*The Centers for Medicare and Medicaid Services' Office of Research, Development, and Information (ORDI) strives to make information available to all. Nevertheless, portions of our files including charts, tables, and graphics may be difficult to read using assistive technology. Persons with disabilities experiencing problems accessing portions of any file should contact ORDI through e-mail at ORDI_508_Compliance@cms.hhs.gov.*

---


# Patient-Centered Medical Home Recognition Tools:
## *A Comparison of Ten Surveys' Content and Operational Details*

By Rachel A. Burton, Kelly J. Devers, Robert A. Berenson

The Urban Institute, Health Policy Center
2100 M Street, NW, Washington, DC 20037

March 2012

For the Centers for Medicare and Medicaid Services (CMS)
CMS Project Officer: Suzanne Goodwin

## Abstract

***Summary.*** This report compares ten provider survey tools designed to measure the extent to which a practice is a "patient-centered medical home" (PCMH). These tools are primarily used for recognition purposes (i.e., to qualify for entry into a payment pilot or demonstration), as opposed to for practice self-improvement, research/evaluation, or quality measurement. Our analysis compares these ten tools' operational details (e.g., price, whether a site visit is required) and their content emphases (i.e., the different practice capabilities that the tools emphasize).

***Operational Details.*** Half of the tools were what could be called "off the shelf" products tabulated by national entities, which are typically free to download but can cost thousands of dollars for practices to use to apply for recognition. The other half of the tools assessed could be called "one-off" tools that were either designed or appropriated for use in only one or a few states' PCMH recognition programs; these tools are generally free to use to apply for recognition as part of such PCMH initiatives. Most tools had not been tested for validity, reliability, or association with patient outcomes. To provide a check on overly-positive practice self-assessments, most tools include mechanisms to verify responses, such as by requiring accompanying documentation and/or site visits. For this reason, most tools are administratively burdensome – taking days, weeks, or months to complete, due to the need to design, implement, and document new ways of delivering care.

***Content.*** To compare the relative content emphases of the ten PCMH recognition surveys reviewed, we counted the number of items in each tool that fell within various content domains associated with the PCMH concept (e.g., access to care, care coordination, population management). In general, the top five content domains that received the most emphasis in these tools were: 1) care coordination, 2) health information technology (IT), 3) quality measurement, 4) patient engagement and self-management, and 5) presence of policies (a category we used to denote items that merely asked if a written policy existed, and did not require such policies' content to reflect specific benchmarks or requirements). There was great variation in the emphasis on health IT: half of the tools assessed included a relatively low percentage of items in this area (0-7%), while a relatively high percentage of the National Committee for Quality Assurance's (NCQA's) questions asked about this capability (46% of items in its 2008 tool, and 40% of items in its 2011 tool – worth 30% of a practice's score in 2008 and 29% in 2011).

**Issues for Payers.** Based on our tool assessment and interviews with experts, some issues for payers to consider emerged. First, since evidence does not yet exist on which PCMH recognition tool produces the best outcomes, payers will have to decide how much stock to put in such tools, and what role quality measurement should play (i.e., what should be the mix between measuring practice capabilities and measuring practice performance?). For payers that choose to use a PCMH recognition tool, they will have to decide whether to use an "off the shelf" tool like NCQA's or to develop their own. (Payers that have a unique vision of what a PCMH should look like and/or highly value dialogue with providers and patients may be more likely to develop their own tool. But practical matters will also have to be considered, like whether a payer has the resources to dedicate to developing a tool and verifying practices' responses on it.) Payers will also have to decide how much administrative and financial burden they want to place on practices. (Payers that tie performance on a PCMH recognition tool to payment may be more likely to require verification of responses, such as through documentation or site visits, even though it increases practice burden.) Moving beyond measurement, payers interested in PCMH initiatives will also have to decide what accompanying strategies to use to facilitate practice transformation to a PCMH, such as technical assistance and learning collaboratives.

# Table of Contents

## Background

Although the concept of a patient-centered medical home has been around for nearly half a century, only in the last few years has it received widespread attention – as professional associations and public and private payers have begun to focus on it as means of strengthening primary care while improving quality and reducing cost. The medical home concept originated in pediatrics during the 1960s as a way to coordinate care for children with special health care needs; under this model, the pediatrician, along with their practice, is considered the central coordinator for the child's medical care and records. However, no similar concept was proposed for adult general practice – although some aspects of the approach are exemplified in excellent primary care practices today.

This changed with the American Academy of Family Physicians' (AAFP) call for every American to have a medical home in 2004,[1] which responded to the growing perception of a deficiency of "patient centeredness" in primary care practices. The concept was quickly endorsed by the American College of Physicians (ACP),[2] representing internists. Then, in 2007, the ACP and AAFP, along with the American Academy of Pediatrics (AAP) and American Osteopathic Academy (AOA), published a joint statement on the principles they believed should form the basis of the patient-centered medical home (PCMH) model.[3] These principles emphasize personal relationships, team delivery of care for the whole person, coordination across specialties and settings of care, quality and safety improvement, and open access.

Building on these principles, many payers have initiated PCMH pilots or demonstrations[4] in recent years – including states, their associated Medicaid programs, and private commercial plans. Because of their longstanding orientation to mothers and children served in Medicaid programs and, thus, familiarity with the pediatric medical home concept, a number of states have been in the forefront of PCMH activities. According to the National Academy for State Health Policy (NASHP), which has been closely following states' efforts, there are currently 39 Medicaid-associated PCMH initiatives underway.[5] Meanwhile, according to the Patient-Centered Primary Care Collaborative (a PCMH advocacy group that follows the activities of a broader set of entities) the current count of multi-stakeholder pilots underway is 27 initiatives in 18 states.[6] Given the broad acceptance of the medical home concept by clinicians and payers, it is very likely that many other medical home initiatives are starting up or underway as well.

---

[1] Future of Family Medicine Project Leadership Committee. 2004. "The Future of Family Medicine: A Collaborative Project of the Family Medicine Community," Annals of Family Medicine 2 (Suppl. 1): S3-32.

[2] Barr, Michael, and Jack Ginsburg. 2006. "The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care: A Policy Monograph of the American College of Physicians." (http://www.acponline.org/advocacy/where_we_stand/policy/adv_med.pdf.)

[3] American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association. 2007. "Joint Principles of the Patient-Centered Medical Home." (http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.dat/022107medicalhome.pdf.)

[4] We use the terms "pilot" and "demonstration" interchangeably in this report, reflecting how these terms are typically used in private-sector initiatives, as opposed to the separate and distinct definitions used by the Centers for Medicare and Medicaid Services for these two terms.

[5] National Academy for State Health Policy. 2010. "Medical Home States." (http://www.nashp.org/med-home-map.)

[6] Patient-Centered Primary Care Collaborative. 2011. "Pilots & Demonstrations." (http://www.pcpcc.net/pcpcc-pilot-projects.)

The Centers for Medicare and Medicaid Services (CMS) recently announced its support for the Multi-Payer Advanced Primary Care Practice Demonstration, which in contrast to most current demonstrations[7] will be multi-payer (including Medicare, Medicaid, and commercial payers). Under this initiative, Medicare is joining multi-payer medical home efforts in eight states, and not imposing a specific PCMH definition but rather adopting states' criteria for qualifying practices as a PCMH.[8]

The industry leader in developing an assessment tool for identifying would-be medical homes for inclusion in pilots has been the National Committee for Quality Assurance (NCQA), which was able to quickly adapt its Physician Practice Connections standards into medical home standards[9] when the four societies released their joint principles in 2007. NCQA's Physician Practice Connections – Patient-Centered Medical Home (PPC-PCMH) assessment instrument was first available in 2008, and has been used by many practices and payers in various medical home initiatives.

Interviews conducted in conjunction with this analysis (discussed below) confirm that commercial insurers – accustomed to working with NCQA in a number of areas – typically have used the PPC-PCMH instrument in their medical home activities, whereas state Medicaid agencies often have not used the NCQA instrument and instead developed their own assessment tool, though some (e.g., Maine, Montana, Vermont) are using the NCQA standards. According to Medicaid officials we interviewed, some of the reasons they have chosen not to use NCQA's standards include: its expense (which can cost thousands per practice), the length of time it takes practices to complete it, its heavy focus on health IT (which would disqualify many otherwise-capable practices who lack such technology), its requirement that physicians lead practices (which NCQA has only recently changed), its predominant use in adult (as opposed to pediatric) medical home initiatives, and skepticism about whether the set of processes it measures will actually lead to improved outcomes. In an effort to address concerns raised about the 2008 PPC-PCMH instrument, NCQA has released in 2011 a new version of their standards.

At present, there are literally dozens of published PCMH definitions, and numerous assessment instruments available to determine the extent to which a clinical practice successfully meets a given set of criteria to be considered a PCMH. Some of the assessment instruments define different levels or tiers of PCMH capabilities, and many have only become available in the past few months. As we discuss further below, the tools have been developed for various purposes by organizations with different missions and pre-existing relationships with different kinds of health care organizations (e.g., plans, providers), and have a range of similarities and differences.

---

[7] Bitton, Asaf, Carina Martin, and Bruce Landon. 2010. "A Nationwide Survey of Patient Centered Medical Home Demonstration Projects," Journal of General Internal Medicine 25(6): 584-92.

[8] U.S. Centers for Medicare and Medicaid Services. 2010. "Multi-payer Advanced Primary Care Practice Demonstration Solicitation." (http://www.cms.gov/DemoProjectsEvalRpts/downloads/mapcpdemo_Solicitation.pdf.)

[9] Scholle, S.H., A. S. O'Malley, and P. Torda. 2007. "Designing Options for CMS's Medical Home Demonstration: Defining Medical Homes" (Second Draft), December. Washington, DC: Mathematica Policy Research; Deloitte Center for Health Solutions. 2008. "The Medical Home: Disruptive Innovation for a New Primary Care Model." (http://www.deloitte.com/dtt/cda/doc/content/us_chs_MedicalHome_w.pdf.); and Stewart, E.E., et al. 2008. "Evaluators' Report on the National Demonstration Project (NDP) to the Board of Directors of TransforMED." February. (http://www.transformed.com/evaluatorsReports/report5.cfm.)

In the current environment, the main advantage of the diversity of tools is it allows innovation. While some of the individual elements of the PCMH model are well-grounded in the literature, we still lack a strong evidence base about whether the aggregate package works as intended or which components of the model are most important. We also lack rigorous head-to-head comparisons of these tools assessing their relative advantages and disadvantages based on important criteria, including their association with high performance, operational feasibility, and reliability and validity. Finally, we do not know with any precision how well a particular assessment instrument aligns with other current or future initiatives, such as the requirements for qualifying for incentive payments for being a "meaningful user" of electronic health records under the HITECH Act or CMS requirements for participation as accountable care organizations (ACOs) in the Medicare Shared Savings Program.

There is logic to permitting a number of assessment instruments to be used in the short term, to let the market converge around the tool(s) that best meet the needs of practices and payers. However, as time goes on, the diversity of tools can pose problems. From payers' perspectives, choosing from among a variety of tools can be challenging; a lot of time can be spent reviewing the tools and trying to select one that is perceived to be a good fit for payers, plans, and providers involved in any given pilot. These stakeholders may not agree on which tool works best; for example, what may be perceived as the most appropriate assessment tool for a Medicaid population may be less so for Medicare beneficiaries or commercial health plan enrollees. Although usually not an issue in collaborative multi-payer initiatives, if general consensus is not reached on a definition and a PCMH assessment tool, many primary care practices might find themselves facing competing definitions, assessment tools, and payment incentives from payers implementing different PCMH initiatives in the same geographical area.

The presence of many assessment instruments also complicates evaluation of the various PCMH demonstrations. This is because researchers do not have a common data collection instrument to measure what capabilities practices are implementing or have in place, thus preventing them from being able to make apples-to-apples comparisons of what practices are achieving. The result is that if one demonstration seems to produce positive outcomes and another does not, it is hard to isolate which practice capabilities are driving these effects (since instruments might not be capturing all of the care delivery processes at play). Evaluation of PCMH initiatives is also complicated by the fact that many PCMH assessment tools have not been assessed for validity or reliability, which can result in tool developers and respondents interpreting the meaning of questions differently.

## Purpose

To help inform CMS's thinking on this topic and provide information that may be useful to other public and private payers embarking on PCMH initiatives, the Urban Institute's Health Policy Center conducted a comparative analysis of ten instruments available for assessing practices' PCMH capabilities. Our primary goal was to highlight key features of these tools, their differences and similarities, and their perceived strengths and limitations, to facilitate the selection of tools by payers. We believe this project can help inform CMS's current and future PCMH activities, including facilitating CMS's own analysis and decisions as to whether to specify particular PCMH instruments in future initiatives and, if so, what instruments may be most appropriate.

## Informing our Study: Interviews with PCMH Experts

To inform all aspects of this study – including identifying PCMH recognition tools to assess and content domains to compare them on, and to gain a deeper understanding of how tools are being used by different types of entities and potential strengths and weaknesses of different assessment approaches – we conducted interviews with 18 PCMH experts in the Fall of 2010. This group included six state officials implementing medical home efforts in their Medicaid plans, an executive in a Medicaid managed care plan and an observer from a national association of such plans, an executive from a private commercial insurance carrier, a consultant who has worked on ten PCMH pilots, two senior leaders from medical societies, a physician leading a large medical home initiative for the U.S. Department of Veterans Affairs, and five national experts who have been closely following PCMH developments.[10]

Our interviews revealed key insights related to the use of PCMH assessment instruments, including a number of potential pitfalls or barriers to successful identification of medical homes, regardless of the assessment tool used. Some of the individuals we spoke to also suggested approaches to avoiding these pitfalls and barriers, which we summarize below.

### *Different Philosophies on the Role of PCMH Assessment Tools*

One of the most fundamental observations we gleaned from our interviews was the need for payers to decide up front how much to rely on structural assessment instruments (which measure practice capabilities) vs. outcome-oriented performance measures (the use of which implicitly minimizes the importance of structural assessments). We learned that different state Medicaid programs took different positions on this basic question. Some either used the NCQA PPC-PCMH instrument or developed their own detailed instrument and gave it priority for identifying practices that would receive additional funds as medical homes. Other programs had very basic entry criteria for participation in medical home programs but reserved extra payments for practices that performed well against quality and cost/utilization metrics. Although most interview respondents agreed that ideally the preferred approach to advancing medical homes would be to assess actual performance, there was a lack of agreement on the adequacy of current

[10] See Appendix for complete list of interviewees and their organizational affiliations.

(and potential) performance measures. Some interviewees thought assessment of practice capabilities and measurement of performance were equally important.

Below we present a more formal listing of attributes of what we perceive as two alternative approaches to PCMH recognition. Table 1, below, terms these approaches "High Bar for Recognition" (emphasizing practice structures and processes) and "Low Bar for Recognition" (focusing more on quality improvement over the long run and measurement of patient outcomes).

### Table 1. Two Philosophies on How to Use PCMH Recognition Tools

| | High Bar for Recognition | Low Bar for Recognition |
|---|---|---|
| **Which Practices Participate in Pilots?** | Advanced practices that meet stringent criteria. | A large number of practices with varied capabilities that all commit to becoming a PCMH. |
| **What is the Goal?** | Help advanced practices become even more advanced. | Help all practices make at least modest improvements by focusing on "low-hanging fruit." |
| **When Does Practice Transformation Occur?** | Primarily before enrolling in the PCMH effort, as a qualification for entry into the program. | On an ongoing, incremental basis, with performance targets continuously raised. |
| **What Type of Content is Included in the PCMH Recognition Tool / Participation Criteria?** | Tool measures a long list of practice capabilities that are believed (but not necessarily proven) to lead to improved outcomes in patients and can be easily documented. May not capture all of the key components of a PCMH. | Practices commit to engage in a few meaningful but hard-to-document PCMH activities (e.g., care coordination, chronic disease management, extended office hours, 24-hour live phone access). Subsequent measurement captures performance on (albeit imperfect) quality measures. |
| **What do plans pay for?** | The bulk of reimbursement is determined by a practice's medical home score upon entrance into the program. | The bulk of reimbursement is based on a practice's ongoing performance on a set of quality or cost/utilization measures. |
| **Example Program** | New York Medicaid's PCMH incentive program. | Illinois Health Connect's (a Medicaid primary care case management program) PCMH program. |

Finally, one interviewee thought that *how a tool was used* was more important than *what the tool measured*. He recommended that a tool be used as part of an ongoing practice improvement process instead of to separate "winners" and "losers" based on practice capabilities at a single point in time. He also suggested providing resources to practices as part of this developmental process (e.g., on-site facilitators, learning collaboratives to bring together practices to learn from each other, instruments to foster internal self-reflective processes by practices). Such an

approach would obviate the need for verification of responses, since remuneration would not be tied to scores on PCMH assessment instruments.

### *Minimizing Administrative Burden*

Another observation from these interviews was the need – stressed over and over again – to minimize administrative burden on already-overwhelmed primary care physicians. To address this, a few suggestions were offered:

- One respondent hoped that a tool could be developed that captured all of the requirements that practices will need to meet to qualify for: 1) HITECH "meaningful use" incentive payments, 2) participation in an ACO, and 3) enhanced reimbursement under PCMH initiatives.

- Another interviewee thought some kind of facilitative agency (e.g., extension centers, health plans) is needed to provide technical assistance to practices to help them understand and measure whatever criteria they need to meet as part of a PCMH recognition tool.

### *Choosing What to Measure*

One of the major unintended consequences of using a PCMH recognition tool according to the people we spoke with is that it can lead to "the tyranny of what can be measured," as providers focus on those aspects of their practice that can be objectively assessed to the detriment of other aspects that may be more central to delivering patient-centered care but not easily observable.

To address this, some interviewees suggested collecting data directly from patients on their experience and satisfaction with care, to help capture whether care is patient-centered and to make the use of PCMH assessment tools "less toxic." Indeed, many published commentaries on assessment instruments, including the initial NCQA PPC-PCMH standards, have emphasized that they tend to give short shrift to the patient-centered part of patient-centered medical homes. Many respondents recommended that assessment of patients' views about the patient-centeredness of practices, likely through surveys, should be a core part of a performance metrics.

We also learned from interviewees that providers generally rate themselves too highly when asked to self-assess their PCMH capabilities, suggesting that some sort of answer verification, accompanying documentation, and/or auditing may be needed.

## Study Methods: Comparative Assessment of PCMH Recognition Tools

### *Inclusion Criteria*

Returning to our main purpose here, we next outline the process we used to select PCMH assessment tools to assess.

First, in an effort to focus only on those tools that would be most relevant for CMS and other payers, we focused our review on PCMH assessment tools that were available ***for recognition purposes, specifically.*** By that we mean tools that were designed to be, or are now being used as, instruments for practices to complete to gain entry into pilots or programs in which enhanced reimbursement is offered if practices are in compliance with a specified set of PCMH standards. We did not include PCMH assessment tools being solely or primarily developed and used for other purposes. Some examples of these other purposes include practice self-improvement, research and evaluation, or structural measurement of quality. However, if a tool was being used for recognition purposes and one of these other purposes, we included it (e.g., TransforMED's Medical Home IQ, the Center for Medical Home Improvement's Medical Home Index).

We further culled the potential pool of PCMH assessment instruments by focusing only on those tools that were designed for practices serving a ***general population of patients*** (as opposed to pediatric practices, for example), in an effort to focus on tools that would be suitable for as wide an audience as possible. We also looked only at tools to be ***completed by a practice,*** as opposed to surveys that might be completed by a patient or a patient's family; such a comparison was beyond the scope of this analysis, given the great number of patient experience surveys.[11]

The above inclusion criteria produced the following list of PCMH recognition tools for our analysis:

- NCQA's PPC-PCMH (Physician Practice Connections - Patient-Centered Medical Home) standards *(released in 2008)*
- NCQA's PCMH 2011 standards *(released January 31, 2011)*
- Accreditation Association for Ambulatory Health Care (AAAHC)'s Medical Home standards *(released in 2009)*
- Joint Commission's[12] Primary Care Medical Home Designation standards *(released in finalized form in May 2011)*

[11] However, we note that several of the provider tools we review have a companion patient/family experience survey to assess PCMH capabilities, or have been coupled with other patient/family experience surveys. Currently, NCQA is developing an AHRQ-funded PCMH version of AHRQ's popular CG-CAHPS patient experience survey – which stands for the Consumer Assessment of Healthcare Providers and Systems, Clinician & Group version – and expects to release this in the summer of 2011. Starting in 2012, NCQA began offering practices extra "distinction" if they collect patient experience data using this tool.

[12] The Joint Commission was formerly known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

- URAC's (formerly the Utilization Review Accreditation Commission) Patient Centered Health Care Home (PCHCH) Program Toolkit *(released in December 29, 2010 for practice self-improvement purposes, and used as the basis for their PCMH auditor certification program announced in March of 2011, and the practice recognition program they announced in June of 2011)*

- TransforMED's[13] Medical Home Implementation Quotient (IQ), version 2.0 *(updated in 2009)*

- Center for Medical Home Improvement's Medical Home Index *(developed in 2008)*

We did not include the medical home recognition program currently offered by the Health Care Incentives Improvement Institute through its Bridges to Excellence programs, since this recognition program does not involve a stand-alone PCMH-specific survey. Instead, practices automatically become a recognized medical home by achieving high enough scores on pre-existing Bridges to Excellence programs – specifically, by 1) achieving a Physician Office Systems Recognition of Level 2 or higher; and 2) achieving at least Level 2 recognition in any two Bridges to Excellence care recognition programs (e.g., hypertension, diabetes).

In addition to including what could be termed "off the shelf" tools – available from national organizations and being used in multiple initiatives in diverse parts of the country – we also included a sampling of some of the many "single-use" PCMH recognition tools – which have been developed by payers at the state level for specific PCMH initiatives – to provide a sense of the variety in available tools. To identify some examples of state-level tools with good reputations, we drew on our interviews with PCMH experts who had been observing and facilitating PCMH initiatives but had not developed their own recognition tools (to ensure objectivity) as well as conversations with other PCMH experts.[14] As a result of these individuals' recommendations and our review of the tools suggested, we added the following state-level tools to our analysis:

- BlueCross BlueShield of Michigan's PCMH Designation Program *(a voluntary component of their Physician Group Incentive Program);*

- Minnesota's state-wide multi-payer Health Care Home Certification Program *(which is voluntary, but entitles participating providers to enhanced reimbursement);*

- Oklahoma's SoonerCare (Medicaid) PCMH Program *(which is mandatory for Medicaid providers, and entitles practices to higher fees depending on their medical home tier).*

[13] A subsidiary of the American Academy of Family Physicians

[14] These conversations were with Melinda Abrams (of the Commonwealth Fund), Meredith Rosenthal (of Harvard's School of Public Health), Neva Kaye and Mary Takach (of NASHP), and Nikki Highsmith, Carolyn Berry, and Alice Lind (of the Center for Health Care Strategies).

***Content Domains Assessed***

We also drew on our interviews and conversations with PCMH experts and recent literature to identify content domains to use to categorize the survey items in these PCMH recognition tools (more on this below). This was supplemented by our review of the tools themselves, which required us to add additional content domains to cover tool elements that are not typically thought of as key components of the medical home (see items at end of following list). The content domains we looked at for each of our PCMH recognition tools is as follows:

- **Access to Care** *(e.g., the ease with which a patient can initiate an interaction for any health problem with a clinician, such as through same-day appointments, clinicians answering patient emails, etc.)*

- **Comprehensiveness of Care** *(e.g., the breadth of services the practice offers, to address any health problem at any given stage of a patient's life)*

- **Continuity of Care** *(e.g., policies that specify that patients are to be seen by the same clinician over time)*

- **Culturally Competent Communication** *(e.g., the practice provides information at an appropriate reading level for patients and in multiple languages; the practice makes available translation services, etc.)*

- **Patient Engagement & Self-Management** *(e.g., the practice counsels patients to adopt healthier behaviors or learn how to better manage a chronic condition)*

- **Coordination of Care** *(e.g., interacting with other providers – e.g., specialists and hospitals – to coordinate all care delivered to the patient, including care transitions)*

- **Care Plan** *(e.g., developing an individualized treatment plan for a patient, basing this care plan on an individualized health risk assessment of the patient, etc.)*

- **Population Management** *(e.g., use of a registry to proactively manage care for patients with a given chronic condition)*

- **Team-Based Care** *(e.g., the primary care physician works with an interdisciplinary team to manage the patient's care, including collaboratively developing a treatment plan)*

- **Evidence-Based Care** *(e.g., use of evidence-based care guidelines, clinical decision support, etc.)*

- **Quality Measurement** *(i.e., quality is measured in some way)*

- **Quality Improvement** *(i.e., required to engage in quality improvement projects and/or set performance targets based on quality measure data collected)*

- **Community Resources** *(e.g., referrals to social services)*

- **Medical Records** *(i.e., specific types of information that should be recorded in patients' medical records)*

- **Health IT** *(i.e., when questions explicitly require the use of an electronic system, like electronic health records (EHRs), e-prescribing, an electronic patient registry, etc.)*

- **Standard Care (Non-PCMH)** *(e.g., very basic care processes that all clinicians should already engage in, such as "physician speaks to the patient about his/her health problems and concerns"[15])*

- **Adheres to Current Law** *(e.g., "records are provided [to patients] upon request")*

- **Business Practices** *(e.g., the financial and organizational management of the practice, such as having a business plan, analyzing the percentage of submitted claims that went unpaid, etc.)*

- **Presence of Policies** *(e.g., requiring a policy on after-hours care for patients, but not requiring that policy to provide patients with in-person access to care after-hours)*

- **Compact between Practice and Patient** *(e.g., requiring practices to execute a written PCMH agreement and/or have a conversation and document it in a patient's medical record in which the practice commits to provide certain services – such as care coordination – and the patient agrees to some basic responsibilities)*

***Overlap between Content Domains***

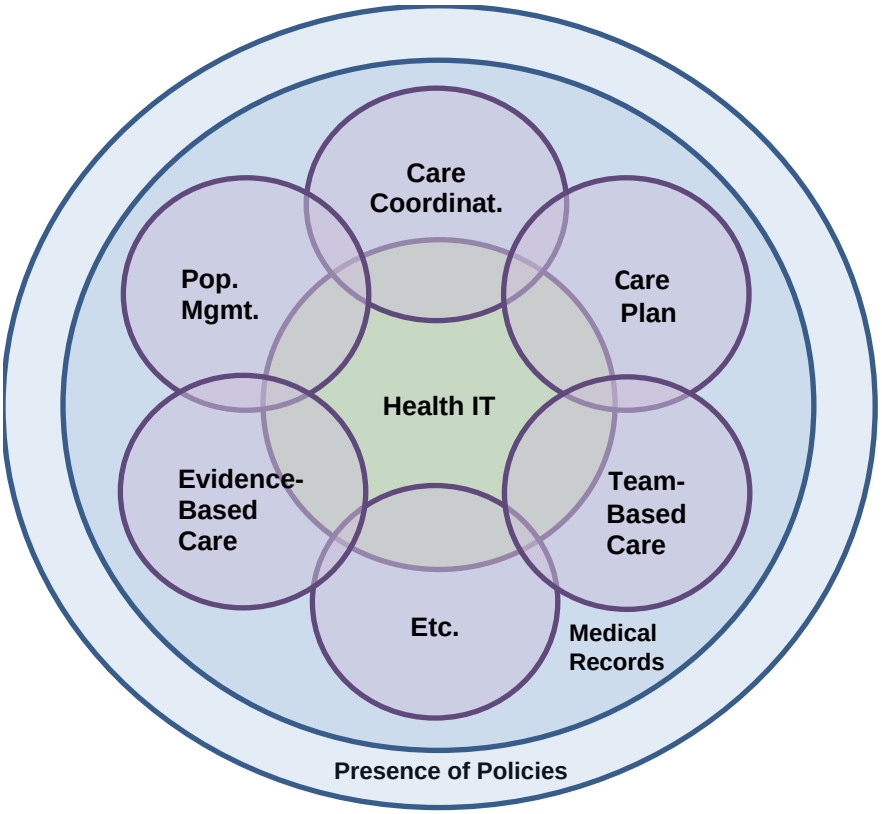
We note that when categorizing PCMH recognition survey items, those that required the use of an electronic health information tool or system were categorized under "Health IT." This approach was used since adopting health IT is perceived by many to be a bigger change to how a practice delivers care than activities encompassed within the other content domains; only 10% of office-based physicians use "fully functional" EHRs or electronic medical records (EMRs), and half use no EHR or EMR whatsoever.[16] If a health IT-blind assessment were conducted on the PCMH recognition tools included in this analysis, it would result in higher percentages for all other content domains, especially for the two versions of NCQA's tool, which both had heavy health IT emphases.

We also note that the scope and overlap of our content domains vary, as represented in Figure 1.

[15] We note that while many tools included items asking about care processes that many – perhaps most – practices are likely engaged in already, we reserved this category for items that were especially basic.

[16] Hsiao, Chun-Ju, Esther Hing, Thomas C. Socey, and Bill Cai. 2010. "Electronic Medical Record/Electronic Health Record Systems of Office-based Physicians: United States, 2009 and Preliminary 2010 State Estimates." U.S. Centers for Disease Control and Prevention, National Center for Health Statistics. (http://www.cdc.gov/nchs/data/hestat/emr_ehr_09/emr_ehr_09.pdf).

**Figure 1. Overlap between Content Domains Assessed**




The bulk of the content domains we assessed are relatively comparable to each other in terms of the breadth of activities that might fall within their areas, and are therefore represented by a ring of overlapping circles of equal size – e.g., "Care Coordination," "Population Management," etc. However, the content domain of "Health IT" has the potential to overlap with activities in each of these areas – for example, population management can be conducted using an electronic registry, or it can be conducted using paper-based index cards – which is why the "Health IT" domain is represented by a larger circle in the center of the diagram, partially overlapping each of the previously-mentioned content domains. Cutting across all of domains mentioned so far is the domain of "Medical Records," represented in the graphic by a large circle encompassing the smaller circles previously described, since standards can specify types of information gathered in the course of conducting any of the previous activities that are required to be included in patients' medical records. Finally, an even larger circle encompasses all other circles, labeled "Presence of Policies," since standards can require that practices have written policies on nearly any topic – including medical records.

The fact that items can often be categorized into more than one content domain (represented by the ring of overlapping circles above) means the exercise of categorizing PCMH recognition tool survey items is a relatively imprecise one – requiring subjective assessments on the part of the tool assessor. As a result, the percentages presented in our content analysis (Tables 3 and 4, in the Appendix) should be viewed as rough estimates offered by an independent third party, as opposed to objective "facts" about these tools.

### *How Content Was Assessed*

To measure the relative emphases of our ten selected PCMH recognition tools' content, we assigned each survey item in each PCMH recognition tool to one of the content domains listed above.[17] To ensure that a consistent approach to categorizing tool items was used, one member of our research team categorized all survey items; a second team member then reviewed these category assessments for a sample of tools, to ensure general agreement with judgments made about which category an item fell within. For each tool, we then summed the number of questions assigned to each category and divided that number by the total number of scored items in the tool to arrive at the percentage of items in that tool within a given content domain.

We note that there are other approaches we could have used to conduct our content analysis; we describe two methodological choices we made below.

**Methodological Choice #1: Assigning Items to a Single Category vs. Tagging Them with Multiple Categories.** Given the overlap in content domains represented in the figure above, we could have tagged tool items with as many content domains as were applicable (e.g., an item could be related to care coordination, population management, patient engagement and self-management, medical records, and presence of policies). However, this approach could have resulted in tools appearing to have good coverage within a given content domain, when in reality the items tagged with this content domain may have all been only indirect references. Instead, we attempted to identify the one content domain that seemed to most accurately capture the essence of what each item was attempting to measure. We believe this approach provides a more useful picture of what types of items are included in these tools.

**Methodological Choice #2: Item Emphasis vs. Scoring Emphasis.** Instead of presenting the percentage of *survey items* within different content domains, an alternative approach would have been to present the percentage of each tool's *score* determined by different content domains. However, this approach would have presented some logistical barriers that would have prevented us from presenting an apples-to-apples comparison of our 10 tools' content. The first challenge to this approach is that one tool's developer offers payers three different scoring approaches from which to choose (the Center for Medical Home Improvement's Medical Home Index). Another tool developer makes determinations of whether a practice meets its standards based on a holistic determination, taking into account the practice's overall capabilities (e.g., AAAHC). In the end, since scoring algorithms and the number of points assigned to particular questions can be easily modified, we chose to focus our content analysis on the percentage of *items* included in the PCMH recognition tools, as opposed to their relative weight for scoring purposes. This approach allows us to present comparable information for each of the ten tools on what the instruments themselves looks like.

Since we recognize that payers may want to assess not only the content of PCMH recognition tools but also the scoring algorithm used by these tools, we offer the following table (below). It

[17] We did not categorize administrative questions about the basic characteristics of practices – e.g., the size of the patient panel, the practice's estimated payer mix, etc. – since these items were not factored into the scoring algorithms for any of the tools we assessed.

identifies which of the 10 tools we looked at would have a different percentage breakout among content domains if we had looked at *scoring* emphasis instead of *item* emphasis.

### Table 2. Scoring Emphasis vs. Item Emphasis for 10 PCMH Recognition Tools

| PCMH Recognition Tool | Relationship |
|---|---|
| NCQA's PPC-PCMH | Scoring Emphasis ≠ Item Emphasis |
| NCQA's PCMH 2011 | Scoring Emphasis ≠ Item Emphasis |
| AAAHC's Medical Home | Scoring Emphasis = Item Emphasis |
| Joint Commission's Primary Care Medical Home | Scoring Emphasis = Item Emphasis |
| URAC's Patient Centered Health Care Home | Scoring Emphasis = Item Emphasis |
| TransforMED's Medical Home IQ | Scoring Emphasis ≠ Item Emphasis |
| Center for Medical Home Improvement's Medical Home Index | Depends on scoring approach used |
| BlueCross BlueShield of Michigan's PCMH | Scoring Emphasis ≠ Item Emphasis |
| Minnesota's Health Care Home | Scoring Emphasis = Item Emphasis |
| Oklahoma SoonerCare PCMH | Scoring Emphasis = Item Emphasis |

In NCQA's two versions of their PCMH standards, points are allocated to sets of questions (e.g., 2 points for 4 questions on cultural competency). Similarly, BlueCross BlueShield of Michigan specifies the percentages of the total score associated with different sets of questions (e.g., responses to the questions in the "Patient Registry" section determine 10% of a practice's PCMH capabilities score).[18] Meanwhile, the Medical Home IQ tool's scoring methodology is not publicly available but appears to be based on the number of positive response options (e.g., a multiple-choice question that asks what methods patients can use to schedule an appointment appears to be worth 5 points – one point for each of the response options: "Phone," "Online", "Email", "Walk In", and "Mail" – while a simple "Yes" / "No" question appears to be worth 1 point).

We believe payers will likely be most interested in assessing the scoring algorithms used by independent third parties that administer and tabulate PCMH recognition tools in exchange for a fee (i.e., the first five tools in the table above), since these scoring algorithms may not be

[18] We note that their methodology for determining which practices qualify for enhanced PCMH reimbursement rates is more complex – factoring in performance on quality and cost/utilization measures, and ranking practices by their performance relative to each other.

customizable for different payers[19] and may have a substantial impact on the relative content emphases of these tools. We therefore present a comparison of these five tools' scoring emphases (which are identical to their *item* emphases for all except the two NCQA tools) in Table 4 of our Appendix.

### *Operational Details Assessed*

In addition to assessing content domains of PCMH recognition tools, we also collected information about operational details of tools, since this information is also likely to influence a payer's selection of a tool. We collected these details primarily through tool developers themselves (through their websites and direct communications). The operational details we present are as follows:

- **Website**
- **About Tool Developer** *(e.g., a sentence about what type of activities the organization is primarily known for)*
- **Release Date** *(e.g., the year the tool was made available to the public)*
- **Other Versions of the PCMH recognition tool** *(e.g., prior versions or versions developed for practices serving different patient populations)*
- **Clinician Types that Can Lead Practice** *(e.g., doctors, nurse practitioners, etc.)*
- **Who Provides Responses?** *(e.g., the practice, an external surveyor, etc.)*
- **Method of Providing Responses** *(e.g., by filling out a survey online, by answering questions during a site visit, etc.)*
- **Answer Format** *(e.g., checklist, essay questions, etc.)*
- **Documentation Required?**
- **Total Number of Items** *(i.e., number of questions or items in the tool)*
- **Time to Complete Tool** *(e.g., number of minutes or hours that the tool developer estimates it takes to fill out the actual survey)*
- **Administrative Burden** *(our summary assessment – i.e., "heavy," "moderate," "light" – taking into account time to complete, cost, documentation requirements, etc.)*

[19] By contrast, payers would likely have complete control over determining a scoring algorithm if using a "single-use" tool developed for a specific initiative or appropriated for such purposes (i.e. the last five tools in the table above).

- **Responses Verified?** *(e.g., is documentation collected and reviewed by someone? are site visits conducted?)*
- **Scoring Instructions**
- **Tested for Validity and Reliability?**
- **Used By** *(i.e., types of entities that are using the tool for recognition purposes)*
- **Endorsed By** *(i.e., organizations external to the tool developer that have endorsed the tool)*
- **Cost** *(e.g., to purchase tool and/or to apply for recognition using the tool)*
- **How to Obtain Tool**
- **How to Obtain Accreditation** *(if offered)*

## Findings: Content Emphases and Operational Details

The following section summarizes findings from our assessment of how the 10 PCMH recognition tools selected for review compared to each other – first in terms of the content domains they emphasized, and then in terms of some of their key operational details. We conclude by offering summary observations of each tool that highlight key content or operational features.

### *Trends in Tools' Content Emphases*

Our assessment of the relative emphases given to different content domains in our 10 PCMH recognition tools is summarized below (and presented in Tables 3 and 4 in the Appendix). We present the content domains that tools gave the greatest emphasis to first, followed in descending order by the remaining domains. We base this order on the *median* percentage of items devoted to a given content area, rather than the *average* across these tools, since some averages are skewed by one or two tools' heavy emphasis on a particular content domain (which is the case for the "Health IT" category, for example).

**Coordination of Care *(12% median emphasis).*** The content domain that received the highest level of emphasis among our 10 tools was the extent to which practices were coordinating care received by their patients from other providers. Tools that put an especially high degree of emphasis on this area were Oklahoma's (26%), BlueCross BlueShield of Michigan's (16%), and URAC's (14%), although most tools allocated a substantial percentage of their items to this area. The tool with the lowest emphasis on care coordination was the Joint Commission's standards.

**Health IT *(10%).*** The content domain with the second-highest level of emphasis was Health IT, with items measuring whether practices had adopted and were using such tools as EHRs, e-prescribing, clinical decision support tools embedded into EHRs, interactive practice websites, electronic disease registries, etc. Outliers within this domain were NCQA's two tools (for which 46% of the 2008 items required the use of specific types of health IT, as did 40% of the 2011 items). We note that once scoring weights are applied to these items, the emphasis given to health IT by the two NCQA tools is reduced to 30% and 29%, respectively – which is still far higher than any other tool.

The emphasis on health IT of the 10 PCMH recognition tools we assessed falls into three groups:

*Heavy Emphasis (25%+)*

- NCQA's PPC-PCMH (2008)
- NCQA's PCMH (2011)

*Moderate Emphasis (10-25%)*

- URAC's Patient Centered Health Care Home
- TransforMED's Medical Home IQ
- BlueCross BlueShield of Michigan's PCMH Designation

*Light Emphasis (0-10%)*

- Oklahoma's SoonerCare (Medicaid) PCMH
- The Joint Commission's Primary Care Medical Home Designation
- Center for Medical Home Improvement's Medical Home Index
- AAAHC's Medical Home
- Minnesota's Health Care Home Certification

**Quality Measurement *(8%).*** Another one of the content domains with the greatest emphasis among our tools was the extent to which practices measured the quality of their services – such as through clinical process measures or patient experience surveys.[20] Oklahoma's was the one tool that did not ask about quality measurement, but this may be because it already runs a separate pay-for-performance initiative for its SoonerCare providers. Minnesota and BlueCross BlueShield of Michigan also collect quality measure data as part of their PCMH initiatives. In terms of measuring quality through data collected from patients on their experience of care, The Joint Commission's tool is the only one to require that patient experience data be collected. Meanwhile, in 2012 NCQA began offering practices "distinction" if they collect such data – using the PCMH version of the U.S. Agency for Healthcare Research and Quality's CG-CAHPS survey, specifically, which was released in October 2011. URAC has also publicly endorsed the use of the PCMH CG-CAHPS survey but does not require its use.

**Patient Engagement & Self-Management *(6%).*** The extent to which practices were working with patients to help them better manage their health was also an area that received enhanced focus among tools. BlueCross BlueShield of Michigan provided the greatest relative emphasis on this area, at 13% of its items, followed by the Joint Commission at 10% and URAC at 8%.

**Presence of Policies *(5%).*** Survey items that required that a written policy be in place, but did not specify particular requirements of that policy, were categorized into "Presence of Policies." Some tools included more of this type of item than others, with AAAHC including the greatest number of this type of item (23%), followed by URAC (17%), TransforMED's Medical Home IQ (13%), and the Joint Commission (12%). The rest of the tools put relatively little emphasis on this sort of survey item.

**Population Management *(4%).*** There was a relatively large range in terms of the emphasis given to measuring whether practices were proactively managing their patients' care – such as through the use of registries. At one end of the spectrum was BlueCross BlueShield of Michigan with 18% of its items devoted to these types of activities; meanwhile, AAAHC allocated less than 1% of its items to this topic.[21]

**Access to Care *(4%).*** Most tools included items designed to measure the extent to which practices are providing enhanced access to their services – such as by leaving time free each day for same-day appointments, or by responding to emails from patients – but their relative

[20] We note that survey items generally asked if quality measurement activities were in place, but did not require practices to achieve certain performance benchmarks on this data.

[21] Note: tool items that explicitly required the used an electronic registry were categorized under the "Health IT" content domain.

emphasis on this area ranged from 0% to 15%. The tool with the least stringent standards regarding access was URAC's; since its items focused on whether patients were provided with information and policies on access, as opposed to requiring that practices reserve a certain percentage of their appointments per day for same-day appointments, items that mentioned access were assigned to the "Presence of Policies" category rather than "Access to Care." Meanwhile, Oklahoma's SoonerCare (Medicaid) program tool had the greatest emphasis on enhanced access to care, at 15% of its 27 items.

**Quality Improvement *(4%).*** In contrast to items that asked if a practice was measuring its quality, relatively fewer items asked if practices actually used these data to try to improve the quality of care they deliver. Outliers included Minnesota (at 18%) and the Medical Home Index (at 13%).

**Care Plan *(4%).*** There was variety in the degree to which tools asked whether practices develop a treatment plan for their patients. At the upper end of the range was Minnesota, which allocated 12% of its items to this content domain, and at the lower end was AAAHC, with only one of its 238 items (0.4%) in this area.

**Evidence-Based Care *(4%).*** Most of the tools asked whether practices were employing evidence-based clinical guidelines in the delivery of care to their patients, except for the Medical Home Index.

**Culturally Competent Communication *(3%).*** Receiving less emphasis than the previous content domains was cultural competency – which tools generally measured through items asking whether practices were making translation services available to patients and providing information to patients at an appropriate reading level. The Joint Commission's tool had the greatest emphasis on this area, with 10% of its items devoted to this area. Oklahoma's was the one tool that did not include any items in this area.

**Medical Records *(3%).*** In terms of items specifying particular types of information to include in patients' medical records, four tools put a relatively high emphasis on this: Minnesota's (13%), AAAHC (10%), the Joint Commission (8%), and Oklahoma (7%). Minnesota's emphasis in this area was linked to ensuring on-call providers treating patients after hours have the necessary information to effectively serve them. Other tools put low or no emphasis on this area.

**Comprehensiveness of Care *(2%).*** Tools varied in terms of the emphasis given to measuring the breadth of services offered by practices. Three tools included no questions in this area (NCQA's 2008 tool, the Medical Home Index, and BlueCross BlueShield of Michigan's tool). Meanwhile, tools that gave this area a relatively high degree of emphasis included Oklahoma's (15%), AAAHC (8%), and the Joint Commission (6%).

**Team-Based Care *(2%).*** A similar degree of variety was seen among items that asked whether a practice employed a team-based model of delivering care, with each team member assigned roles and practicing to the top of their license. Six tools allocated 2% or fewer of their items to this, but Minnesota and TransforMED's Medical Home IQ bucked this trend – allocating 6% and 7% of their items, respectively, to this content domain.

**Adheres to Current Law *(2%).*** A little over half of the tools included items that asked whether practices were complying with basic Federal or state laws governing the practice of medicine (e.g., HIPAA privacy rules, state licensing requirements). No tool included very many questions in this area.

**Community Resources *(1%).*** Relatively little emphasis was given to asking practices if they provided referrals to services in the community, such as social services. However, the outlier among this group was the Medical Home Index, which devoted 13% of its items to this.

**Continuity of Care *(1%).*** One of the content domains with the least overall emphasis was the extent to which practices had policies specifying that patients should be seen by the same clinician over time. The exceptions were AAAHC (5%) and the Joint Commission (4%).

**Standard Care (Non-PCMH) *(0%).*** A few tools included survey items that measured relatively basic practice capabilities that would be assumed to be present in a medical home but might not necessarily be considered advanced practice capabilities, which we have assigned to a "Standard Care" category.[22] In particular, the Medical Home Index included many such questions (at 28% of its items), in a deliberate effort to give practices credit for foundational capabilities and thereby avoid discouraging practices that are only beginning their practice transformation journey. This was a relatively unique approach, with most tools opting not to include items asking about such basic care processes.

**Business Practices *(0%).*** TransforMED's Medical Home IQ was unique among our 10 tools in that it asked a series of questions related to business practices, particularly related to financial management (e.g., having a business plan, analyzing the percentage of submitted claims that went unpaid, etc.). While this tool allocated nearly a fifth of its 139 items to this area, no other tool included any questions related to this domain.

**Compact between Practice and Patient.** Six of the PCMH recognition tools we assessed required practices to enter into an agreement or compact with their patients to establish a medical home relationship. This typically required the practice to describe the enhanced capabilities it would make available to the patient and to seek agreement on certain basic patient responsibilities. Two tools did not require the use of an explicit agreement but required practices to inform patients of the enhanced capabilities it would offer patients (AAAHC and the Joint Commission), and two other tools did not mention practice-patient compacts (NCQA's 2008 standards and the Medical Home Index).

[22] We note that while many tools included items asking about care processes that many – perhaps most – practices are likely engaged in already, we reserved this category for items that were especially basic (e.g., "physician speaks to the patient about his/her health problems and concerns").

### *Trends in Tools' Operational Details*

Trends observed in key operational details of the 10 PCMH recognition tools we assessed are discussed below. (Complete operational details for all tools are presented in Table 5, in the Appendix to this analysis.)

**Organizational Type of Tool Developer.** All of the PCMH recognition tools we identified were developed by non-profit organizations. Four of these are national organizations that accredit various types of health care organizations (NCQA, the Joint Commission, AAAHC, and URAC). Two other organizations promote the PCMH model by developing free tools to help practices increase their "medical homeness" and offering consulting services to practices (TransforMED and the Center for Medical Home Improvement). One organization is a commercial health insurance plan (BlueCross BlueShield of Michigan), and two others are state agencies (Minnesota's Department of Health and Department of Human Services, and Oklahoma's Health Care Authority).

**Clinician Types that Can Lead Practice.** Four of the tools specified that a PCMH needed to be led by a physician, while another four also permitted Nurse Practitioners or Physician Assistants to lead medical homes (NCQA's PCMH 2011 standards, the Joint Commission's finalized standards, Minnesota's standards, and Oklahoma's). Two other tools did not specify a required clinician type to lead the practice.

**How are Responses Provided?** Seven of the tools we assessed are designed to be completed by the practice, while three tools (AAAHC's, the Joint Commission's, and URAC's) are designed to be completed by an external surveyor during a site visit. Minnesota's and Oklahoma's tools are somewhat unique, in that they require both the submission of responses to an application survey and a site visit (and Minnesota also requires accompanying documentation). None of the tools specify the particular member of a practice that should complete their tool (e.g., the lead physician, the office manager, etc.).

**Answer Format.** Most of the tools are presented in the form of a checklist, but two tools (Minnesota's and Oklahoma's) also require short written answers demonstrating how a practice meets the stated capability.

**Documentation Required?** Half of the tools that we assessed require practices to submit accompanying documentation at the time of applying to be recognized as a medical home (both of NCQA's tools, AAAHC, Joint Commission – for the base accreditation that is a prerequisite to obtaining medical home accreditation, at least – and Minnesota).

**Time to Complete Tool.** According to estimates provided by tool developers, the amount of time required to fill out the PCMH recognition tool and/or participate in a site visit varies dramatically across the 10 tools assessed, ranging from a mere 20 minutes to fill out the Medical Home Index to 40-80 hours to upload documentation into NCQA's tools.

**Administrative Burden.** Most of the "off the shelf" tools offered by national accrediting organizations involve heavy administrative burdens, due to extensive documentation requirements or mandatory site visits. Meanwhile, the "single-use" tools had either light or moderate administrative burdens.

**Responses Verified?** Information reported by practices is verified in some way for most tools, such as by reviewing documentation submitted, reading written answers submitted, or conducting site visits.

**Scoring Instructions.** Tools varied in their scoring approach, with some requiring compliance with 100% of their items (the Joint Commission's tool, Minnesota's, and Oklahoma's), and most others requiring that only a certain percentage be met (e.g., 25% for NCQA's 2008 standards, 35% of their 2011 standards, 35% of URAC's standards). Some tools assigned different weights to different survey items (e.g., both of NCQA's tools, the Medical Home IQ, the Medical Home Index, and BlueCross BlueShield of Michigan's tool) while others did not. AAAHC's tool was unique in that it did not assign any weights or specify any cut-off scores – instead basing recognition determinations on a holistic assessment of the practice's overall capabilities.

**Tested for Validity and Reliability?** Most tools had not been tested for validity or reliability, although the pediatric version of the Medical Home Index had been.

**Used By.** The most widely-used PCMH recognition tool (geographically) appears to be the 2008 version of the NCQA tool, which NCQA reports using to certify over 1,500 sites across the country as of the end of 2010. In addition, a recent journal article summarizing PCMH pilots nationwide found that 21 were requiring the use of NCQA's PPC-PCMH, either as a target level for practice transformation (the more common approach) or as a requirement for entry (in five pilots).[23] That same article reported that three other demonstrations were using the Medical Home IQ tool (in Colorado, Greater Cincinnati, and Maine). And although it is only being used in Michigan, BlueCross BlueShield of Michigan reports that their PCMH initiative is technically the largest PCMH initiative in the country, with 1,800 doctors designated in 500 practices across the state, and another 3,200 physicians currently working on improving their processes and implementing medical home capabilities in an effort to earn designation in coming years.

**Endorsed By.** Endorsements of PCMH recognition tools are rare. Although NCQA's PPC-PCMH standards have been endorsed in the past for use in demonstrations by four professional societies (the American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association), it is likely that these groups will not endorse a particular tool now that there are competitors in this market and now that these four societies have issued joint "Guidelines for Patient-Centered Medical Home (PCMH) Recognition and Accreditation Programs."[24] NCQA's PPC-PCMH tool has also been endorsed for use in demonstrations by the Patient Centered Primary Care Collaborative (a PCMH advocacy group) and the National Quality Forum (NQF); NCQA plans to submit its new PCMH 2011 standards to NQF for potential endorsement as well. The other PCMH recognition tool that has been endorsed by external organizations is BlueCross BlueShield of Michigan's, which in 2010 was awarded URAC's "Bronze URAC Award" and adapted by URAC in its own

[23] Bitton et al, 2010.

[24] American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association. 2011. "Guidelines for Patient-Centered Medical Home (PCMH) Recognition and Accreditation Programs." (http://www.aafp.org/online/etc/medialib/aafp_org/documents/membership/pcmh/pcmhtools/pcmhguidelines.Par.0001.File.dat/GuidelinesPCMHRecognitionAccreditationPrograms.pdf.)

PCMH tool. The national BlueCross BlueShield Association has also awarded its Michigan plan two awards – its "Best of Blue Clinical Distinction Award" and "Best in Show" award.

**Cost.** The cost of obtaining a copy of a PCMH recognition tool is usually free or relatively inexpensive ($59 for URAC's), but the cost for practices to obtain national accreditation using these tools is in the thousands of dollars (currently offered through NCQA, AAAHC, URAC, and the Joint Commission). All of these organizations verify practices' responses on their PCMH recognition tools, through either document review or site visits. Meanwhile, we are unaware of state-level PCMH initiatives that require practices to pay application fees to apply for entry.

## Summary Assessments of Each Tool

Next we highlight key features and potential strengths and weaknesses of each of our 10 PCMH recognition tools, taking into account both operational information and content emphases of these tools.

**NCQA's PPC-PCMH (2008).** The most notable feature of NCQA's 2008 standards is the heavy emphasis on the use of health IT, at 46% of the tool's items (or 30% of its score). Other content domains with high levels of emphasis are care coordination (12% of items, or 17% of the score), quality measurement (7% of items, or 11% of the score), and access to care (6% of both the items and the score). An obvious strength of NCQA's tool is its widespread use by a variety of plans and providers across the country – including Medicaid and state programs, multi-payer efforts, community health centers, federally qualified health centers, and military treatment facilities. Because of its wide use, sponsors of PCMH initiatives could potentially compare their practices' performance using the NCQA 2008 standards to that of other providers who used those standards in their demonstrations or initiatives – though scores on the 2008 NCQA survey are not comparable to scores on the 2011 NCQA survey, due to differences in question wording and scoring cut-offs for different NCQA medical home levels. The biggest drawback of the 2008 NCQA tool is its burdensome documentation requirements, which NCQA estimates takes 40-80 hours to comply with (just in terms of time to upload the documentation into their online survey tool).[25] NCQA has also been criticized for its high price (which is approximately $500 per physician in a practice for the first eight physicians – see Table 5 for full pricing details for all tools).

**NCQA's PCMH 2011.** NCQA appears to have made an effort to respond to some of its criticisms in its 2011 standards. These new standards appear to be modestly less burdensome (since there are 12% fewer items), and have a slightly reduced emphasis on health IT (the percentage of items devoted to this is now 40% instead of 46% – or 29% of the score, instead of 30%).[26] Another change NCQA has made is to offer practices extra "distinction" if they voluntarily collect patient experience survey data using the PCMH CG-CAHPS survey that AHRQ released in October 2011; for now, "distinction" is based on the reporting of this data to NCQA, as opposed to actual scores on the instrument. We also note that the number of items that we perceived as falling into the "Access to Care" category actually went down from 2008 to 2011, from 6% of items (11 items) in 2008 to 3% (4 items) in 2011 (similarly, the percentage of the score determined by "Access to Care" items went down, from 6% to 3%). Another criticism of NCQA – its price – has not been addressed, but it should be noted that the cost of accreditation through NCQA appears to be lower than organizations that conduct mandatory site visits for all PCMH applicants (instead of the 5% sample that NCQA does). In terms of the weight NCQA gives to different content domains in its scoring, it has adjusted the relative emphasis it gives different topics in other ways: it has reduced emphasis on care coordination (from 17% to 12% of the score) and evidence-based care (from 7% to 4%), and increased

[25] Interviewees told us anecdotally that the amount of time practices need to apply for NCQA recognition can often take 3-6 months, since practices find they must devote time to develop written policies for many practice activities.
[26] NCQA has also released a crosswalk showing how CMS's "meaningful use" requirements are comparable to their PCMH 2011 standards, and is pursuing "meaningful use" criteria "deeming" status from CMS for PCMH-recognized practices.

emphasis on population management (from 4% to 9%) and quality improvement (from 3% to 6%). In 2011, practices have the option of using either the 2008 or 2011 version of NCQA's PCMH standards, but starting in 2012 practices seeking recognition from NCQA will have to use the 2011 standards.

**AAAHC's Medical Home Accreditation Standards.** Unlike NCQA, AAAHC conducts mandatory site visits to all applicants of its PCMH recognition program – not just a 5% sample. (URAC and the Joint Commission also do mandatory site visits to all applicants.) Of all the tools assessed, AAAHC had the highest percentage of survey items assigned to the "Presence of Policies" category, which was used when standards merely required that a written policy be in place but did not include specific requirements for what that policy should state. AAAHC's recognition program involves the highest number of survey items by far, at 238, and AAAHC is unique in that it allows applicants to apply for either "accreditation" (which involves obtaining base AAAHC accreditation in addition to meeting AAAHC's medical home standards) or a less-burdensome option called "certification" (which does not require base AAAHC accreditation). AAAHC does not make pricing information public, other than to note that it is based on the size, type and range of services provided by the organization. However, its "accreditation" option appears to be comparable to the Joint Commission's, for which pricing information is listed below.

**Joint Commission's Primary Care Medical Home Designation Program.** As mentioned above, the Joint Commission's Primary Care Medical Home designation is most similar to AAAHC's existing on-site "accreditation" program, in that both of these programs require practices to obtain base accreditation in addition to meeting specific medical home standards (but another option offered by AAAHC, called "certification," does not require base AAAHC accreditation). The Joint Commission allows practices to satisfy the requirements of both its base accreditation and medical home designation through a single 2-3 day site visit, and there is no additional cost to apply for medical home designation beyond the cost of base accreditation, which is required (and is expensive – starting at $9,140 for three-year recognition for a single small practice and topping out at $27,080 for larger practices with multiple sites). In terms of content, the Joint Commission's draft standards had the most even distribution of survey items among the various PCMH content domains.[27] It is also the only PCMH recognition tool to claim to be based on AHRQ's recently-posted PCMH definition,[28] and is the only tool to *require* that practices collect patient experience data (meanwhile, NCQA offers practices additional "distinction" if they collect this data, but does not require its collection).

**URAC's Patient Centered Health Care Home Program.** URAC is the only tool developer that is currently charging money to obtain a copy of its PCMH standards (at $59). Released at the end

[27] Note: The Joint Commission's draft standards present both the items contained in its base Ambulatory Care Accreditation program that it believes are related to the PCMH concept and additional items they propose evaluating practices on who seek PCMH designation from them. To make these standards comparable to the Joint Commission's closest competitor, AAAHC (which also offers a PCMH designation on top of a base ambulatory accreditation program), we only assessed the additional items that the Joint Commission would be collecting, not all the other elements from its base criteria as well.

[28] U.S. Agency for Healthcare Research and Quality. 2011. "What is the PCMH? AHRQ's Definition of the Medical Home." (http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/what_is_pcmh_.)

of December 2010 as a practice self-improvement tool, URAC began offering auditor certification using their PCMH standards in March of 2011, and announced a practice recognition program in June of 2011, which results in practices either being recognized for "Achievement" or "Achievement with electronic health records" (meaning their certified EHR also meets standards that URAC believes are consistent with HITECH's "meaningful use" requirements). In terms of content, URAC's tool had the second highest percentage of items devoted to "Presence of Policies" (after AAAHC). It also put special emphasis on adoption of health IT (16% of items) and coordination of care (14%). Pricing information for URAC's PCMH programs is not publicly available.

**TransforMED's Medical Home IQ.** Although originally developed to be a practice self-improvement tool (as well as an NCQA prep tool[29]), at least three multi-payer pilots are using TransforMED's Medical Home IQ tool as a recognition tool (in Colorado, Greater Cincinnati, and Maine).[30] Despite the relationship to NCQA's tool, the Medical Home IQ has several differences in its content emphases: it has a greater emphasis than the NCQA tools on asking whether certain policies are in place, and it is also notable for its emphasis on business practices – an area on which no other tool includes items – such as questions about whether the practice has a business plan, whether practice leadership reviews income and expenses statements on a monthly basis, whether contracts with payers are reviewed on an annual basis, etc. At 139 questions and an estimated time to complete of 2 ¼ hours, the Medical Home IQ is relatively long for a PCMH self-assessment tool (as compared to tools like the Medical Home Index, which takes a mere 20 minutes to complete). However, a nice feature of this tool is that it is available online for free for practice self-improvement, and automatically tabulates scores and presents hyperlinks to educational resources to help practices improve capabilities identified as lacking.

**Center for Medical Home Improvement's Medical Home Index.** The Medical Home Index is unique for its deliberate inclusion of many "low-bar" practice capabilities (which we termed "Standard Care" items), designed to give low-performing practices some credit in order to avoid discouraging them from continuing on in their journey to becoming a medical home. As mentioned above, it is also one of the least burdensome tools administratively, due to its lack of documentation requirements or site visit components and its limited number of survey items. Like the Medical Home IQ tool, the Medical Home Index was designed to be a practice self-improvement tool, but has since be re-appropriated for purposes of PCMH recognition – the Medical Home Index is currently being used in a state-wide PCMH effort in Colorado's Medicaid program. One limitation of the Medical Home Index tool is that, of the 10 tools assessed, it is the least-suited to performing double-duty as a data collection instrument for research or evaluation purposes. This is because its questions are two-part, and the answer options presented ("Partial" or "Complete") do not allow a respondent to indicate which of the two components it has in place. The Medical Home Index also included some items that may appear to be above-and-beyond the call of duty for the typical medical home (e.g., "Patients with

[29] There are frequent references and links to NCQA's PPC-PCMH tool throughout the Medical Home IQ website and the tool itself. Upon completion of the survey, a report is generated showing what responses to the Medical Home IQ would be needed to be recognized as a medical home by NCQA.
[30] Bitton et al, 2010.

chronic conditions are integrated into office staff orientations and educational opportunities as teachers or 'patient faculty'").

**BlueCross BlueShield of Michigan's PCMH Designation Program.** This tool seems most suited to serving double-duty as a practice self-improvement tool. This is because the tool does not merely ask a question like "Do you have a patient registry?", but instead presents a whole suite of questions about registries, outlining in a more granular level of detail than the other tools the specific activities that practices should be doing with their registries. This tool also includes more specific (and frequently, ambitious) performance expectations in their standards – for example, the tool doesn't just ask if same-day scheduling is available, instead it specifies that 30% of appointments should be reserved for same-day appointments; it doesn't just ask whether patients can speak with a clinician after-hours, instead it specifies that after-hours calls from patients should be returned within 15-30 minutes, and within 60 minutes at maximum. In terms of content, this tool opted not to spread its items across a variety of content domains (as other tools, such as the Joint Commission's, did) and instead targeted a few areas more deeply: population management (18%), care coordination (16%), and patient engagement and self-management (13%), health IT (12%), and quality measurement (11%).

**Minnesota's Health Care Home Certification Program.** Minnesota's Health Care Home certification assessment tool was the only tool to require documentation, short written answers, *and* a mandatory site visit for all applicants. Although this level of evidence may sound administratively burdensome, the written responses practices are asked to submit are no more than one paragraph each (in the sample filled-out survey posted on Minnesota's website), and the state certifiers tell us that "See document" is a sufficient response when one of the ten accompanying documents demonstrates that a practice meets at particular standard. Also, Minnesota's tool states on its front page that it specifically tried to create a tool where new policies would not need to be written to obtain recognition; instead, on-site evaluators are used to observe practice processes and observe how clinicians use their electronic registries, rather than requiring practices to upload computer screenshots. In terms of content, the clear focus of Minnesota's tool is on quality improvement activities (18% of its items) and using individualized care plans to guide patients' care (12%). Minnesota's tool included relatively few items related to health IT since a state law already requires all providers to use e-prescribing (starting in 2011), and all providers are required to have an interoperable EHR by 2015. Once certified as a health care home, practices are required to re-certify annually by meeting the standards in the state's certification survey and attaining quality measure targets, which can change annually.

**Oklahoma's SoonerCare (Medicaid) PCMH Program.** Oklahoma's tool was unique in its predominant use of essay questions and its light administrative burden on practices (at only 27 items and no documentation requirements). Oklahoma's PCMH initiative is also interesting because it is implementing medical homes state-wide among Medicaid providers while maintaining budget neutrality.[31] In terms of content, Oklahoma placed the greatest emphasis on care coordination (26%) of any of the tools, and placed much more emphasis on access to care and comprehensiveness of care (15% each) than the other tools.

[31] Oklahoma's new SoonerCare payment approach was approved by CMS as a modification to the state's 1115 Medicaid waiver.

## Discussion

When selecting a PCMH recognition tool, payers like CMS will need to consider factors such as:

- **Which practice capabilities to emphasize, and what operational approach to use to administer recognition programs.**

    - ***Content Emphases:*** Each PCMH recognition tool measures a different constellation of practice capabilities. Based on our assessment of these tools, coordination of care and use of health IT appeared to have the greatest emphasis, followed by quality measurement and patient engagement and self-management. By contrast, continuity of care had a relative low level of emphasis among the tools, as did items about whether practices refer patients to community resources such as social services.

    - ***Operational Details:*** Administrative burden of the 10 tools we assessed varies tremendously. For practices, some tools take weeks (or perhaps even months) to complete and cost thousands of dollars, and others take a matter of hours (or minutes) to complete and are free. Tools also present different administrative burdens for payers, with some allowing payers to essentially outsource the specification, processing, and verification of practices' PCMH recognition applications, and other tools representing instances in which payers have dedicated staff to define, administer, and verify whether practices meet their PCMH criteria.

    - ***Making a Decision:*** Since evidence does not yet exist on which particular combination of practice capabilities produces the best outcomes for patients, payers will likely have to decide: 1) how much stock to put in PCMH recognition tools at all, and 2) whether an "off the shelf" tool offered by an external organization measures the aspects of a medical home that a payer is most interested in emphasizing (with a price and administrative burden level that they are comfortable imposing on practices) or whether they need to develop their own recognition criteria.

- **How stringent to be with PCMH recognition criteria, and what role quality measurement should play.** Requiring practices to have a long list of structures and processes in place (what we call the "High Bar" approach, in our earlier Table 1) may cause practices to focus too heavily on passing someone's test – potentially leading to stifling of innovation and distraction from the ultimate goal of improving patient care. The alternative approach (what we call the "Low Bar" approach, since entry criteria are minimal and payment is instead tied to long-run performance) focuses more on outcomes, through metrics like clinical quality-of-care measures, emergency department utilization, and patients' experience of care and functional outcomes.[32] But this approach presents its

[32] CareOregon's PCMH initiative, not reviewed here, is an example of a program that focuses on quality measures, requires the collection of patient survey data, and uses a more limited set of practice capabilities.

own problems, due to the lack of good quality measures in all areas one might be interested in measuring. And even if using such as "low bar" approach, the selection of PCMH recognition criteria will still have an important impact on outcomes; payers don't want to use a tool that wastes resources measuring practice capabilities that do not ultimately improve quality and lower cost – even if feasible to administer.

- **How a PCMH initiative should align with or support other health care reform initiatives.** In particular, primary care physicians will soon be facing requirements both to qualify for incentive payments for being "meaningful users" of electronic health records and to participate in ACOs. If consideration is not given to how these programs should interact, practices could end up facing conflicting requirements and may become overwhelmed. One possible alignment approach could be to simply require that PCMH practices be "meaningful users" of health IT as a pre-requisite, and then focus questions in PCMH recognition criteria on non-health IT-related areas. But on the other hand, there may be value to combining and streamlining reporting requirements, such as by creating a super-tool that measures "meaningful use," "medical homeness," and meets ACO requirements. Clearly, burden on practices would have to be factored into such decisions.

- **Whether to implicitly endorse a tool at this early stage or see what market competition produces in the next few years.** None of the PCMH recognition tools we identified have been rigorously assessed for reliability and validity, and we do not have evidence on whether adoption of practice capabilities included in specific PCMH recognition tools is associated with improved patient outcomes. Payers are likely to learn a lot in the next few years, as demonstration results become available; as noted previously, there are literally dozens of PCMH pilots currently underway. The results of these initiatives can inform future refinements of PCMH recognition instruments and may lead to a streamlining of criteria to only those capabilities that have been demonstrated to positively affect patient outcomes. The experts we interviewed anticipate some narrowing of the field over time to perhaps to 3 or 4 major competitors with strong ties to health care organizations and infrastructure to administer recognition programs. We believe narrowing should not happen prematurely, since it could stifle innovation and lead to the standardized usage of a tool that is not based on a sufficient level of evidence (or an instrument that is ill-suited to certain populations). Many interviewees did not favor a major payer like CMS choosing a single PCMH recognition tool at this time.

- **What accompanying approaches to use to facilitate practice transformation to a medical home.** We believe other approaches to quality improvement (e.g., supporting practices through technical assistance or learning collaboratives, developing tools designed for other purposes, or developing new quality measures) may be needed to help practices learn how to make the changes necessary to become a medical home. These complementary activities could encourage practice transformation in areas that may not be measurable using a PCMH recognition tool, such as practice culture or more advanced aspects of team-based care.

# Appendix

## List of PCMH Experts Interviewed

*(Phone interviews conducted October-November 2010)*

1. Ann O'Malley (Center for Studying Health System Change)
2. Ann Torregrossa (Pennsylvania Governor's Office of Health Care Reform)
3. Ross Owen (Minnesota Department of Human Services)
4. Bruce Landon (Harvard Medical School, Department of Health Care Policy)
5. Margaret Kirkegaard (Illinois Health Connect)
6. Michael Barr (American College of Physicians)
7. Robert Graham (University of Cincinnati School of Medicine, Department of Family Medicine)
8. Bruce Bagley (American Academy of Family Physicians)
9. Gina Robinson (Colorado Department of Healthcare Policy and Financing)
10. Jeanene Smith (Office for Oregon Health Policy Research)
11. Deborah Kilstein (Association for Community Affiliated Plans)
12. Craig Thiele (CareSource Ohio)
13. Melody Anthony (Oklahoma Health Care Authority)
14. Margaret Mason (BlueCross BlueShield of Michigan)
15. Michael Bailit (a private consultant on 10 PCMH demonstrations)
16. Kurt Stange (Case Western Reserve University)
17. Deborah Piekes (Mathematica Policy Research, Inc.)
18. Stephan Fihn (U.S. Department of Veterans Affairs, PCMH initiative)

**Table 3. Content Emphases of 10 PCMH Recognition Tools (by Number of Items)**

| Standards Developer | NCQA | | AAAHC | Joint Commission | URAC | TransforMED | Center for Medical Home Improvement | BlueCross BlueShield of Michigan | Minnesota | Oklahoma SoonerCare (Medicaid) | MEDIAN *(rows sorted by Median)* | AVERAGE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Name of Standards** | **PPC-PCMH 2008** | **PCMH 2011** | **Medical Home** | **Primary Care Medical Home** | **Patient Centered Health Care Home** | **Medical Home IQ** | **Medical Home Index** | **Patient-Centered Medical Home** | **Health Care Homes** | **Patient Centered Medical Home** | | |
| **CONTENT DOMAINS** | | | | | | | | | | | | |
| **Coordination of Care** | 12% | 11% | 9% | 4% | 14% | 7% | 8% | 16% | 6% | 26% | 10% | 11% |
| **Health IT** | 46% | 40% | 2% | 4% | 16% | 14% | 4% | 12% | 6% | 7% | 10% | 15% |
| **Quality Measurement** | 7% | 9% | 11% | 8% | 8% | 8% | 2% | 11% | 7% | 0% | 8% | 7% |
| **Patient Engagement & Self-Mgmt.** | 5% | 4% | 6% | 10% | 8% | 4% | 5% | 13% | 6% | 7% | 6% | 7% |
| **Presence of Policies** | 2% | 5% | 23% | 12% | 17% | 13% | 4% | 5% | 1% | 0% | 5% | 8% |
| **Population Management** | 2% | 5% | 0.4% | 4% | 9% | 2% | 4% | 18% | 1% | 4% | 4% | 5% |
| **Access to Care** | 6% | 3% | 1% | 4% | 0% | 5% | 3% | 7% | 6% | 15% | 4% | 5% |
| **Quality Improvement** | 1% | 5% | 8% | 8% | 2% | 2% | 13% | 0% | 18% | 4% | 4% | 6% |
| **Care Plan** | 4% | 6% | 0.4% | 6% | 3% | 1% | 2% | 3% | 12% | 4% | 4% | 4% |
| **Evidence-Based Care** | 5% | 2% | 5% | 2% | 6% | 4% | 0% | 5% | 4% | 4% | 4% | 4% |
| **Culturally Competent Communication** | 4% | 3% | 4% | 10% | 1% | 6% | 8% | 1% | 3% | 0% | 3% | 4% |
| **Medical Records** | 3% | 1% | 10% | 8% | 3% | 2% | 2% | 2% | 13% | 7% | 3% | 5% |
| **Comprehensiveness of Care** | 0% | 1% | 8% | 6% | 2% | 2% | 0% | 0% | 1% | 15% | 2% | 4% |
| **Team-Based Care** | 1% | 2% | 0.4% | 4% | 1% | 7% | 2% | 2% | 6% | 4% | 2% | 3% |
| **Adheres to Current Law** | 0% | 0% | 4% | 4% | 2% | 3% | 1% | 0% | 3% | 0% | 2% | 2% |
| **Community Resources** | 1% | 2% | 0.4% | 0% | 5% | 0% | 13% | 5% | 1% | 0% | 1% | 3% |
| **Continuity of Care** | 1% | 1% | 5% | 4% | 0% | 0% | 1% | 1% | 3% | 0% | 1% | 2% |
| **Standard Care (Non-PCMH)** | 0% | 0% | 3% | 6% | 0% | 0% | 28% | 0% | 0% | 4% | 0% | 4% |
| **Business Practices** | 0% | 0% | 0% | 0% | 0% | 19% | 0% | 0% | 0% | 0% | 0% | 2% |
| **Compact between Practice & Patient** | | Yes | * | * | Yes | Yes | | Yes | Yes | Yes | Yes | Yes |
| **Total # of Standards** | **170** | **149** | **238** | **52 (+base)** | **86** | **139** | **100** | **128** | **67** | **27** | 114 | 116 |

* = No compact/agreement between practice and patient, but practices required to tell patients about their PCMH services.

**Table 4. Content Emphases of 5 "Off the Shelf" PCMH Recognition Tools (by Scoring Emphasis)**

| Standards Developer | NCQA | | AAAHC | Joint Commission | URAC | MEDIAN *(rows sorted by Median)* | AVERAGE |
|---|---|---|---|---|---|---|---|
| **Name of Standards** | **PPC-PCMH 2008** | **PCMH 2011** | **Medical Home** | **Primary Care Medical Home** | **Patient Centered Health Care Home** | | |
| **CONTENT DOMAINS** | | | | | | | |
| **Health IT** | 30% | 29% | 2% | 4% | 16% | 16% | 16% |
| **Presence of Policies** | 1% | 5% | 23% | 12% | 17% | 12% | 12% |
| **Coordination of Care** | 17% | 12% | 9% | 4% | 14% | 12% | 11% |
| **Quality Measurement** | 11% | 12% | 11% | 8% | 8% | 11% | 10% |
| **Patient Engagement & Self-Mgmt.** | 5% | 6% | 6% | 10% | 8% | 6% | 7% |
| **Quality Improvement** | 3% | 6% | 8% | 8% | 2% | 6% | 5% |
| **Evidence-Based Care** | 7% | 4% | 5% | 2% | 6% | 5% | 5% |
| **Population Management** | 4% | 9% | 0.4% | 4% | 9% | 4% | 5% |
| **Culturally Competent Communication** | 4% | 3% | 4% | 10% | 1% | 4% | 4% |
| **Care Plan** | 4% | 4% | 0.4% | 6% | 3% | 4% | 3% |
| **Medical Records** | 4% | 2% | 10% | 8% | 3% | 4% | 5% |
| **Access to Care** | 6% | 3% | 1% | 4% | 0% | 3% | 3% |
| **Comprehensiveness of Care** | 0% | 1% | 8% | 6% | 2% | 2% | 3% |
| **Team-Based Care** | 2% | 2% | 0.4% | 4% | 1% | 2% | 2% |
| **Adheres to Current Law** | 0% | 0% | 4% | 4% | 2% | 2% | 2% |
| **Continuity of Care** | 1% | 1% | 5% | 4% | 0% | 1% | 2% |
| **Community Resources** | 0.3% | 2% | 0.4% | 0% | 5% | 0% | 2% |
| **Standard Care (Non-PCMH)** | 0% | 0% | 4% | 6% | 0% | 0% | 2% |
| **Business Practices** | 0% | 0% | 0% | 0% | 0% | 0% | 0% |
| **Compact between Practice & Patient** | | Yes | * | * | Yes | | |

Note: Percentages in this table are identical to those in Table 3, except for the two NCQA tools.

* = No compact/agreement between practice and patient, but practices required to tell patients about their PCMH services.

## Table 5. Operational Details of 10 PCMH Recognition Tools

| Tool Developer | National Committee for Quality Assurance (NCQA) | | Accreditation Association for Ambulatory Health Care (AAAHC) | Joint Commission | URAC |
|---|---|---|---|---|---|
| **Name of Tool** | **PPC-PCMH 2008** (Physician Practice Connections - Patient-Centered Medical Home) | **PCMH 2011** | **Medical Home** | **Primary Care Medical Home** | **Patient Centered Health Care Home (PCHCH)** |
| **OPERATIONAL DETAILS** | | | | | |
| **Website** | http://www.ncqa.org/tabid/629/Default.aspx | http://www.ncqa.org/tabid/631/Default.aspx | http://www.aaahc.org/eweb/dynamicpage.aspx?webcode=mha | http://www.jointcommission.org/accreditation/pchi.aspx | http://www.urac.org/healthcare/prog_accred_pchch_toolkit.aspx |
| **Organizational Type of Tool Developer** | A non-profit organization that is primarly known for accrediting health insurance plans. | | A non-profit organization that accredits ambulatory health care organizations (e.g., ambulatory and surgery centers, managed care organizations, Indian health facilities, student health centers). | A non-profit organization, formerly known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), that accredits a wide variety of health care organizations (e.g., hospitals, ambulatory care facilities, behavioral health care organizations, home care providers, laboratories, long term care facilities). | A non-profit organization that accredits an even wider variety of organizations (e.g., health plans, HMOs, PPOs, provider groups, hospitals, PBM organizations, health education companies, HIT firms), and also accredits functional areas within an organization (e.g., case management, claims processing, credentialing). |
| **Release Date** | 2008 | 2011 (January) | 2009 | 2011 (May) | 2010 (December) |
| **Other Versions** | PCMH Standards (2011 successor) | PPC-PCMH Standards (2008 predecessor) | | | |
| **Clinician Types that Can Lead Practice** | Physicians | Primary Care Physicians; Nurse Practitioners and Physician Assistants. (Note: NPs can apply if allowed under state law.) | Physicians | Doctors of Medicine; Doctors of Osteopathy; Advanced Practice Nurses; Physician Assistants. | Not specified. |
| **Who Provides Responses?** | Practice | | External Surveyor | External Surveyor | External Surveyor |
| **Method of Providing Responses** *(e.g., by filling out a survey online, by answering questions during a site visit, etc.)* | Practice completes an online tool and uploads documentation for NCQA to verify. | | Site visit. | Site visit. | Site visit. |
| **Answer Format** *(After stating a practice capability, answer options are presented in the following format)* | Yes / No / NA; __% of patients for whom something is done. | | Substantial Compliance / Partial Compliance / Non-Compliance / Not Applicable; Yes / No with short essay answers. | No answer options. | Yes / No |
| **Documentation Required?** | Yes | | Yes | Yes (for base ACA accreditation) | TBD |
| **Total Number of Items** | 170 | 149 | 238 (+ optional base accreditation) | 52 (+ base accreditation) | 86 |
| **Time to Complete Tool** *(e.g., number of minutes or hours that the tool developer estimates it takes to fill out the actual survey)* | 40-80 hours | | Unknown. | 2-3 day site visit. | Unknown. |
| **Administrative Burden** | Heavy | Heavy | Moderate | Moderate | Moderate |

## Table 5. Operational Details of 10 PCMH Recognition Tools

| Tool Developer | TransforMED (Subsidiary of American Academy of Family Physicians) | Center for Medical Home Improvement | BlueCross BlueShield of Michigan | Minnesota Department of Health and Department of Human Services | Oklahoma SoonerCare (Medicaid) |
|---|---|---|---|---|---|
| **Name of Tool** | **Medical Home Implementation Quotient (IQ)** Version 2.0 | **Medical Home Index** Adult (Long) | **Patient-Centered Medical Home** | **Health Care Homes (HCH)** Certification Assessment Tool | **Patient Centered Medical Home** Tier 3 Self-Evaluation Form |
| **OPERATIONAL DETAILS** | | | | | |
| **Website** | http://www.transformed.com/mhiq/welcome.cfm | http://www.medicalhomeimprovement.org/knowledge/practices.html | http://www.valuepartnerships.com/pcmh/index.shtml | http://www.health.state.mn.us/healthreform/homes/certification/index.html | http://www.okhca.org/medical-home |
| **Organizational Type of Tool Developer** | A non-profit subsidiary of AAFP that offers PCMH consulting services (e.g., medical home facilitation, retreats, and tailored training). | A non-profit organization that promotes the PCMH model, including by offering PCMH consulting services. (Affiliated with the Crotched Mountain Foundation and Rehabilitation Center, which is a charitable organization that provides direct care to people with disabilities in New Hampshire and New England.) | A non-profit commercial health insurance plan. | State government agencies. | State government agency. |
| **Release Date** | 2009 | 2008 | 2009 | 2010 | 2009 |
| **Other Versions** | Medical Home IQ (2008) | Adult (short; long); Pediatric (short; long); Medical Home Family Index (family experience survey). | | | Tier 1 and Tier 2 Self-Evaluation Forms. (Tier 3 form includes these forms' questions plus others.) |
| **Clinician Types that Can Lead Practice** | Physician | Not specified. | Primary Care Physicians (specialists not currently eligible). | Physician (including specialists who provide comprehensive primary care); Nurse Practitioner; Physician Assistant. | Physician; Advanced Practice Nurse; Physician Assistant. |
| **Who Provides Responses?** | Practice | Practice | Practice (through their Physician Organization) | Practice | Practice |
| **Method of Providing Responses** *(e.g., by filling out a survey online, by answering questions during a site visit, etc.)* | Web-based form. | Paper-based questionnaire. | Physician Organizations complete a table listing the date each of their practices implemented each practice capability to BlueCross BlueShield of Michigan (BCBSM). Physician Organizations are responsible for collecting this information from their practices. BCBSM then conducts site visits and "phone visits" for a sample of practices in each Physician Organization. | Web-based form with requirements to upload documentation, plus a site visit. | Paper-based questionnaire(s) submitted to Oklahoma Health Care Authority (there are three questionnaires, which correspond to the three tiers of medical home recognition available). Then, randomly-scheduled site visits ("contract compliance audits") are performed in the practice every 3 years. |
| **Answer Format** *(After stating a practice capability, answer options are presented in the following format)* | Yes / No; some multiple-choice. | Partial / Complete / (Leave Blank) | (Date practice capability implemented) / Not In Place. | Yes / No; practices also provide short written responses (up to 1,000 characters per response) explaining how they meet the standard | Yes / No; essay answers (1 paragraph per item). |
| **Documentation Required?** | | | | Yes | |
| **Total Number of Items** | 139 | 100 | 128 | 67 | 27 |
| **Time to Complete Tool** *(e.g., number of minutes or hours that the tool developer estimates it takes to fill out the actual survey)* | 2.25 hours | 20 minutes (or ~1 hour, if completed as a group) | Up to a few days per practice, and up to 1-2 weeks per Physician Organization. | Unknown. (Length of site visits varies, based on size of clinic -- e.g., a clinic with 10 providers and 25,000 patients would require a full-day, 8-hour site visit.) | 30-60 minutes (plus random contract compliance site visit every 3 years) |
| **Administrative Burden** | Light | Light | Moderate | Moderate | Light |

## Table 5. Operational Details of 10 PCMH Recognition Tools

| **Tool Developer** | **National Committee for Quality Assurance (NCQA)** | | **Accreditation Association for Ambulatory Health Care (AAAHC)** | **Joint Commission** | **URAC** |
|---|---|---|---|---|---|
| **Name of Tool** | **PPC-PCMH 2008** (Physician Practice Connections - Patient-Centered Medical Home) | **PCMH 2011** | **Medical Home** | **Primary Care Medical Home** | **Patient Centered Health Care Home (PCHCH)** |
| **OPERATIONAL DETAILS** | | | | | |
| **Responses Verified?** *(e.g., is documentation collected and reviewed by someone? are site visits conducted?)* | Yes. NCQA reviews submitted documentation, and conducts on-site audits for 5% of practices (chosen randomly or based on specific criteria).<br><br>NCQA may also conduct a discretionary surveys of *recognized* practices, which can consist of an off-site document review, on-site review, or a tele-conference. | Yes. NCQA reviews submitted documentation, and conducts audits of 5% of applicants (chosen either randomly or based on specific criteria); audits may be completed by on-site review, teleconference, webinar, email, or other electronic means.<br><br>NCQA also conducts discretionary surveys of *recognized* practices, which may consist of an off-site document review, an on-site review, or a teleconference. Practices have 60 days notice before the survey occurs. | Yes. AAAHC conducts on-site surveys for all applicants.<br><br>Also conducts random and discretionary on-site surveys of accredited organizations, which are unannounced, can last up to a full day, and can result in reducing or revoking an organization's Medical Home accreditation term. | Yes. Joint Commission conducts on-site evaluations for all applicants.<br><br>For health care organizations that became accredited after initially having to submit information on corrective actions taken to meet the standards, Joint Commission also conducts random unannounced on-site validation surveys of 5% of these organizations to verify the accuracy of the evidence submitted. | Yes. Auditors conduct on-site reviews.<br><br>Also mid-cycle, on-site reviews of randomly-selected practices, with 3-5 days notice. |
| **Scoring Instructions** | Three tiers of medical home recognition possible. Level 1 = 25-49 points (out of 100), including 5 of the 10 "must pass" sections; Level 2 = 50-74 points, including 10 "must pass" sections; Level 3 = 75-100 points, including 10 "must pass" sections. The number of survey items does not correspond to the number of points in the tool. | Three tiers of medical home recognition possible. Level 1 = 35-59 points; Level 2 = 60-84 points; Level 3 = 85-100 points. All three levels require meeting ≥50% of the criteria for each of 6 "must pass" sections. Starting in 2012, practices may receive additional "distinction" by voluntarily reporting patient experience data using the PCMH version of AHRQ's CG-CAHPS patient/family experience survey, but results will not be publicly reported or used to score practices, at least for the time being. | No cut-off score, but the length of the accreditation term (which can last 1, 2, or 3 years) is determined by the degree to which the organization meets the standards. | Practices must be in compliance with 100% of applicable elements. | Scoring is still being finalized, but the latest thinking is that practices will have to meet 35% of the standards (7 specific mandatory standards plus an additional 23 standards of the practice's choosing, from among the 86 standards in total). Practices that meet 100% of the standards would be recognized for "exemplary achievement."<br><br>Sponsors of PCMH initiatives that are using URAC's standards can choose which standards and score to require, but practices must meet the standards/score outlined above to be recognized as a URAC PCHCH. |
| **Tested for Validity & Reliability?** | | | | | |

## Table 5. Operational Details of 10 PCMH Recognition Tools

| **Tool Developer** | **TransforMED (Subsidiary of American Academy of Family Physicians)** | **Center for Medical Home Improvement** | **BlueCross BlueShield of Michigan** | **Minnesota Department of Health and Department of Human Services** | **Oklahoma SoonerCare (Medicaid)** |
|---|---|---|---|---|---|
| **Name of Tool** | **Medical Home Implementation Quotient (IQ)** Version 2.0 | **Medical Home Index** Adult (Long) | **Patient-Centered Medical Home** | **Health Care Homes (HCH)** Certification Assessment Tool | **Patient Centered Medical Home** Tier 3 Self-Evaluation Form |
| **OPERATIONAL DETAILS** | | | | | |
| **Responses Verified?** *(e.g., is documentation collected and reviewed by someone? are site visits conducted?)* | No. | No. | Yes. BCBSM conducts site visits and "phone visits" for a sample of practices in each Physician Organization. | Yes. Application responses and accompanying documentation is reviewed, and site visits are conducted to verify that all standards are being met. (Note: With large clinic systems with multiple sites, site visits are only conducted to a sample of clinics.) | Yes. Completed surveys (including essay answers) are reviewed by the Oklahoma Health Care Authority. One year of educational support is offered before the practice is audited. Medical homes are monitored through random contract compliance audits performed in the practice every 3 years. |
| **Scoring Instructions** | The tool (and each of its 9 modules) are automatically scored upon completion online as: "Level I: Need significant improvement," "Level II: Needs improvement," "Level III: Good progress, continue improvement," or "Level IV: Excellent progress, continue improvement." Items are worth varying numbers of points. | Groups of 4 items are considered "themes," and scored out of 8 points, where "Partial" mastery of the most basic item = 1 point, and "Complete" mastery of the most advanced of the 4 items = 8 points.<br><br><u>3 Scoring Approaches</u>:<br>1) Average scores on each theme within a domain to generate an average score for each of the 6 domains.<br>2) Average scores on all questions for an overall average score.<br>3) Sum all points for a total score. | Scores are based on the number of PCMH capabilities in place (50%) and quality and use data (50%, with different weights assigned to the measures depending on if the practice primarily serves families, adults, or pediatric patients). BCBSM ranks all PCMH practices, then determines a qualifying score (based on funding availability), and pays practices with scores above that level enhanced reimbursement rates for Evaluation & Management services. | 54 of the 67 items must be met to obtain initial certification. However, practices can apply for a "variance" if they have not met one/some of these standards, if the practice: generally meets the requirements; has a plan and timeline to meet the standard; would face a hardship it forced to meet the standard; is not meeting the standard because it is using some other innovative, experimental approach to meet the intent of the standard. Practices must submit a corrective action plan with timelines, and usually must submit quarterly progress updates. At 1-year re-certification, an additional 11 items must be met, and at 2-year re-certification, all 67 survey items must be met; but again, variances can be granted. | Practices must be in compliance with 100% of required elements. |
| **Tested for Validity & Reliability?** | | Yes (Pediatric version) | | | |

## Table 5. Operational Details of 10 PCMH Recognition Tools

| **Tool Developer** | **National Committee for Quality Assurance (NCQA)** | | **Accreditation Association for Ambulatory Health Care (AAAHC)** | **Joint Commission** | **URAC** |
|---|---|---|---|---|---|
| **Name of Tool** | **PPC-PCMH 2008** (Physician Practice Connections - Patient-Centered Medical Home) | **PCMH 2011** | **Medical Home** | **Primary Care Medical Home** | **Patient Centered Health Care Home (PCHCH)** |
| **OPERATIONAL DETAILS** | | | | | |
| **Used By** *(i.e., types of entities that are using the tool for recognition purposes)* | 1,500+ sites have been recognized by NCQA as a PCMH as of 12/31/10, including solo and large groups, community health centers, military health facilities, residency clinics. A recent survey of PCMH demonstrations nationwide reported that 21 demonstrations were requiring the use of NCQA's PPC-PCMH either as a target level for practice transformation (the more common approach) or as a requirement for entry (in 5 demos) (http://www.mc.uky.edu/equip-4-pcps/documents/PCMH%20Literature/PCMH_demo_results.pdf). Also, Bridges to Excellence considers PPC-PCMH recognition to satisfy their requirements to qualify for Physician Office Link rewards. | None. (New standards just released 1/31/11.) | Community Health Centers and a few specialty practices. AAAHC is one of two organizations that HRSA has contracted with to provide accreditation services to health centers. (More info at http://bphc.hrsa.gov/policiesregulations/accreditation.html.) | 10 organizations have applied for PCMH designation so far in 2011. Also, the Joint Commission's PCMH designation program is recognized by Medicaid agencies and state payers in 3 states. The Joint Commission is also one of two organizations that HRSA has contracted with to provide accreditation services to health centers. (More info at http://bphc.hrsa.gov/policiesregulations/accreditation.html.) | URAC is mentioned as an eligible PCMH program by the Maryland Health Care Commission in its Single Carrier PCMH demo. |
| **Endorsed By** *(i.e., organizations external to the tool developer that have endorsed the tool)* | Endorsed for use in demos by: ACP, AAFP, AAP, and AOA, NQF, and the Patient Centered Primary Care Collaborative (PCPCC, a PCMH advocacy group). | | | | |
| **Cost** *(e.g., to purchase tool and/or to apply for recognition using the tool)* | $0 to obtain a copy of the standards. Cost to apply for 3-year recognition is $80 for a Survey Tool License, plus an application fee of $500 multiplied by the number of physicians in the practice. Discounts of 20% off are available for practices with multiple sites and practices that are part of a larger demo. To move from one level of PCMH recognition to a higher one, an "add-on survey" is $250 multiplied by the number of physicians in the practice. | | Custom pricing, depending on the size, type and range of services provided by the organization. | Ranges from $9,140 for three-year recognition for a single small practice to $27,080 for larger practices with multiple sites. (See: http://www.jointcommission.org/assets/1/18/AHC_Med-Dental_pricing_11.pdf.) | $59 for a copy of the *Patient Centered Health Care Home Program Toolkit, Version 1.0* standards.<br><br>Cost of URAC's PCHCH Practice Achievement Program is TBD. |

## Table 5. Operational Details of 10 PCMH Recognition Tools

| **Tool Developer** | **TransforMED (Subsidiary of American Academy of Family Physicians)** | **Center for Medical Home Improvement** | **BlueCross BlueShield of Michigan** | **Minnesota Department of Health and Department of Human Services** | **Oklahoma SoonerCare (Medicaid)** |
|---|---|---|---|---|---|
| **Name of Tool** | **Medical Home Implementation Quotient (IQ)** Version 2.0 | **Medical Home Index** Adult (Long) | **Patient-Centered Medical Home** | **Health Care Homes (HCH)** Certification Assessment Tool | **Patient Centered Medical Home** Tier 3 Self-Evaluation Form |
| **OPERATIONAL DETAILS** | | | | | |
| **Used By** *(i.e., types of entities that are using the tool for recognition purposes)* | A recent survey of PCMH demonstrations nationwide found that 3 multi-payer demos (in Colorado, Greater Cincinnati, and Maine) were requiring the use of the Medical Home IQ for entry into these demonstrations (http://www.mc.uky.edu/equip-4-pcps/documents/PCMH%20Literature/PCMH_demo_results.pdf). | Being used by Colorado's Medicaid program state-wide along with additional requirements (http://www.cchap.org/nl36/#8). | BCBSM claims its PCMH program is the largest in the nation, with 1,830 doctors designated in 500 practices across the state in 2010, and another 3,200 physicians currently working on improving their processes and implementing medical home capabilities in an effort to earn designation in coming years. These practices belong to Physician Organizations (e.g., IPAs, medical groups, etc. typically with 100+ doctors) participating in BCBSM's Physician Group Incentive Program (PGIP). (The PCMH Designation Program is a voluntary component of PGIP.) Also, the 17 health insurance plans participating in Michigan's Medicare Advanced Primary Care demonstration are accepting BCBSM's PCMH designation to identify medical home practices. | Providers participating in Minnesota's multi-payer "health care home" implementation, which is a state-wide certification process (not a temporary demonstration) established under state law. Providers are not required to become a health care home, but certification is required to qualify for care coordination payments per member per month. | SoonerCare Choice (Medicaid) providers in Oklahoma. |
| **Endorsed By** *(i.e., organizations external to the tool developer that have endorsed the tool)* | | | URAC awarded BCBSM a "Bronze URAC Award" for these standards in 2010, and adapted portions for their PCMH program; also, the Blue Cross and Blue Shield Association awarded BCBSM two awards for this PCMH program in 2010. | | |
| **Cost** *(e.g., to purchase tool and/or to apply for recognition using the tool)* | $0 | $0, but notification of use is requested (but not required). | Not applicable. | $0 | $0 |

## Table 5. Operational Details of 10 PCMH Recognition Tools

| **Tool Developer** | **National Committee for Quality Assurance (NCQA)** | | **Accreditation Association for Ambulatory Health Care (AAAHC)** | **Joint Commission** | **URAC** |
|---|---|---|---|---|---|
| **Name of Tool** | **PPC-PCMH 2008** (Physician Practice Connections - Patient-Centered Medical Home) | **PCMH 2011** | **Medical Home** | **Primary Care Medical Home** | **Patient Centered Health Care Home (PCHCH)** |
| **OPERATIONAL DETAILS** | | | | | |
| **How to Obtain Tool** | Download *2008 PPC-PCMH Standards and Guidelines* online at http://www.ncqa.org/tabid/629/Default.aspx. | Download *2011 PCMH Standards and Guidelines* online at http://www.ncqa.org/view-pcmh2011. | Request an electronic copy of AAAHC's standards by emailing info@aaahc.org. If interested in the less-burdensome "certification" option, email rsmothers@aaahc.org. | Download the finalized Primary Care Medical Home standards at http://www.jointcommission.org/primary_care_medical_home_prepublication_standards. | The *Patient Centered Health Care Home Program Toolkit, Version 1.0,* is available for purchase online at http://www.urac.org/forms/store/ProductFormPublic/search?action=1&Product_productNumber=PCHCH03. In addition to this PCHCH toolkit, URAC also directs health care organizations to two optional separate reports containing: 1) quality measures, and 2) the PCMH version of the CG-CAHPS patient/family experience survey, released by AHRQ in October 2011. |
| **How to Obtain Accreditation** *(if offered)* | Practice submits initial application forms by mail or online. Practice self-assesses itself using NCQA's web-based PPC-PCMH survey tool, including uploading documentation. When ready, practice submits this online survey tool to NCQA with application fee. NCQA evaluates data and documentation submitted. NCQA also conducts on-site audits for 5% sample of applicants, chosen randomly or based on specific criteria. NCQA notifies practice of recognition decision. Recognition lasts for 3 years. NCQA may also conduct a discretionary survey of a *recognized* practice, which could consist of an off-site document review, on-site review, or a tele-conference.<br><br>Note: In 2011, practices have the option of using either the 2008 or 2011 version of NCQA's PCMH standards, but starting in 2012 practices seeking recognition from NCQA will have to use the 2011 standards. | Practice self-assesses itself using PCMH 2011 standards. Purchases access to online Survey Tool. Submits initial application (http://www.ncqa.org/Communications/Publications/index.htm). Fills out online PCMH Survey Tool and uploads documents and makes payment. NCQA reviews documentation and scores responses within 60 days. NCQA audits 5% of applicants, either randomly or based on specific criteria (by email, teleconference, webinar, on-site review, etc.). Recognition lasts 3 years. NCQA conducts discretionary surveys of *recognized* practices (by off-site document review, on-site review, teleconference), scheduled 60 days in advance. PPC-PCMH practices can apply for PCMH 2011 recognition with reduced documentation requirements if they have already achieved Level 2 or 3 and still have 2 years left in their recognition term. | Practices have two options: they can apply for "accreditation" as a medical home, which requires also obtaining base AAAHC accreditation, or "certification," which does not. The process for obtaining medical home accreditation/certification is: Practice reviews AAAHC's medical home standards. Submits the AAAHC Application for Survey at https://application.aaahc.org. Participates in pre-survey conference call with AAAHC, then on-site survey 30 days later. AAAHC decides on a Medical Home accreditation term (of either 0, 1, 2, or 3 years), then sends the applicant a detailed report with surveryor's findings and certificate of accomplishment. A 1-year term requires applicant to submit a Plan for Improvement within 6 months; a 2-year term requires a Plan within 1 year. AAAHC also conducts random and discretionary on-site surveys of accredited organizations, which are unannounced, can last a full day, and can result in reducing or revoking a Medical Home accreditation term. | Starting June 1, 2011: Practice reviews CAMAC standards for base accreditation. Requests Application for Accreditation at http://www.surveymonkey.com/s/CDN26YX. Participates in a site visit. (If organization has multiple sites, Joint Commission visits a sample.) After, practice receives report identifying standards not in compliance, then report with potential accreditation decision. If all standards met, organization is accredited; if not, organization submits "Evidence of Standards Compliance" within 45-60 days. Final decision is made within 10 days of receipt of acceptable evidence of standards compliance. 4 months later, practices that did not meet some standards must submit additional data to ensure compliance. 5% of these organizations are subject to random, unannounced, on-site surveys. All organizations submit annual self-assessments, and agree to unannounced re-surveys every 18-39 months. Organizations are accreditated for 3-year terms. | Practices can seek recognition through URAC's PCHCH Practice Achievement Program, launched in June. Practices are reviewed during site visits by a URAC PCHCH Certified Auditor or a URAC clinical reviewer. Practices that meet scoring requirements (described above) receive a URAC PCHCH Practice "Achievement" Certificate and are listed in URAC's Directory, or "Achievement with electronic health records" recognition (meaning their certified EHR also meets standards consistent wIth HITECH Meaningful Use).<br><br>URAC will also license the use of their standards to sponsors of PCMH initiatives, who can set their own scoring and audit requirements. However, practices will not be eligible for *URAC* recognition if they do not meet URAC's scoring requirements (described above). |

## Table 5. Operational Details of 10 PCMH Recognition Tools

| Tool Developer | TransforMED (Subsidiary of American Academy of Family Physicians) | Center for Medical Home Improvement | BlueCross BlueShield of Michigan | Minnesota Department of Health and Department of Human Services | Oklahoma SoonerCare (Medicaid) |
|---|---|---|---|---|---|
| **Name of Tool** | **Medical Home Implementation Quotient (IQ)** Version 2.0 | **Medical Home Index** Adult (Long) | **Patient-Centered Medical Home** | **Health Care Homes (HCH)** Certification Assessment Tool | **Patient Centered Medical Home** Tier 3 Self-Evaluation Form |
| **OPERATIONAL DETAILS** | | | | | |
| **How to Obtain Tool** | Interactive web-based tool available at http://www.transformed.com/MHIQ/welcome.cfm. | Download the *Medical Home Index - Adult* tool online at http://www.medicalhomeimprovement.org/pdf/CMHI-MHI-Adult-Primary-Care_Full-Version.pdf. | Not available online, but BlueCross BlueShield of Michigan may provide copies of their *PGIP PCMH Interpretive Guidelines* at their discretion in response to direct requests. | Download the *Health Care Homes Certification Assessment Tool* online at http://www.health.state.mn.us/healthreform/homes/certification/CertificationAssessmentTool_100423.doc | Download the *Medical Home Self-Evaluation Forms* for *Tier One, Two,* or *Three* online at: http://www.okhca.org/providers.aspx?id=8470&menu=74&parts=8482_10165. |
| **How to Obtain Accreditation** *(if offered)* | Not applicable. | Not applicable. | Voluntary program offered to Physician Organizations (POs) that contract with BlueCross BlueShield of Michigan. Physician Organizations complete a table twice a year listing the date each of their participating practices implemented each practice capability. (Physician Organizations are responsible for collecting this information from their practices.) A BCBSM team then conducts site visits in a sample of practices within each Physician Organization to educate individual practices and their Physician Organization about the BCBSM PCMH standards and to collect feedback on them. Top-scoring PCMH practices receive 10% higher reimbursement for Evaluation & Management services for one year, and must re-qualify for designation each year. | Providers fill out a letter of intent form online, complete the certification assessment tool online (including uploading documentation), and then participate in a site visit. (Application checklist is available online at: http://www.health.state.mn.us/healthreform/homes/certification/CertificationChecklist_February2010.pdf.) Within 90 days of the site visit, MN notifies applicants of determination. Unsuccessful applicants may re-apply or appeal the determination. An entire clinic can be certified only once all its providers meet the certification requirements. Certified health care homes are required to participate in a state-wide learning collaborative. Annual re-certification will be based on meeting quality measure benchmarks, which may evolve each year. Providers are not required to become a health care home, but certification is required to qualify for care coordination payments per member per month. | In 2008, SoonerCare providers completed a self-evaluation form for the PCMH tier (1, 2, or 3) of their choice. The next year, OKHCA did "educational reviews" with providers, where staff advised practices (90%+ in-person, the rest by phone) if they believed the practice had self-declared into the wrong tier. OKHCA now conducts random contract compliance audits in practices every 3 years. Physicians found to not be compliant with their tier are downgraded to a lower tier for 12 months, after which they can re-apply for that tier or a higher one. Practices downgraded from Tier 1 to no tier have 12 months to become a Tier 1 practice or lose their Medicaid patients. (OKHCA has only downgraded 5% of its practices.) Forms from new practices that apply for Tier 2 or 3 are reviewed and 1 year of educational support is offered before practices are audited. |