 5 percent of the practices that submit an application. We will contact you if your practice is selected.

Recognized practices receive:

- A letter and Certificate of Recognition
- Posting in the NCQA Recognition Directory
- A media kit that includes NCQA *Marketing and Advertising Guidelines*
- A press release announcement of Recognition to their choice of five publications

NCQA PPC-PCMH Recognition is valid for three years. During that time, a practice might be able to raise its Recognition level by completing additional relevant Survey Tool items.



“The comprehensive and coordinated care that the medical home promotes leads to better health, longer lives, higher patient satisfaction and less expensive care. The question isn’t whether we should implement the medical home, but how. NCQA standards clearly assess and identify effective medical homes.”

Paul Grundy, MD, IBM Global Director of Healthcare Transformation and President, Patient-Centered Primary Care Collaborative (PCPCC)



Patient-Centered Medical Homes Improve Care and Efficiency

A variety of studies have demonstrated that medical homes improve access and reduce unnecessary medical costs.

- In a controlled study at Pennsylvania's Geisinger Health System, medical home patients had a 14 percent reduction in hospital admissions relative to the control group. That accompanied "a trend toward a 9 percent reduction in medical costs" after two years.
- Group Health Cooperative of Puget Sound experienced a 29 percent reduction in ER visits and an 11 percent reduction in ambulatory sensitive care admissions as a result of a primary care redesign of a Seattle clinic.
- The Genesee Health Plan HealthWorks model in Michigan reduced ER visits by 50 percent and inpatient hospitalizations by 15 percent.

Other reports on the outcomes of implementing medical homes are available at www.pcpc.net.

NCQA's PPC-PCMH Recognition Program joins its predecessor, the PPC Recognition Program, and three other NCQA performance measurement programs that recognize excellence in caring for patients with diabetes, cardiovascular disease or stroke and back pain.

For more information about PPC-PCMH and other Recognition Programs, visit www.ncqa.org or contact NCQA Customer Support at 888-275-7585.

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