

**For Public Comment**

May 27 - June 28, 2010

Comments due 5:00 pm EST

# **Patient-Centered Medical Home (PCMH) 2011 Draft Standards**

## **Overview**

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# Overview

## **NCQA Seeks Input on PCMH 2011**

Public comment is integral to the development of NCQA standards and measures. NCQA actively seeks input from all interested parties during the development process and integrates recommendations in the final version of its programs.

We welcome your suggestions and encourage you to comment on the overall structure, the standards (e.g. PCMH 1, 2) and elements (e.g. PCMH 1A) as well as the patient experience domains and accompanying table. Suggestions on the proposed PCMH 2011 changes will be considered as we finalize the standards scheduled for release January 2011.

With this version NCQA is seeking to:

- Enhance patient-centeredness and the use of patient experience survey results
- Strengthen alignment of the requirements with processes demonstrated to improve quality and eliminate waste
- Have practices use clinical performance measurement and results to demonstrate improvement
- Identify requirements appropriate for practices initially seeking recognition and those renewing their recognition
- Move toward standardized clinical and patient experience measure reporting, with a goal for the future of establishing performance benchmarks and ultimately assessing practices with regard to benchmarks
- Align with the Centers for Medicare and Medicaid Services (CMS) proposed Measures of Meaningful Use.

## **Background**

### **National Committee for Quality Assurance's (NCQA) Mission: Improve the Quality of Health Care**

For 20 years, NCQA has been driving improvement throughout the health care system and helping to raise the issue of health care quality to the top of the national agenda. NCQA's recognition programs provide a road map for measurement, improvement, transparency and accountability. Since the PPC-PCMH program's launch in 2008, NCQA has recognized over 3,100 physicians at more than 600 practices (as of 4/30/2010), and the program has gained increasing visibility in demonstration and pilot programs becoming the most widely used qualification tool across the country.

## **Current Standards: 2008 Physician Practice Connections®—Patient-Centered Medical Home™ (PPC®-PCMH™)**

The concept of a patient-centered medical home (PCMH) is receiving much attention as an important foundation for changing the way care is delivered in the U.S. and internationally. Payers, purchasers, and policymakers see it as a vehicle for improving quality and moderating costs. Guided by input from research, advisory groups, pilot tests and public comment, NCQA developed the 2008 Physician Practice Connections®—Patient-Centered Medical Home™ (PPC®-PCMH™) standards to provide a standardized tool for qualifying practices in demonstration projects evaluating the PCMH model. The PPC-PCMH standards were based on NCQA's experience with the previous version of the standards, Physician Practice Connections® (PPC), released in 2006.

The Joint Principles for the Patient-Centered Medical Home, endorsed by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), the American Osteopathic Association (AOA) and now many others, provided high-level guidance for the content. The four primary care specialty societies (AAFP, AAP, ACP and AOA) endorsed the PPC-PCMH standards for use in demonstration projects. The standards also are endorsed by the National Quality Forum (NQF).

### **PPC-PCMH Update: PCMH 2011**

Across the country public and private payers, purchasers and clinicians have come together to create demonstration programs that provide financial incentives for primary care practices to achieve NCQA recognition as Patient-Centered Medical Homes. We are receiving roughly 100 applications a month. We have been delighted with the interest and the stories we have heard about how practices redesign their systems to meet the requirements and the difference it has made for practices and their patients. A few of the comments we've heard from practices about their experience going through PPC-PCMH:

“The Medical Home design will revitalize primary care by improving the efficacy of our efforts while more fairly rewarding its inherent value.”

“The Medical Home allows physicians to do reliably and consistently the things they want to do anyway.”

“The Medical Home....it's just better care, helping patients and staff.”

With all of this activity we have received many, sometimes conflicting suggestions, on how to improve the standards. We welcome the input and continue to solicit suggestions from a wide range of stakeholders, experts and interested parties.

An extensive review of the literature on medical home also provided background for revising the standards. We are not attempting to summarize or present a literature review here but instead to highlight recent journal articles that specifically examine the model of the medical home. Many of those support the general direction of our proposed changes to current PPC-PCMH standards. Fields et al (Fields, 2010) identified key features of successful medical home pilots: 1) use of non-physician care coordinators, 2) expanded access to health practitioners, 3) data-driven analytic tools to assist practices in meeting clinical goals for population management and individual patient tracking, and 4)

use of payment to incentivize change. Patient access to care through available visits outside of regular practice hours and same day access has been shown to reduce emergency department use (<sup>2</sup>Bodenheimer and Pham 2010). Another study evaluating a PCMH demonstration project in an integrated group practice showed significant improvements in patients' and providers' experiences and in the quality of clinical care (<sup>3</sup>Reid 2009).

One of the existing tensions in the medical home model is the extent of electronic system capability needed by a practice to be a medical home. While a practice can have successful care management systems without an electronic medical record (EMR), practices with a fully functioning EMR achieve higher scores on the PPC survey (<sup>4</sup>Solberg, 2005). Research also demonstrates a positive correlation between the overall PPC score and diabetes care measures (<sup>5</sup>Solberg, 2008). In addition, a study of the impact of the PCMH model on the costs of care indicated a relationship between practices with established practice systems/processes and a decreased use of inpatient and emergency care by diabetic patients (<sup>6</sup>Flottesmesch, under review).

Late last year, we convened a Patient-Centered Medical Home (PCMH) Advisory Committee to guide revision of the current standards.

### **PCMH Advisory Committee**

**Chair: Susan Edgman-Levitan, PA**, Stoeckle Center for Primary Care Innovation, Mass General Hospital

**Melinda Abrams, M.S.**, The Commonwealth Fund

**Bruce Bagley, M.D.**, American Academy of Family Physicians

**Michael Barr, M.D., M.B.A., F.A.C.P.**, American College of Physicians

**Duane Davis, M.D., F.A.C.P., F.A.C.R.**, Geisinger Health System

**Thomas Foels, M.D., M.M.M.**, Independent Health Plan of Buffalo, N.Y.

**Foster Gesten, M.D.**, New York State Department of Health

**Alan Glaseroff, M.D.**, Humboldt Del Norte IPA

**Veronica Goff**, National Business Group on Health

**Paul Grundy, M.D., M.P.H.**, IBM Global Wellbeing Services and Health Benefits

**Marjie Harbrecht, M.D.**, Colorado Community Guidelines Collaborative

**Edward G. Murphy, M.D.**, Carilion Health System

**Mary Naylor, Ph.D., FA.A.N., R.N.**, University of Pennsylvania School of Nursing

**Ann S. O'Malley, M.D., M.P.H.**, Center for Studying Health System Change

**Amanda Parsons, M.D., M.B.A.** New York City Department of Health & Mental Hygiene

**Lee Partridge**, National Partnership for Women and Families

**Carol Reynolds-Freeman, M.D.**, Potomac Physicians

**Marc Rivo, M.D., M.P.H.**, Prestige Health Choice

**Jeffrey Schiff, M.D., M.B.A.**, Minnesota Department of Human Services

**Xavier Sevilla, M.D., F.A.A.P.**, American Academy of Pediatrics

**Ann S. Torregrossa**, Commonwealth of Pennsylvania

**Ed Wagner, M.D., M.P.H.**, Group Health Cooperative of Puget Sound

Our intent is for the next version of the standards to continue to be feasible for individual practices and move primary care practices toward improved quality, reduced waste and enhanced patient experience. We believe that it is appropriate to increase expectations given the progress practices have made toward serving as medical homes.

## **What’s in the Draft Revisions?**

It is NCQA’s goal to have standards that are within reach of a range of practice sizes, configurations (e.g. solo, multi-site, community health center), electronic capabilities and locations (e.g. urban, rural) and to raise the threshold of requirements.

The overall structure of the PCMH 2011 draft standards is very similar to PPC-PCMH but more compact while maintaining alignment with the key components of primary care. The revised version has six standards instead of nine standards accomplished by merging some elements (e.g. referral and test tracking are now part of care coordination). The six PCMH 2011 draft standards are:

- 1) *Access and Continuity,*
- 2) *Identify and Manage Patient Populations,*
- 3) *Plan and Manage Care,*
- 4) *Self-Management Support,*
- 5) *Track and Coordinate Care and*
- 6) *Performance Measurement and Quality Improvement.*

The table below outlines the high-level goals for PCMH 2011 and identifies examples of how the goal is addressed in the draft standards.

<b>PCMH 2011 Goals</b>	<b>Examples of How Goals are Integrated into Standards</b>
<b>Increase patient-centeredness</b>	Standard 1 <ul style="list-style-type: none"> <li>• Provide continuity of care with the same provider</li> <li>• Provide information to the patient about medical home</li> <li>• Provide access to care during and after office hours</li> <li>• Provide patient materials and services to meet the language needs of patients</li> </ul> Standard 6 <ul style="list-style-type: none"> <li>• Involve patients/families in quality improvement</li> <li>• Obtains performance data for key vulnerable populations</li> </ul>
<b>Align the requirements with processes that improve quality and eliminate waste</b>	Standard 3 <ul style="list-style-type: none"> <li>• Conduct medication reconciliation and management</li> <li>• Use electronic prescribing</li> </ul> Standards 5 <ul style="list-style-type: none"> <li>• Track unscheduled hospitalizations and emergency department visits</li> </ul>

<p><b>Increase the emphasis on patient feedback</b></p>	<p>Standard 6</p> <ul style="list-style-type: none"> <li>Expanded the survey categories (access, communication, coordination, self-management support, whole person orientation, comprehensiveness, shared decision-making) and the requirements for the practice.</li> <li>Use of patient survey results for quality improvement</li> <li>Involve patients/families in quality improvement</li> </ul> <p>Optional Recognition for reporting results using a standardized Patient Experiences survey &amp; methodology</p>
<p><b>Enhance the use of clinical performance measure results</b></p>	<p>Standard 6</p> <ul style="list-style-type: none"> <li>Increased number of performance measures</li> <li>Requirement to monitor utilization/overuse data</li> <li>Requirement for practices to demonstrate improvement when renewing PCMH status.</li> </ul>
<p><b>Integrate behaviors affecting health, mental health and substance abuse</b></p>	<p>Standard 1</p> <ul style="list-style-type: none"> <li>Comprehensive assessment includes depression screening for adolescents</li> </ul> <p>Standard 3</p> <ul style="list-style-type: none"> <li>One of three clinically important conditions identified by the practice must be a condition related to unhealthy behaviors (e.g. obesity) or a mental health or substance abuse condition.</li> </ul> <p>Standard 5</p> <ul style="list-style-type: none"> <li>Tracks referrals and coordinates care with mental health and substance abuse services</li> </ul>
<p><b>Enhance coordination of care</b></p>	<p>Standard 5</p> <ul style="list-style-type: none"> <li>Arrange for information exchange with facilities, including afterhours care providers</li> <li>Coordinate referrals</li> <li>Coordinate with community service agencies</li> </ul>

We encourage you to comment on the individual standards and elements. Individual items may seem ambitious for some practices. As in the past, practices will not need to meet all requirements in order to achieve Recognition.

## **Recognition Program Design Issues**

We would like your thoughts on some **key design issues** we are considering:

**Number of levels:** The current version of PPC-PCMH has three levels of scoring. Most practices achieve Level 1 or Level 3. We have very few Recognized practices at Level 2. We believe that two levels may be more appropriate for the future and that a future Level 1 should require more than the 25 percent of the total points (25 points) currently required. The current scoring dates from 2006 when becoming a medical home was much less understood. We want to maintain the ability for practices new to this endeavor to achieve Recognition but we also believe that we can go further than we could in 2006.

**Measures of Meaningful Use (MU):** NCQA intends to embed requirements aligned with the Centers for Medicare and Medicaid Services (CMS) Measures of Meaningful Use (MU) within the PCMH 2011 requirements as soon as they are announced. Our intent is to help practices combine their efforts to demonstrate that they meet the CMS MU measures and thus to be eligible for incentives under the American Recovery and Reinvestment Act of 2009 (ARRA). To what extent should NCQA provide alternatives for practices that have not adopted health information technology to support PCMH functions?

**Multi-specialty organizations:** Patient-centered medical homes are primary care practices that agree to serve a coordinating function on behalf of their patients. There are limits to the influence primary care practices can have on specialty care and to how much coordination the infrastructure of a primary care practice can support. It is also difficult to measure primary care practices on utilization, primarily because of the relatively small numbers involved per practice. With a version of PCMH requirements specifically for multi-specialty arrangements (medical group, IPA or virtual arrangements) NCQA can include additional expectations in a number of areas, including use of specialty care and measurement of cost. Does it make sense to have a set of requirements that build on the primary care requirements and allow multispecialty arrangements to demonstrate that they meet additional expectations desired by payers, purchasers, consumers and others?

**Initial vs. renewal:** Acknowledging that the many practices that have achieved Recognition, or are aiming to do so, will need to seek renewal of their status after three years, NCQA would like to streamline the renewal process. Practices that satisfactorily demonstrated basic medical home redesign in their initial applications can then focus on more advanced aspects of redesign for their renewal applications. We invite comment on how we might accomplish this including elements that may be excluded from renewal applications and elements that may not be appropriate for those applying for the first time.

**Optional Module for use of standardized patient experience survey:** As noted above, the revised standards have greater emphasis on patient-centeredness and patient feedback. In addition, NCQA intends to offer an optional recognition in Patient Experiences Surveys. This module will require that practices report the results of patient experiences using the Medical Home version of the CAHPS Clinician and Group Survey (currently in development by the research team sponsored by the federal Agency for Healthcare Quality and Research (AHRQ), with collaboration from NCQA). Once available, practices will be able to achieve recognition for collecting data using the specified survey and methods and reporting results to NCQA. Because there are no national data sources for benchmarking performance on patient experiences results using the newly developed tool, we do not intend to report results publicly or to score practices on the results of patient experiences surveys. In a future version of this optional module, NCQA does intend to score practices as “high” performing on patient experiences. Benchmarks for national performance and scoring will be developed based on data reported through this optional module. We invite comment on this phased approach.

**Use of clinical performance measures:** NCQA and others are interested in moving towards evaluating practices based on clinical performance results in addition to the other areas assessed for PPC-PCMH. To move in this direction, we would ask practices applying for recognition to report their results to us so that we could begin to create a national database, establish appropriate benchmarks

and understand the methodological issues related to doing so. We welcome comment on this approach and ideas about appropriate ways to assess levels of clinical performance for different types of practices.

**Transition Period:** The current PPC-PCMH Standards will remain active for a period of time after the PCMH 2011 Standards are released to enable practices that previously purchased the 2008 version and initiated the process, to complete and submit their application for Recognition. Additionally, practices currently recognized under the 2008 version will continue to be allowed to upgrade recognition to higher levels (Level 1 to Level 2 or 3) following those standards through the expiration of their current status. Meanwhile the new standards will become available for practices to undergo review beginning in the 2<sup>nd</sup> quarter of 2011. NCQA proposes this period of overlap to continue throughout 2011 retiring the PPC-PCMH 2008 program as of 12/31/2011. We invite comment on this transition plan.

## **Public Comment Documents**

Interested parties should review this overview document as well as the draft standards and the optional module on patient experiences.

## **Submitting Comments**

### **Due Date**

Comments must be received by **Monday, June 28, 2010, 5 p.m. ET**, to be considered.

### **How to Submit Comments**

Submit all comments through NCQA's Public Comment Website <http://publiccomments.ncqa.org>. **NCQA does not accept comments via mail, e-mail or fax.**

To enter comments:

1. Go to the Public Comment database
2. Enter your e-mail address and contact information.
3. Select **Patient-Centered Medical Home (PCMH) 2011 Update**.
4. Select the **Topic** and **Element** you would like to comment on.
5. Select your support option (e.g., Support, Do not support, Support with modifications, Other).

If you choose Do not support, include your rationale in the text box. If you choose Support with modifications, enter the suggested modification in the text box.

**There is a 1,800 character limit for each comment.** If you exceed this limit, your comment will be cut off at 1,800 characters. Please try to be brief and to the point in your feedback.

We suggest that you develop your comments in Word, in order to check your character limit and save a copy for reference. Use the "cut and paste" function to copy your comment into the text box.

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<sup>1</sup>Fields D, Leshen E, Patel K. Driving Quality Gains and Cost Savings Through Adoption Of Medical Homes. *Health Affairs*. 2010; 29(5): 819-826.

<sup>2</sup>Bodenheimer T, Pham H. Primary Care: Current Problems and Proposed Solutions. *Health Affairs*. 2010;29(5):799-805

<sup>3</sup>Reid R., Fishman P., Yu O., Ross T., & Tufano JT. (2009). Patient-Centered Medical Home Demonstration: A prospective, quasi-experimental, before and after evaluation. *American Journal of Managed Care*. 15(9), e71-e87.

<sup>4</sup>Solberg S Solberg LI, Scholle SH, Asche SE, Shih SC, Pawlson LG, Thoele MJ, et al. Practice Systems for Chronic Care: Frequency and Dependence on an Electronic Medical Record. *Am J of Manage Care*. 2005; 11(12):789-96.

<sup>5</sup>Solberg L, Asche S, Pawlson LG, Scholle SH, Shih S. Practice Systems Are Associated With High-quality Care for Diabetes. *Am J of Manage Care*. 2008; 14(2):85-92.

<sup>6</sup>Flottemesch T, Scholle SH, O'Connor PJ, Solberg L, Asche S, Pawlson LG. Are Characteristics of the Medical Home Associated with Diabetes Care Costs? 2010. Under review.