SNCHC PCMH Recognition & Transformation Journey

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SNCHC Governing Board Meeting
Prepared by: Dawn Gentsch

NEVADA
PRIMARY CARE ASSOCIATION

Overview

- What is PCMH
- HRSA BPHC & PCMH
- HRSA & PCMH Criteria Alignment
- SNCHC PCMH Transform Process
- Next Steps

What is PCMH?

- It’s not a place
- It’s a model of primary care initiated to **maximize health outcomes**
- It is collaborative care centered around the **patient’s needs**
- It’s a **team-based approach which includes the patient** as a care team member
- It’s a **foundation** for ACO’s and VBC’s

Medical Home Neighborhood

Functions describe the heart of the Medical Home

Accessible Care
Adopting advanced and timely access, virtual access, and team-based approaches, accessible care ensures that patients can be seen quickly.

Continuity of Care
Patients live healthier, fuller lives when they receive care from a responsible provider that sticks with them and knows how their health changes over time.

Patient- and Family- Partnered Care
Family practices are responsive to the unique needs of patients and their families within the context of their environment.

Comprehensive Team-Based with Family Physician Leadership
Broad range of services offered by an interprofessional team. The patient does not always see the FP but interactions with all team members are communicated efficiently within a PMH. The team might not be co-located but the patient is always seen by a professional with relevant skills who can connect with a physician as necessary.

Community Adaptiveness and Social Accountability
When a practice is informed by the broader social needs of the populations served, both the individual and the community benefit.

Why Obtain PCMH recognition?

- PCMH practices have demonstrated significantly better clinical quality metric performance than non-PCMH practices
- Provides a foundation for success in value-based initiatives
- May allow for eligibility in other advanced payment models, value-based programs and other initiatives
- Annual renewal offers a mechanism for sustainability to assure that the foundational workflows are sustained and promotes CQI
- PCMH is a national recognition, which is earned and stays with the practice and is recognized by payers
- Aligned with the goal to provide the ultimate in quality care safely to patients, with more predictability leading to better outcomes
- NCQA PCMH provides board MOC credit for physicians

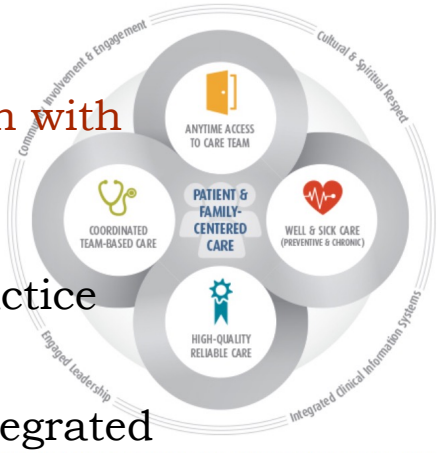
Understanding the patient-centered model of care.

PCMH Development History:

Joint Principles of the PCMH

Standards were developed to align with Joint Principles

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety
- Enhanced access
- Payment



What is Patient-Centered care?

1. Ongoing relationship with a personal clinician – first contact, continuous, comprehensive care
2. Responsibility for all patient's health care – needs or arranged care
3. Care for all stages of life – acute care, chronic care, preventive services, and end of life care
4. Team care includes clinician who take responsibility for care of patients

American Academy of Family Physicians, American College of Physicians, American Academy of Pediatrics, American Osteopathic Association

To Earn, and Maintain, Recognition Practices Must …

Demonstrate Patient Satisfaction	Use surveys to collect, analyze and improve satisfaction with: Access, Communication, Care Coordination & Whole Person Care (Self-Management)
Demonstrate High Value	Monitor the use of resources to ensure high quality, cost-effective performance outcomes
Demonstrate Health Equity	Use information about race, ethnicity, or other characteristics to provide culturally and linguistically appropriate services
Address Social Drivers of Health	Identify patients who need community resources in order to achieve health goals and provide assistance accordingly

PCMH, Value Based Care (VBC) & the Quintuple Aim

Medical homes are the foundation for a health care system that gives more value by achieving the "Quintuple Aim", thus health equity!

- ➔ NCQA PCMHs lower costs through CCM, preventive medicine and coordination across care settings and transitions.
- ➔ PCMH PCMH patients have high-quality disease management and better medication adherence, and emphasize self-care and community support, and thus experience fewer acute incidents.

HRSA Expectations and PCMH

- HRSA BPHC began promoting PCMH recognition in 2010, following the Patient Protection and Affordable Care Act (ACA) of 2009.
- Health centers provide comprehensive primary care services and many have multidisciplinary provides and staff to address the needs of their frequently low-income and uninsured patients.
- PCMH recognition is expected to improve patient outcomes.
- HRSA has promoted PCMH recognition under the Health Center Program through funding and technical assistance.

HRSA BPHC UDS Community Health Center Quality Recognition (CHQR) Badges

77.76% August 2025 based on 2024 UDS Data Reported

HRSA BPHC 330 Program Requirements (OSV)

PCMH

UDS

FTCA

PATIENT

Value Based Contracts

$V = \frac{Q + S}{\$}$ (VALUE) (QUALITY) (SERVICE) (COST)

Population Health

HEDIS

MCOs

Health Equity: SDOH

Health Center Operations and PCMH Overlap:

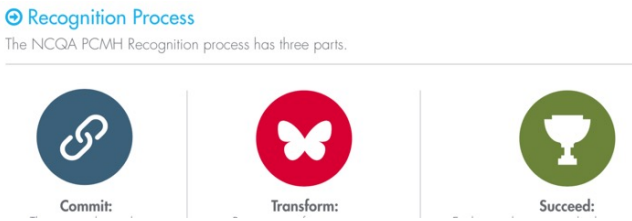
- Provide **comprehensive**, required services ranging from **preventive screenings** to care coordination and outreach.
- Provide **culturally appropriate care**, including interpretation services.
- Ensure office **locations** & health center **hours** of operation are based on **patient needs**.
- Track and **coordinate care** of hospitalized/ER patients.
- Provide patients with **accessible and affordable care**, with options for a sliding fee discount program.
- Demonstrate a **robust QI and QA program** that includes clinical measures and the patient voice (satisfaction and complaints).
- Ensure continuous QI through specific clinical quality and performance measure results.

NCQA PCMH Program & Process

Concepts → Competency → Criteria → Evidence

- 39 core criteria, most demonstrate all
- 65 elective criteria, most obtain 25+ elective criteria credits

- QPASS platform for recognition



Process

- Transform: 12 months with up to 3 virtual reviews
- Sustain: annual reporting survey submission
- Attestation, constant compliance

NCQA PCMH Standards (6 Concepts)

Team-Based Care and Practice Organization (TC)

Knowing and Managing Your Patients (KM)

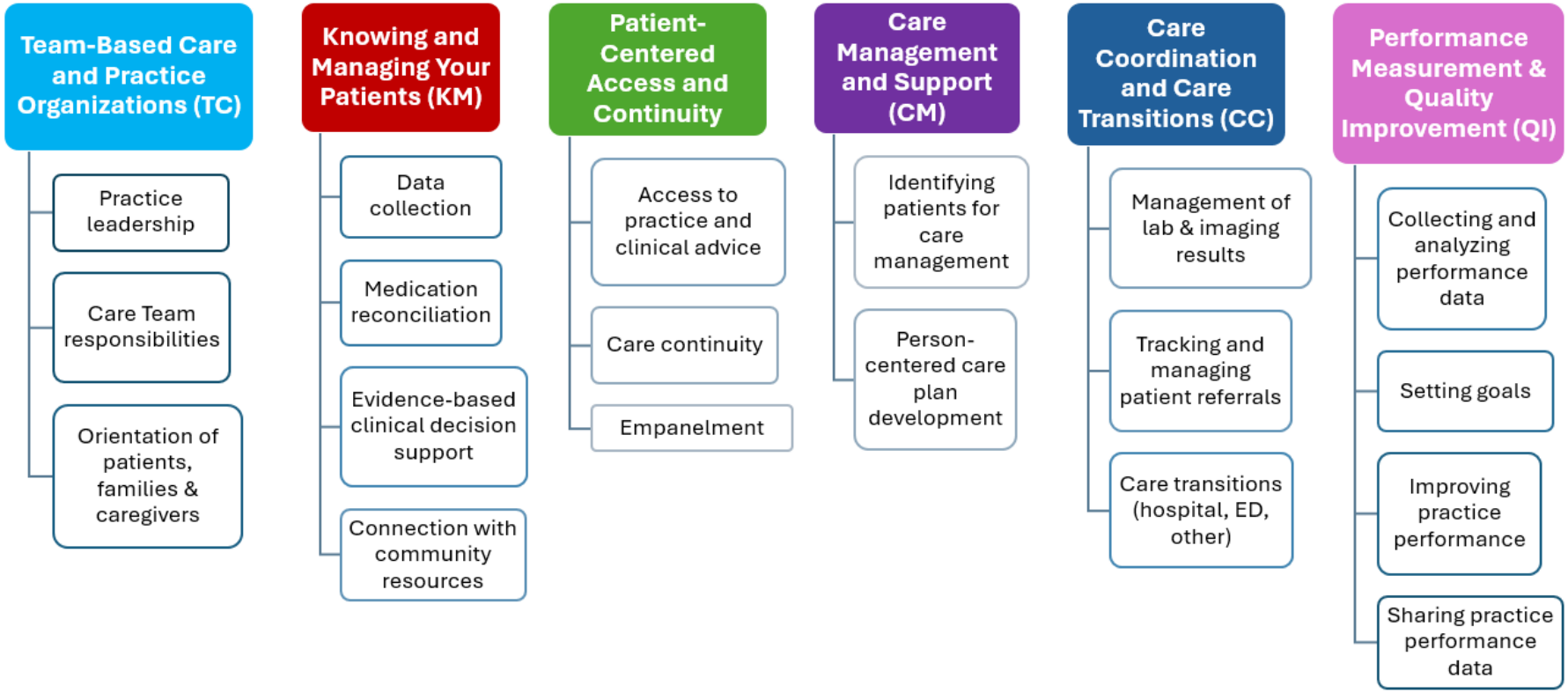
Patient-Centered Access and Continuity (AC)

Care Management and Support (CM)

Care Coordination and Care Transitions (CC)

Performance Measurement & Quality Improvement (QI)

PCMH Framework – Concept Areas



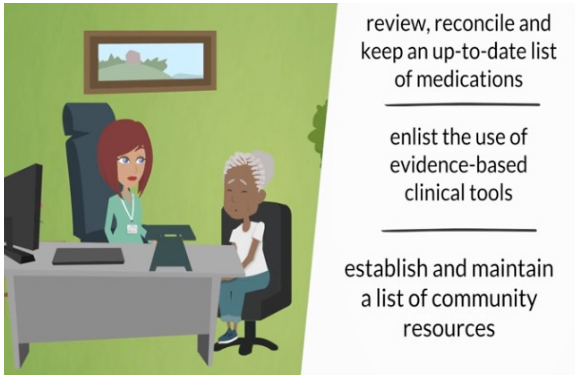
HRSA & PCMH Criteria Alignment: TC & KM

Team-Based Care and Practice Organization (TC)

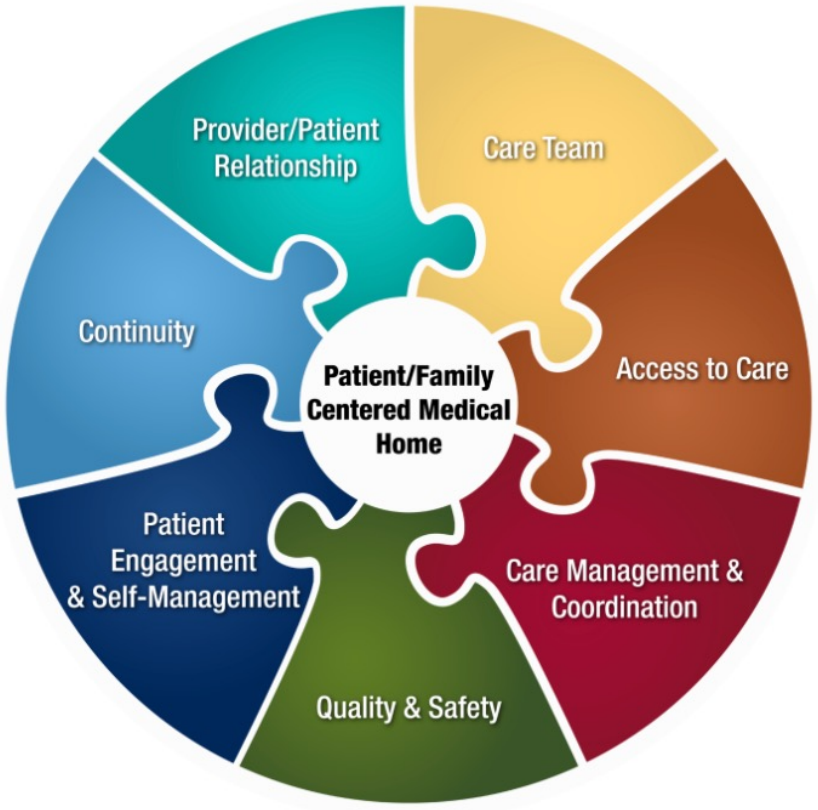
- **Staffing** – HCs should have providers and staff to provide required services (Form 5AB)
- **Governance/QI** – HCs should obtain input from staff on operations
- **Patient Materials** – the population served should be educated on the availability of staff and services and how to communicate with the health center

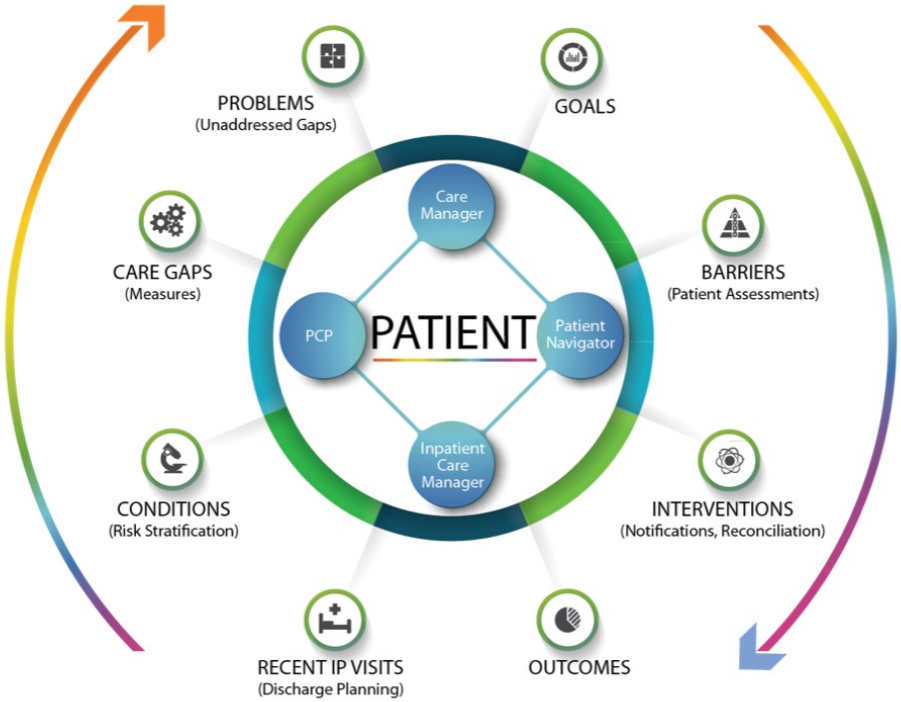
Knowing and Managing Your Patients (KM)

- **Needs Assessment** – HCs should track incidence and prevalence of chronic conditions as well as assess health disparities and the impact of SDOH (Table 6A,6B,7)
- **Diversity** – HCs gather data on patient demographics, geographic distribution and characteristics



Care Teams in Primary Care





HRSA & PCMH Criteria Alignment: AC & CM

Patient-Centered Access and Continuity (AC)

- **Needs Assessment** – HCs should gather information on patient access and ensure locations and hours meet patient expectations
- **Coverage During & After Hours** – HCs should address patient concerns in a timely manner

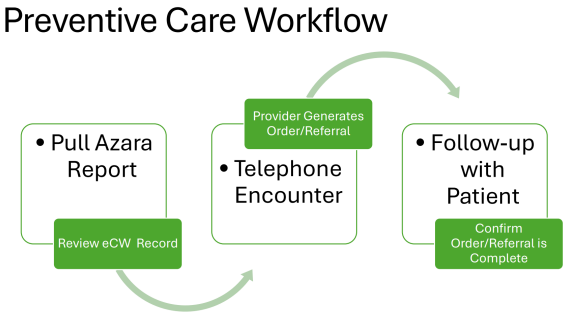
Care Management & Care Support (CM)

- **Diversity** – HCs gather data on patient demographics, geographic distribution and characteristics to identify patients for CM [high risk pt groups: require specific outreach, programs, staffing, partners]
- **Hospitalization Tracking** – HCs should track and follow up on hospitalized (+ER) patients, providing additional data to factor into patient identification for CM programs

HRSA & PCMH Criteria Alignment: CC & QI

Continuity and Coordination of Care (CC)

- **Required and Additional Services** – HCs should have processes to track diagnostic (lab/imaging) testing and referral management
- **Hospitalization Tracking** – HCs should track and follow up on hospitalized (+ER) patients



Performance Management and Quality Improvement (QI)

- **Quality Improvement Program** – HCs should have a robust QI program that:
  - Tracks quality metrics
  - assess patient satisfaction and
  - patient grievances

  Share/report out QI data to patients, staff, BOD, community partners, payors

  Data transparency

SNCHC PCMH Transformation Journey

2019-2024

Gap Analysis

PCMH Education

Commit

2025-2026

Workplan to achieve PCMH Recognition by 12.01.2026

- Compile evidence July 2025-June or Sept 2026
- Virtual Review 1: June 2026
- Virtual Review 2: Sept 2026
- Virtual Review 3: '26 TBD

Goal: Obtain Recognition by 12.01.2026

2024-2025+

Documented processes

- Policies and procedures created and/or updated
- Workflow changes implemented
- Charting aligned
- Care Management care plans: templates & enrollment

Regular Team Meetings 2025-2026

- Core group leadership
- Care Management

Sustain Recognition 2027+

- annual report to NCQA on select core criteria
- attestation maintain program requirements

Benefits of PCMH Recognition

For Patients:

- Stay healthy
- Better communication
- Better manage chronic conditions
- Have a better experience
- Improved access to medical care and services
- Better coordination of care

For Clinicians *[+ Care Team]*:

- Earn higher reimbursement
- Earn Maintenance of Certification (MOC) credits
- Focus on patient care
- Team-based care allows focused time for provider with patient

For Practices:

- Align with where healthcare is headed
- Integrate services across your entire organization
- Support revenue growth
- Improve your practice
- Keep your staff happy
- Improved safety and quality of care
- Evidence-based medicine
- Market your practice

Resources

- Accreditation and PCMH Recognition Initiative Program Assistance Letter. 2022-04. 09.01.2022. https://bphc.hrsa.gov/sites/default/files/bphc/compliance/pal-2022-04.pdf
- Key Processes Explained (PCMH Recognition Processes and Systems) https://www.ncqa.org/videos/key-processes-explained/
- Value of PCMH. https://www.ncqa.org/videos/value-of-pcmh/
- https://www.ncqa.org/programs/health-care-providers-practices/state-and-government-recognition/health-resources-services-administration-hrsa
- HRSA PCMH Video Series, December 2025. https://www.ncqa.org/videos/hrsa-pcmh-video-series-new-heath-center-videos-december-2-2025/

Questions or Comments ??

For More Information Contact:

Dawn Gentsch, MPH, MCHES, PCMH CCE

PCMH Consultant & Practice Facilitator

515.360.1731 | dgentsch@nvpca.org