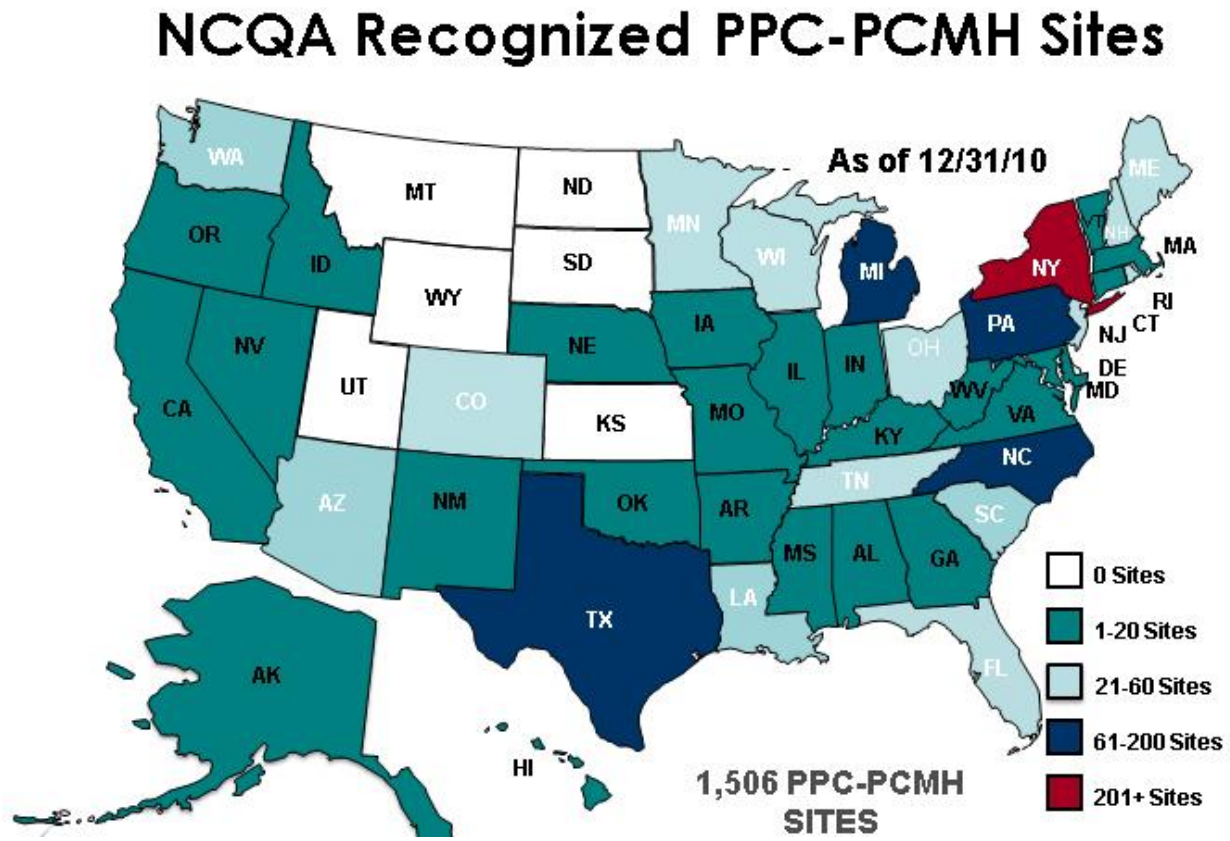
# THE NCQA PATIENT CENTERED MEDICAL HOME MODEL

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization that was established in 1990 to build consensus around important health care quality issues. The NCQA has developed a set of comprehensive standards and assessment tools through its Patient Centered Medical Home (PCMH) Program. Many states, including New York, have adopted the NCQA guidance and recognition of medical homes for demonstration programs and other initiatives. Nationally, the number of practices meeting the PCMH standards has grown exponentially; in 2008, there were approximately 28 NCQA recognized sites across the United States and, as of December 21, 2010, there were approximately 1,506. As indicated in the NCQA's Standards for PCMH 2011, a large number of recognized sites exist in New York State.




Source: The NCQA's Standards for PCMH 2011[1]

[1] "Standards for PCMH 2011." NCQA. 1 February 2011. < https://inetshop01.pub.ncqa.org/publications/product.asp?dept_id=2&pf_id=30004-301-11>.

# THE NCQA 2011 PCMH STANDARDS[2,3]

On January 31, 2011, the NCQA released its new 2011 PCMH standards for medical home designation. These new standards build off of the NCQA's 2008 PCMH standards, which will be phased out. The NCQA recognizes three levels of PCMHs, whereby practices are evaluated across 6 standards on a scale of 100 points. The level of recognition is determined by the number of points an entity receives for each standard and the number of "must pass" elements each practice passes. Levels are defined as follows: Level 1: 35-59 points and all 6 must-pass elements; Level 2: 60-84 points and all 6 must-pass elements; and Level 3: 85-100 points and all 6 must-pass elements. The NCQA recognizes eligible practices for a duration of three years. During this time, eligible practices may apply for a higher level of recognition if they choose.

The NCQA recognition is determined by a set of standards, elements, and factors. The NCQA has 6 standards, 27 elements, and 149 factors. Standards are defined by their broader purposes that align with the PCMH goals and objectives. Elements are sub-sets of standards that detail what performance measures will be evaluated. Elements are comprised of specific factors that will be scored.

The PCMH 2011 program's six standards include:

1. Enhancing access and continuity;
2. Identifying and managing patient populations;
3. Planning and managing care;
4. Providing self-care and community support;
5. Tracking and coordinating care; and
6. Measuring and improving performance.

Practices of all recognition levels are required to meet at least a score of 50 percent or higher on must-pass elements. There are six must-pass elements considered essential to the PCMH model, which include:

1. Access During Office Hours;
2. Use Data for Population Management;
3. Care Management;
4. Support Self-Care Process;
5. Referral Tracking and Follow-Up; and
6. Implement Continuous Quality Improvement.

A summary of the 6 standards and 27 elements are highlighted on the next two pages.

[2] "PCMH 2011 Standards." NCQA. 1 February 2011. <https://inetshop01.pub.ncqa.org/publications/product.asp?dept_id=2&pf_id=30004-301-11>.

[3] "Standards for PCMH 2011." NCQA. 1 February 2011. <https://inetshop01.pub.ncqa.org/publications/product.asp?dept_id=2&pf_id=30004-301-11>.

## PCMH 1: Enhance Access and Continuity (20 Point)

- This standard ensures access to culturally and linguistically appropriate routine and urgent care. It also requires defining the role of the care team and standards for patient access and communication:
  - Element A: Access during office hours - ***Must-Pass*** - 4 Points
  - Element B: After-hours access - 4 Points
  - Element C: Electronic access - 2 Points
  - Element D: Continuity - 2 Points
  - Element E: Medical Home Responsibilities - 2 Points
  - Element F: Culturally and Linguistically Appropriate Services - 2 Points
  - Element G: Practice Organization- 4 Points

## PCMH 2: Identify and Manage Patient Populations (16 Points)

- This standard highlights the documentation of information, assessment of patient risk factors, and the use of this information to manage populations:
  - Element A: Patient Information - 3 Points
  - Element B: Clinical Data - 4 Points
  - Element C: Comprehensive Health Assessment - 4 Points
  - Element D: Use Data for Population Management - ***Must-Pass*** - 5 Points

## PCMH 3: Plan and Manage Care (17 Points)

- This standard outlines elements that focus on care management and the use of evidence-based guidlines:
  - Element A: Implement Evidence-Based Guidelines - 4 Points
  - Element B: Identify High-Risk Patients - 3 Points
  - Element C: Care Management - ***Must-Pass*** -4 Points
  - Element D: Medication Management - 3 Points
  - Element E: Use Electronic Prescribing - 3 Points

## PCMH 4: Provide Self-Care and Community Supports (9 Points)

- This standard reinforces community linkages and supports in addition to consumer education:
  - Element A: Support Self-Care Process - ***Must-Pass*** - 6 Points
  - Element B: Provide Referrals to Community Resources - 3 Points

## PCMH 5: Track and Coordinate Care (18 Points)

- This standard focuses on tracking, following, and coordinating care across the continuum:
  - Element A: Test Tracking and Follow-Up - 6 Points
  - Element B: Referral Tracking and Follow-Up - ***Must-Pass*** - 6 Points
  - Element C: Coordinate With Faciltiies and Care Transitions - 6 Points

## PCMH 6: Measure and Improve Performance (20 Points)

- This standard reinforces measurment of patient and family experiences, process improvement, and performance reporting:
  - Element A: Measure Performance - 4 Points
  - Element B: Measure Patient/Family Experience - 4 Points
  - Element C: Implement Continuous Quality Improvement - ***Must-Pass*** - 4 Points
  - Element D: Demonstrate Continuous Quality Improvement - 3 Points
  - Element E: Report Performance - 3 Points
  - Element F: Report Data Externally - 2 Points

PCMH standards are available at the NCQA website at no cost and can be found here.