New York State Patient-Centered Medical Home (NYS PCMH) Recognition Program

Background

The American Academy of Pediatrics introduced the medical home concept in 1967, and in 2007 leading primary care-oriented medical professional societies released the Joint Principles of the PCMH. The next year, NCQA released its PCMH Recognition Program, the first evaluation program in the country based on the PCMH model.

Today, NCQA's PCMH Recognition Program has evolved to feature a set of six concepts that make up a medical home. Underlying these concepts are criteria (activities for which a practice must demonstrate adequate performance to obtain NCQA PCMH Recognition) developed from evidence-based guidelines and best practices.

NYS PCMH Recognition Program

The New York State Patient-Centered Medical Home (NYS PCMH) Recognition Program is an exclusive model developed upon the NCQA PCMH model and supports the state's initiative to improve primary care and promote the Triple Aim: better health, lower costs and better patient experience.

The NYS PCMH Standards and Guidelines Document contains program requirements and information your practice needs to demonstrate to NCQA that you have met the necessary criteria. The document is available for free to download in the NCQA Store.

Structure: Concepts, Criteria and Competencies

Concepts. There are six concepts—the overarching themes of PCMH. To earn recognition, your practice must complete criteria in each concept area. If you are familiar with past iterations of NCQA PCMH Recognition, the concepts are equivalent to standards.

Criteria. Criteria are specific activities in which a practice engages to demonstrate that it meets recognition requirements. The practice must meet all 40 core criteria and 12 NYS required criteria (with elective credit), earning a total of 25 credits in elective criteria across 5 of 6 concepts (16-19 credits are earned by the required NYS criteria, crossing all 6 Concepts). Which of the remaining 6-9 credits of elective criteria you complete are up to the practice.

Competencies. Competencies categorize the criteria. Competencies do not offer credit.

Concept Areas

Team-Based Care and Practice Organization

Helps structure a practice's leadership, care team responsibilities and how the practice partners with patients, families and caregivers.

Knowing and Managing Your Patients

Sets standards for data collection, medication reconciliation, evidence-based clinical decision support and other activities.

Patient-Centered Access and Continuity

Guides practices to provide patients with convenient access to clinical advice and helps ensure continuity of care.

Care Management and Support

Helps clinicians set up care management protocols to identify patients who need more closely-managed care.

Care Coordination and Care Transitions

Ensures that primary and specialty care clinicians are effectively sharing information and managing patient referrals to minimize cost, confusion and inappropriate care.

Performance Measurement and Quality Improvement

Improvement helps practices develop ways to measure performance, set goals and develop activities that will improve performance.

Requirements

To achieve recognition, practices must:

1. Meet all 40 core criteria and 12 NYS required criteria (with elective credit).
2. Earn a total of 25 credits in elective criteria across 5 of 6 concepts (16-19 credits are earned by the required NYS criteria, crossing all 6 Concepts).

See the table below for a list of the NYS required criteria.

Concept Area	Criteria	Description
Team-Based Care and Practice Organization	TC 05	Certified EHR system - Attestation
Knowing and Managing Your Patients	KM 04	Behavioral Health Screenings – Standardized tool, and report or process B. Alcohol use disorder C. Substance use disorder
Knowing and Managing Your Patients	KM 11	Population Needs A.Target population health management on disparities in care–Assessment, goals and actions **- And -** B.Address health literacy of the practice staff - Documentation **- Or -** C.Educate practice staff in cultural competence - Documentation
Patient-Centered Access	AC 08	Two-Way Electronic Communication – Process and report
Patient-Centered Access	AC 12	Continuity of Medical Record Information - Process
Care Management and Support	CM 03	Comprehensive Risk- Stratification Process – Report
Care Management and Support	CM 09	Care plan is integrated and accessible across settings of care – Process and example
Care Coordination and Care Transitions	CC 08	Specialist Referral Expectations – Agreement or process
Care Coordination and Care Transitions	CC 09	Behavioral health Referral Expectations – Agreement OR process and report, log or tracking
Care Coordination and Care Transitions	CC 19	Patient Discharge Summaries – Process and examples
Care Coordination and Care Transitions	CC 21	External Electronic Exchange of Information – Exchange of data A.Regional health information organization (RHIO) or other health information exchange source that enhances ability to manage complex patients
Performance Measurement and Quality Improvement	QI 19	Value-Based Contract Agreements – Agreement or data A.Practice engages in up-side risk contract

NCQA
Measuring quality. Improving health care.

For information on NYS PCMH, visit www.ncqa.org/nyspcmh or contact Support at (888) 275-7585.

1100 13th St., NW Third Floot / Washington, D.C. 20005

NCQA1096-0318