PCMH 2025

WHAT WE NEED TO KNOW

Patient Centered Medical Home (PCMH)

- Is a designation from NCQA (National Center for Quality Assurance).
- It is an accreditation/recognition that is awarded once and status is reviewed and recognized on an annual basis.
- Reporting is based on an annual standard year (ex. 2025).
- Program accreditation is by individual site and providers.
- We are accredited at Utica, Ilion and Rushville medical for all practicing medical providers.

What Does "Patient Centered Care" Mean?

- Patient Centered Care is an approach that prioritizes patient engagement, care coordination and access to the medical team.
- Focus is on putting the patients at the center of their care.
- This encourages patients to have an equal partnership with their provider and increases active participation in treatment decisions.
- This all helps to increase the patient's quality of care.

PCMH Application Design

- **Phase 1: Commit**: Requires a full review of your current practice with a NCQA Rep. You identify strengths and weaknesses and prepare your site for the transformation process.

- **Phase 2: Transform**: Prepare and submit all required documentation to PCMH for review. Once reviewed and all requirements are met you are awarded accreditation.

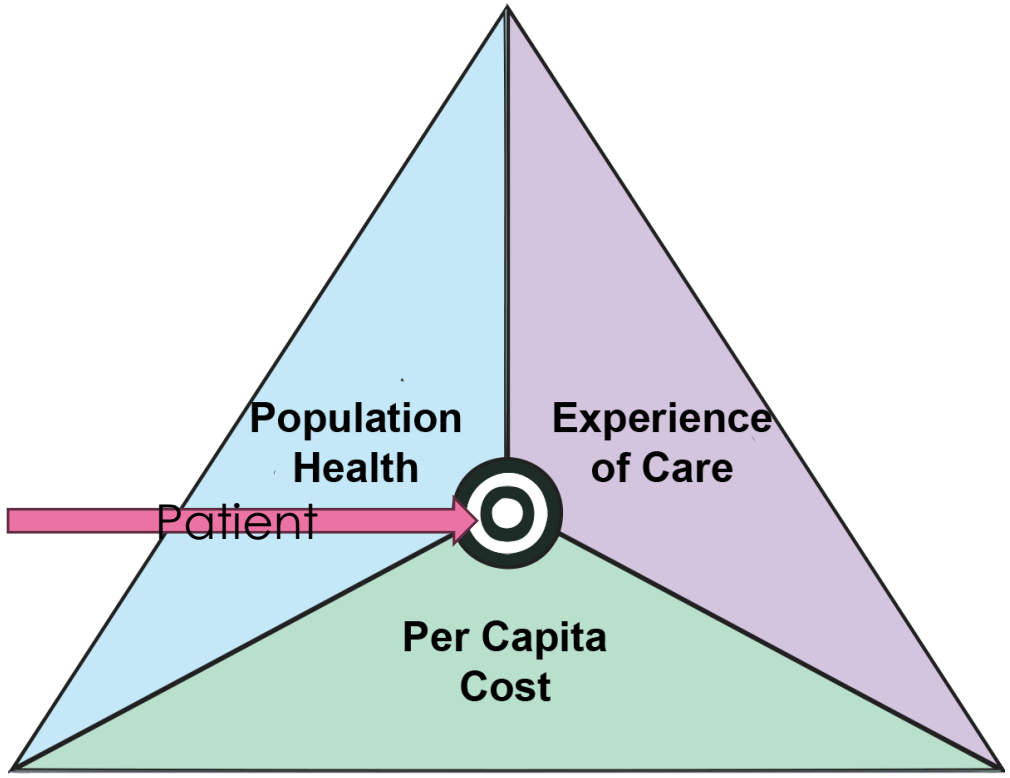
- **Phase 3: Succeed:** Detailed report completed annually to confirm the PCMH focused care for patients is ongoing.

- We have been in the succeed phase for several years for Mosaic Health.

- We submit annually in November for our accreditation/recognition.

PCMH Triple Aim

- PCMH utilizes the Triple Aim Framework that was developed by the institute for Healthcare Improvement (IHI).
- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care.



IHI Triple Aim

Value of PCMH Designation, Is It Worth It?

- **Financial** :
  - Higher Reimbursement rates (Per member per month rate).
  - This potentially brings in $200,000-300,000 a year for Mosaic Health (depending on patient volumes)
  - It increases reimbursement for State and Federal initiatives.

- **Cost Savings:**
  - Lowers hospital and ED visits.
  - Proactive management of patient's health can reduce avoidable visits/admissions.

- **Quality Improvement:**
  - Increases quality payment program performances.
  - Improves outcomes for preventative and chronic conditions.

- **Team-Based Approach:**
  - Encourages staff to operate at the highest level of their knowledge, skills, abilities and license for their roles and responsibilities.
  - Decreases staff burnout by 20% per a PCMH analysis.
  - Recognizes patient as part of the team.

PCMH Standards

- There are 6 Standards or categories that must be reported on annually:
  - Team-Based Care and Practice Organization (TC)
  - Knowing and Managing your Patients (KM)
  - Patient Centered Access and Continuity (AC)
  - Care Management and Support (CM)
  - Care Coordination and Care transitions (TC)
  - Performance Measurement and Quality Improvement (QI)

PCMH Annual Reporting Criteria

- Each year the practice must attest to the total 40 criteria that were originally approved with the first recognition.

- Each year the practice must additionally submit supporting documentation for around12 criteria within the 6 standards.

- These can very annually.

2025 Annual Reporting Requirements

- This year they have changed 9 requirements from the previous year. (this rotation is normal to cover reviews on all 40 criteria)
- They have added 2 additional criteria to submit over last year
- We have done a lot of improvement in capture of this data, our workflows and training to staff and will be able to provide supporting documentation for all criteria.

Annual Reporting Requirements		Site-Specific vs. Shared	PCMH Criteria	
Team-Based Care and Practice Organization (AR-TC)				
AR-TC 1: PCMH Transformation Leads	Required	Shared	TC 01	Core
AR-TC 2: Structure and Staff Responsibilities	Required	Shared	TC 02	Core
Knowing and Managing Your Patients (AR-KM)				
AR-KM 1: Comprehensive Health Assessment	Required	Shared	KM 02	Core
AR-KM 2: Diversity	Required	Site-specific	KM 09	Core
AR-KM 3: Community Resource Needs	Required	Shared	KM 21	Core
Patient-Centered Access and Continuity (AR-AC)				
AR-AC 1: Clinical Advice Documentation	Required	Shared	AC 05	Core
Care Management and Support (AR-CM)				
AR-CM 1: Identifying Patients for Care Management	Required	Shared	CM 01	Core
AR-CM 2: Care Plans for Care Managed Patients	Required	Site-specific	CM 04	Core
Care Coordination and Care Transitions (AR-CC)				
AR-CC 1: Referral Management	Required	Shared	CC 04	Core
AR-CC 2: Post-Hospital/ED Visit Follow-Up	Required	Shared	CC 16	Core
Performance Measurement and Quality Improvement (AR-QI)				
AR-QI 1: Clinical Quality Measures	Required	Site-specific	QI 01	Core
AR-QI 2: Resource Stewardship Measures	Required	Site-specific	QI 02	Core
AR-QI 3: Patient Experience Measure	Required	Site-specific	QI 04	Core
AR-QI 4: Goals and Actions to Improve Measures	Required	Site-specific	QI 08 & QI 09	Core

Mosaic Health's Patient Centered Care Approach:

- **Care management:**
  - Social Services Care Management.
  - RN Care Management.
  - BH Care Coordination.
  - Patients are given SDOH(SCN) screenings.
  - Patients are actively involved in creating their Individualized Care Plan.
  - Staff complete regular Care Team Meetings to support complex patient needs.

Mosaic Health's Patient Centered Care Approach:

- **Care Coordination and Care Transitions:**
  - Referral Tracking and support.
  - ED/Hospital Discharges and Follow up tracking/support.
  - Lab and Imaging completion and results discussions.
- **Patient Engagement/Involvement:**
  - Patient experience surveys to improve team-based approach.
  - Comprehensive wellness visits/reviews to support holistic wellbeing.
  - Strong open communication and documentation of anticipatory guidance or clinical advice.
  - Capturing of Diversity and Equity information to respect and improve patient care on individual level.

For more information about the criteria this year please see the PDF document:

Annual Reporting Requirements for PCMH Recognition 2025

Questions?