Patient-Centered Medical Home-Recognized Practices Provide a Strong Front Line for Accountable Care Organizations

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The National Committee for Quality Assurance (NCQA)-recognized patient-centered medical homes (PCMHs) provide a strong front line of support to accountable care organizations (ACOs) by achieving improved health outcomes, improved patient experience of care, and reduced costs (dabbed by the Institute for Healthcare Improvement the "Triple Aim"). The PCMH model puts the patient at the center of care, delivering "whole person" care that considers patient engagement, clinical measurement, population health management, and standard work flows designed to support the goals of the Triple Aim. The core tenets of the PCMH focus on:

- Enhanced access and continuity of care
- Delivering "team-based" care
- Identification and management of patient populations
- Planning and managing care
- Tracking and coordination of care
- Continuous commitment to quality improvement

With support of legislation outlined in the Affordable Care Act (ACA), primary care has been called on to raise the bar in identifying and managing high-risk populations, to include social determinants of health in care criteria and to deliver integrated care through co-management of behavioral/mental and physical health. Primary care practices need robust resources to meet the standardized requirements for patient engagement, shared decision making, delivery of appropriate cultural and linguistic services, and assessments of health literacy. More than 7000 NCQA-recognized PCMH practices across the country, representing more than 35,000 clinicians, have demonstrated their ability to be creative in their care team design, focused in their collaboration with specialists, and innovative in their patient engagement strategies.

PCMH standards provide a framework of standardized requirements, vetted by healthcare leaders through a national Public Comment period that invites insights and perspectives from all areas of the delivery system. This gathering of perspectives has resulted in standards that are customizable and can be adapted to a wide variety of primary care practice settings. The model continues to evolve as new research and insights into best practices are revealed, but ongoing support is necessary from health-system leaders, public and commercial payers, medical societies, and academic institutions. ACOs have a unique opportunity to leverage the knowledge they gained in working with practices that transformed to meet PCMH requirements and have exhibited a commitment to sustaining the model of patient-centered care.

Among the greatest challenges primary care practices face in meeting the charge of transformation—especially small, independent practices—is finding the financial and human resource support necessary to make the shift. With continued support from medical societies, academic institutions, regional employers, regional extension centers, and public and commercial payers, and with strong resource stewardship from ACOs, adoption of the PCMH model will grow. PCMH support continues to climb as incentives tied to PCMH transformation increase, as payers direct consumers to recognized practices and provide greater access to embedded and network case managers to support wellness, complex case management, and management of overall population health. Recognized PCMHs have been essential in driving quality improvement initiatives through CMS innovation programs, such as the Multi-Payer Advanced Primary Care Practice (MAPCP) and Comprehensive Primary Care (CPCi) initiatives, which offer enhanced payment to primary care practices that coordinate better primary care for their Medicare patients. Having a strong foundational understanding of open-access scheduling, using practice staff to the highest extent of their licenses, and ensuring that patients are surveyed about their access, communication, care coordination, and self-management support needs can alleviate the burden of meeting the rigorous requirements of these programs.

Patient-centered specialty practices (PCSPs) understand the need to establish effective turnaround times for screenings and availability for consultations between physicians, to help co-manage their shared populations, to forge agreements that ensure essential, unduplicated diagnostic testing, and to collaborate on integrated care plan designs. A baseline of standards and guidelines reflects best practices in collaborative, patient-centric methods to deliver care.

Community pharmacies, urgent care sites, hospitals, rehabilitation

sites, nursing homes, and home health are all vital components of a complex delivery system and require collaboration with PCMHs to ensure comprehensive, integrated care. With support from ACA legislation and innovation grants through the Pioneer and Shared Savings programs, ACOs are accountable for achieving the goals of the Triple Aim. Tracking, monitoring, and reporting on activities that impact cost, quality, and clinical outcomes all involve support and leadership from providers armed with a solid understanding of the methods necessary to achieve these primary goals of health reform at the practice level. It is important to note that the PCMH model itself is evolutionary—and practices must evolve with the model.

The first version of NCQA's PCMH model was released in 2008. PPC-PCMH incorporated the Joint Principles as outlined by the American College of Physicians, the American Academy of Pediatrics, the American Osteopathic Association, and the American Academy of Family Physicians. Its purpose was to evaluate alignment of requirements with practice capabilities, and it focused on established policies and procedures for ensuring that practices with varied technology support could earn recognition for delivering patient-centered care. PCMH 2011 raised the bar by encouraging use of electronic health records (EHRs), clinical decision support tools, enhanced registries, and population health management solutions that aligned with criteria to meet Meaningful Use Stage 1 requirements. With support from ACA legislation, the Office of the National Coordinator for Health Information Technology provided implementation and training support through Regional Extension Centers, to help advance the movement to a more technology-based healthcare system.

PCMH 2014 standards and guidelines include annual reporting requirements to support sustainability of the model and help ensure that recognized practices remain committed to continuous quality improvement in the areas of improved outcomes, patient experience, and cost. Evaluating costs is now part of the core requirements: practices must measure quantitative data on at least 2 utilization measures, which helps ensure that they evaluate opportunities associated with all 3 points of the Triple Aim.

Since 2008, NCQA's PCMH Recognition program has been cited in health reform initiative criteria of 38 states (at the time this article was published) as a viable model for meeting key reform requirements. Provider contracts for a number of commercial payers, such as Aetna, Cigna, WellPoint, and a growing number of Blue health plans, have built PCMH recognition into their criteria for receiving pay-for-performance and enhanced fee-for-service payments. State departments of health, such as in New York, have established graduated payments for their recognized PCMHs, encouraging continued alignment with newer versions of the standards.

The value of recognition has been questioned, specifically with regard to whether practices simply "check the box" to receive enhanced incentive payments—although even the naysayers agree that requirements for recognition are patient-centric, apply to both solo practices and large, integrated systems, and can be more rigorous than other PCMH programs. The model must continue to build on lessons learned during the last 6 years. Practices recognized under PCMH 2008 requirements need support to meet the advanced requirements of PCMH 2014, and all should work to meet requirements outlined in the most recent version of the standards.

To conclude, ACOs can benefit from a strong front line of PCMH-recognized practices that provide resources and support the ongoing evolution of the medical home. Clinicians who understand the value of standardized, customizable, patient-centric best practices of care will require less oversight and can help ACOs meet the challenging goals of achieving the Triple Aim.

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