What Is a Patient-Centered Medical Home (PCMH)?

The patient-centered medical home (PCMH) is a model of care where patients are engaged in a direct relationship with a chosen provider who coordinates a cooperative team of health care professionals, takes collective responsibility for the comprehensive integrated care provided to the patient, and advocates and arranges appropriate care with other qualified providers and community resources as needed.

PCMH practices develop transdisciplinary care teams to improve care coordination and care management of patient populations aiming to improve safety, efficiency and quality in patient care. By becoming a recognized PCMH, practices can improve care delivery and take advantage of private or public incentive payments that reward patient-centered medical homes. The Patient Protection and Affordable Care Act (ACA) offers enhanced federal funding to states for health homes serving Medicaid beneficiaries. Provider groups and health care organizations can visit their federal and state governments' and private insurers' web sites for information on funding and reimbursement initiatives. Delivery system reform and the potential for shared savings available through programs promoted by the Center for Medicare & Medicaid Innovation (the Comprehensive Primary Care Initiative, the Advanced Primary Care Practice Demonstration, and the Advance Payment ACO Model) hold promise to further expand access to PCMHs for patients, specifically for elderly, chronically ill, and low income populations across the country. Because the PCMH is foundational to Accountable Care Organizations (ACOs), also known as "medical neighborhoods," the PCMH is likely to gain greater prominence as ACOs continue to develop in the marketplace.

There are several steps necessary to begin the PCMH recognition and/or accreditation process. To start, review the mission and vision of your practice organization. Develop a working definition of patient-centered care. Begin to develop, review, and update documentation of your practice policies and procedures and do a thorough analysis of your operational workflows. This catalogue provides available resource tools and manuals to support your organization's journey toward developing a patient centered medical home.

This catalogue is organized into three parts:

- **Section 1** provides PCMH resources including websites and newsletters that will provide continuous updates about PCMH initiatives including best practice examples and payment reform models.

- **Section 2** lists several PCMH practice assessment tools to assist you in engaging your organization in readiness to implement the PCMH model in the clinical practice.

- **Section 3** lists the organizations that currently have a formal PCMH recognition or certification process.

Section 1. Resources

The Safety Net Medical Home Initiative
The focus of this initiative is to develop a replicable and sustainable implementation model for medical home transformation in safety net practices. Listed are links to key articles, tools, and resources on patient-centered care, medical home, and quality improvement topics. Register for the Medical Home Digest, a quarterly newsletter on updated issues and tools specific to the safety net populations. The November 2012 issue is devoted to vulnerable populations.
http://www.safetynetmedicalhome.org/resources-tools

Paying for the Medical Home: Payment Models to Support Patient-Centered Medical Home Transformation in the Safety Net. Safety Net Medical Home Initiative. Bailit, M., Phillips, K., Long, A. Bailit Health Purchasing and Qualis Health, Seattle, WA: October 2010.
This publication provides an introduction to a series of policy briefs focused on payment reform opportunities to support and sustain the medical home.

Patient-Centered Primary Care Collaborative PCMH Resources
The Patient-Centered Medical Home Purchaser Guide developed by the Patient-Centered Primary Care Collaborative (PCPCC) provides insightful overviews of the patient-centered medical home including supplemental resources such as detailed case studies, descriptions of pilot programs, and a draft request for information (RFI) and contract language for employers/purchasers to use with their health plans.

> *Transforming Patient Engagement: Health IT in the Patient-Centered Medical Home* is a compendium of 15 articles and 23 case examples and tools for providers across the health care continuum to engage patients in their own care. This comprehensive resource was compiled by the Patient Engagement Task Force of the PCPCC's Center for eHealth Information Adoption and Exchange and includes articles for a range of stakeholders—primary care providers, patients, caregivers, health IT developers, policy makers, employers, and the broad spectrum of clinical team members who serve patients every day.
> http://www.pcpcc.net/publications
>
> *H2RMinutes*, a **free** weekly e-newsletter sponsored by the Patient-Centered Primary Care Collaborative and produced by Health2 Resources created to deliver the latest multimedia news about the PCMH.
> http://www.health2resources.com/h2rminutes-pcmh.html

Healing Hands Vol. 16, No. 2, Spring 2012
This HCH Clinicians' Network accredited, peer-reviewed publication summarizes PCMH in the health care for the homeless setting and highlights best HCH practices that are PCMH recognized.

http://www.nhchc.org/wp-content/uploads/2012/03/Spring2012HealingHands.pdf
Enabling Patient-Centered Care through Health Information Technology
June 15, 2012, Number 206. This report reviews the evidence on the impact of health IT applications developed and implemented to enhance the provision of patient-centered care (PCC). The report identifies barriers and facilitators for the use of health IT applications to deliver PCC, identifies gaps in the literature, and recommends future research endeavors. The report addresses the role of health IT in improving shared decision making, patient – clinician communication, and access to medical information by patients.

Medical Home State Data Pages
The Data Resource Center, funded by the Maternal and Child Health Bureau, has partnered with the American Academy of Pediatrics to help state and family leaders quickly access data on how children and youth in each state experience care within a medical home. Measurement resources are available by state, practice, and policy.

State Implementation of Medical Home & Patient-Centered Care: The National Academy for State and Health Policy (NASHP) has a database of information on all 50 states policies and programs regarding medical home implementation. This site provides an interactive map with detailed information on each state's current laws, partnerships, methods of defining a medical home, financing structure, and measurement of quality improvement. Resources include strategies for state implementation, archived webinars, and publications provide in-depth analysis of state-level policy on medical home implementation.
http://nashp.org/med-home-map

States in Action Health Homes for the Chronically Ill: An Opportunity for States
The Commonwealth Fund. Silow-Carroll, S., Rodin, D. December 2010/January 2011. Accessed online January 20, 2011
This issue of *States in Action* defines health homes, highlights best practice demonstrations, discusses the ACA provision and the latest federal guidance to states, and presents opportunities and options for states to pursue development of health homes.

Closing the Quality Gap: Revisiting the State of the Science (Vol. 2: The Patient-Centered Medical Home). Rockville (MD): Agency for Healthcare Research and Quality (US); 2012 July (Evidence Reports/Technology Assessments, No. 208.2.)
This report includes reviews of effectiveness of bundled payment programs, effectiveness of the patient-centered medical home, QI strategies to address health disparities, effectiveness of medication adherence interventions, effectiveness of public reporting, prevention of health care-associated infections, QI measurement of outcomes for people with disabilities, and health care and palliative care for patients with advanced and serious illness. The overview describes the scope of the eight reports; summarizing the quality levers, populations, interventions, outcomes, and other features across the reports as well as discussing key messages by audience.
Available from http://www.ncbi.nlm.nih.gov/books/NBK99094/

Section 2. PCMH Practice Assessment Tools

Patient-Centered Medical Home Assessment Tool (PCMH-A)
The Patient-Centered Medical Home Assessment (PCMH-A) is a self-assessment tool created by the Safety Net Medical Home Initiative to allow practices to gauge their progress in implementing each of the change concepts. The PCMH-A is an interactive PDF that can be downloaded, completed, saved, and shared.
http://www.safetynetmedicalhome.org/sites/default/files/PCMH-A_0.pdf

Advancing the Practice of Patient- and Family-Centered Care in Primary Care and Other Ambulatory Settings: Getting Started
http://www.ipfcc.org/tools/downloads-tools.html

Assessing, Diagnosing and Treating Your Outpatient Primary Care Practice
This workbook provides a guide for assessing your practice and change management tools for quality improvement and performance. This workbook provides examples, tools, and customizable forms to guide your clinical microsystem on a journey to develop better performance.
www.clinicalmicrosystem.org

Primary Care Development Corporation Patient-Centered Medical Home Assessment Tool and Manual
The Primary Care Development Corporation, a not-for-profit organization providing financing and services to expand access to care in underserved communities, has released an update of its free online tool for assessment to meet 2011 NCQA PCMH recognition. PCDC's tool helps guide practices through the NCQA medical home survey process. Providers and staff can assess how their practice operates compared to PCMH 2011 standards, including their use of electronic health records; patient and provider communication; data and patient outcomes reporting; workflow redesign; and care management and coordination.

PCDC's Online Medical Home Solutions for Safety Net Providers offers an overview of the tenets of the NCQA PCMH 2011 Recognition Program and focuses on individual NCQA PCMH standards. Through a practice assessment and interactive lessons, users determine a roadmap for transformation or formal recognition. The online training program then offers field-tested strategies to guide users through PCMH transformation or recognition, addressing key topics such as team selection and communication with stakeholders. **This course is designed for all levels of staff at practices who either want to obtain NCQA PCMH 2011 recognition and/or for practices looking to transform into a medical home without formal recognition.**

Section 3. Medical Home Recognition & Accreditation Programs

HRSA's Patient-Centered Medical/Health Home (PCMHH) Initiative supports and encourages all federally qualified community health centers to achieve patient-centered medical home (PCMH) recognition by 2015. Four organizations that offer PCMH recognition or accreditation are the National Commission for Quality Assurance (NCQA), the Joint Commission in conjunction with its Ambulatory Care Accreditation, the Accreditation Association for Ambulatory Health Care, and URAC.

The American Academy of Pediatrics has developed a **National Center for Medical Homes Implementation**. This website provides contacts for organizations that have developed or are in the process of developing programs that recognize and/or accredit various health care organizations as medical homes according to specified sets of standards.

The Patient-Centered Medical Home Guidelines: A Tool to Compare National Programs Medical Group Management Association
This resource is a comparison chart of four medical home recognition programs (NCQA, AAAHC, Joint Commission, and URAC) to assess how each of them meets the Guidelines for Patient-Centered Medical Home Recognition and Accreditation Programs. This comparison is aimed at helping organizations narrow their assessment of the various programs and focus on the most important elements.

National Committee for Quality Assurance (NCQA) NCQA is currently the most widely adopted evaluation model with 16,000 clinical sites recognized and currently expanding to military and health center program clinics. The most recent 2011 standards emphasize behavioral health inclusion and incorporate meaningful use of EHRs, stages 1 and 2. The timeframe for recognition approval 30 – 60 days and 5% of clinical practice sites will be audited.

NCQA Government Recognition Initiative works with CMS and other federal agencies to help health centers and military treatment facilities (MTFs) become NCQA patient-centered medical homes. Resources include educational and training video sessions, recognition readiness self-assessment materials, and webinars on NCQA PCMH recognition standards. To register for the GRIP program, contact the NCQA project liaison at PCMH-GRIP@ncqa.org or (888) 275-7585.

*****HRSA PCMH Initiative encourages its 330(h) grantees to apply for NCQA recognition and will cover the costs for the NCQA survey tools and recognition fees. HRSA will provide a PCMH training/mentoring program. Organizations interested in HRSA support for initial NCQA PCMH recognition under the PCMHH Initiative must complete a Notice of Intent (NOI) located at http://www.bphc.hrsa.gov/policiesregulations/policies/pal201101.html.*

NCQA Patient-Centered Medical Home Standards and Guidelines
The Adobe PDF version of the PCMH Standards and Guidelines includes the requirements to meet the standards as well as explanations and examples. The six PCMH 2011 standards include six must-pass elements, which can result in one of three levels of recognition. Practices seeking PCMH complete a web-based data collection tool and provide documentation that validates responses.

NCQA Patient-Centered Medical Home Survey Tool
This web-based publication includes the standards and guidelines (the requirements to meet the standards as well as explanations and examples). The Survey Tool also includes all the information and the electronic data collection tools needed to prepare and submit materials to apply for recognition.

Joint Commission Primary Care Home Initiative
The Joint Commission has expanded the process of accrediting ambulatory health care organizations to those who are also interested in electing the primary care home option. This initiative complements the Ambulatory Care Accreditation Program and is consistent with the new health care reform efforts to improve the coordination, quality, and efficiency of health care services. This initiative is designed to combine the improvements in quality of care and patient safety achieved through accreditation with increased reimbursement from third party payers when the additional requirements of a primary care home are met.

For more information about the Primary Care Home Initiative, please visit www.jointcommission.org/PCHI or contact Lon Berkeley LBerkeley@jointcommission.org or (630) 792-5787.

Accreditation Association for Ambulatory Health Care (AAAHC)
The Accreditation Association for Ambulatory Health Care is a private, nonprofit organization that develops standards to advance and promote patient safety, quality, and value for ambulatory health care through peer-based accreditation processes, education, and research. **The AAAHC Medical Home Onsite Certification Handbook** provides specific standards for the medical home.
For more information, contact (847) 853-6060 or email Marsha Wallender, mwallender@aaahc.org, or Mona Sweeney, msweeney@aaahc.org.
https://www.aaahc.org/accreditation/primary-care-medical-home/

URAC PCHCH Achievement Program
URAC (formerly the Utilization Review Accreditation Commission) PCHCH Achievement program is a comprehensive onsite validation of the range of processes and management functions leading to a URAC PCHCH Achievement valid for two years. The URAC toolkit is designed to educate and guide health care practices and/or their sponsoring health plans, insurers, and pilot programs on how to transform practices into patient-centered health care homes. The 28 essential standards align to the joint

principles of the patient-centered medical home and directly address key requirements for all meaningful use requirements for electronic medical records, e-prescribing, and quality data submission.
https://www.urac.org/pchch/