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 provider who coordinates a cooperative team of health care professionals, takes collective responsibility for the comprehensive integrated care provided to the patient, and arranges appropriate care with other qualified providers and community resources as needed.

By becoming a recognized PCMH, practices will improve safety, efficiency and quality in patient care and position the practice to take advantage of private or public incentive payments that reward patient-centered medical homes. Other benefits of recognized PCMH practices include team building among providers and clinicians, as well as precise patient care documentation regarding PCMH policies and procedures that are in primary care practices. The Patient Protection and Affordable Care Act (ACA) offers enhanced federal funding to states for health homes serving Medicaid beneficiaries. Provider groups and healthcare organizations can visit their federal and state government and private insurers' web sites for information on funding and reimbursement initiatives.

As your first step to this process, 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 work flows. 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. The initiative website lists links to key articles, tools and resources on patient-centered care, medical home and quality improvement topics.
http://www.qhmedicalhome.org/safety-net/index.cfm
http://www.qhmedicalhome.org/publications.cfm

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. The full Guide includes 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.
http://pcpcc.net/content/purchaser-guide

Health IT in the PCMH: A Compendium of Resources
This resource is a compendium of articles, case examples and tools for providers across the health care continuum to engage patients in their own care. *Transforming Patient Engagement: Health IT in the Patient Centered Medical Home* includes 15 core articles and 23 case examples to help primary care clinicians enhance patient engagement in the process of care delivery. 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/files/pep-report.pdf

H2RMinutes
This free weekly e-newsletter was created to deliver the latest news about the PCMH. Sponsored by the Patient-Centered Primary Care Collaborative and produced by Health2 Resources, *H2RMinutes* brings you targeted, timely news about the PCMH.
http://www.h2rminutes.com/about.html

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.
http://medicalhomedata.org/content/Default.aspx

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*
This briefing document summarizes key findings from recent PCMH evaluation studies in a variety of settings ranging from integrated delivery systems to community-based office practices. The evaluations span privately insured patients, Medicaid, SCHIP and Medicare beneficiaries, and the uninsured. The evaluation findings consistently indicate that investments to redesign the delivery of care around a primary care PCMH yield an excellent return on investment.
http://www.pcpcc.net/files/pcmh_evidence_outcomes_2009.pdf

States in Action Health Homes for the Chronically Ill: An Opportunity for States
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.
http://www.commonwealthfund.org/Content/Newsletters/States-in-Action/2011/Jan/December-2010-January-2011/Feature/Feature.aspx

Paying for the Medical Home: Payment Models to Support Patient-Centered Medical Home Transformation in the Safety Net
This publication provides an introduction to a series of policy briefs focused on payment reform opportunities to support and sustain the medical home.
http://www.qhmedicalhome.org/safety-net/policyresources.cfm

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.qhmedicalhome.org/safety-net/upload/PCMH-A_SNMHI_102910.pdf

Implementation Guide: Patient Centered Interactions Part 2: Engaging Patients in Their Health and Healthcare
http://www.qhmedicalhome.org/safety-net/upload/PatientCenterImpGuide_pt2.pdf

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

Assessing, Diagnosing and Treating Your Outpatient Primary Care Practice
This workbook provides a guide for making a path towards higher performance. The workbook provides examples, tools and customizable forms to guide your clinical microsystem on a journey to develop better performance.
http://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.
http://pcdcny.org/data/org/128/media/doc/9669_2011_ncqa_self_assessment_tool.xls
http://www.pcdcny.org/data/org/128/media/doc/8045_master_manual.pdf

Patient Centered Health Care Home (PCHCH) Program Toolkit
URAC (formerly the Utilization Review Accreditation Commission) has developed this toolkit 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. This is an easy to follow, step-wise, organized framework to allow self-assessment and tracking of progress providing real time, self paced steps for building PCMH.
http://www.urac.org/healthcare/prog_accred_pchchp_toolkit.aspx

SECTION 3. MEDICAL HOME RECOGNITION & ACCREDITATION PROGRAMS

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.
http://www.medicalhomeinfo.org/national/recognition_programs.aspx

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 FQHC clinics. The most recent 2011 standards emphasize behavioral health inclusion and incorporate Stage 1 Meaningful Use of Electronic Health Record standards. The timeframe for recognition approval is 30-60 days, and 5% of clinical practice sites will be audited.
http://www.ncqa.org/tabid/629/Default.aspx

****The HRSA PCMH Initiative promotes its grantees (330h) 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/policy/pal1101/. The completed NOI must be submitted via email to PCMHHinitiative@hrsa.gov. The application deadline for HRSA support is Sept. 30, 2011.*

NCQA Patient-Centered Medical Home Standards and Guidelines
The Adobe PDF version of the PCMH Standards and Guidelines includes requirements to meet the standards, as well as explanations and examples. There are six PCMH 2011 standards, including 6 must pass elements, which can result in one of three levels of recognition. Practices seeking PCMH must complete a Web-based data collection tool and provide documentation that validates responses.

2011 PCMH Standards and Guidelines
Item # 30004-301-11
Price: Free

NCQA Application for Patient-Centered Medical Home
The application materials include an overview of the PCMH program, eligibility criteria and pricing information.

2011 PCMH Online Application Available March 2011
Item #: 30002-150-11
Price: Free

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 tool needed to prepare and submit materials to apply for recognition.
2011 PCMH Survey Tool (1-4 users) Available April 2011 **Note: Use of the Survey Tool is required for recognition*
Item # 30003-322-11 (Effective 03/28/11)
Price: $80

Additional information regarding the NCQA PCMH recognition process can be found at *http://www.ncqa.org/* or by contacting the NCQA project liaison at *PCMH –GRIP@ncqa.org* or 888–275–7585.

Joint Commission Primary Care Home Initiative
The Joint Commission is developing standards to expand 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 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.

Proposed new standards for the Primary Care Home Initiative are expected to be posted for a field review in early 2011. Pilot testing of the standards will also be conducted before they are considered for approval. If approved in accordance with the expected timetable, standards would be available in spring 2011, and on-site surveys of organizations interested in Primary Care Home accreditation would begin in July 2011.

The Joint Commission is also seeking feedback from Medicare and Medicaid officials and insurance companies to ensure that the Primary Care Home standards will enable organizations to be eligible for enhanced reimbursement.

For more information about the Primary Care Home Initiative, please visit *http://www.jointcommission.org/PCHI* or contact Michael Kulczycki at 630.792.5290 or *mkulczycki@jointcommission.org*.

Accreditation Association for Ambulatory Health Care (AAAHC)
The Accreditation Association for Ambulatory Health Care, also known as AAAHC or the Accreditation Association, is a private, non-profit organization formed in 1979 that develops standards to advance and promote patient safety, quality and value for ambulatory health care through peer-based accreditation processes, education and research. Accreditation is awarded to organizations that are found to be in compliance with the Accreditation Association standards. *The AAAHC Medical Home On-site Certification Handbook* provides specific standards for the Medical Home. The standards specify that a certified Medical Home is patient-centered, physician-directed, comprehensive, accessible, and provides for ongoing continuity of care. Before completing the Medical Home On-Site Certification Application, please contact Ron Smothers, Assistant Director of Accreditation Services at *rsmothers@aaahc.org* or 847 853-6067.
https://application.aaahc.org/medicalhome.aspx
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[i] Catalogue prepared by Anna M. Gard, FNP-BC, Association of Clinicians for the Underserved, in partnership with the National Health Care for the Homeless Council, with support from the Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services, March 31, 2011.