WHITE PAPER

How NCQA Patient-Centered Medical Homes Address Disparities

RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME

NCQA Measuring quality. Improving health care.

How NCQA Patient-Centered Medical Homes Address Disparities

National Committee for Quality Assurance (NCQA) Patient-Centered Medical Homes (PCMHs) transform primary care practices into a central place to receive high-quality, personalized care. This person-centered approach improves quality, reduces costs and improves the experience of receiving health care. NCQA's PCMH program also helps practices develop capacity to address health care disparities that harm our most vulnerable patients, diminish health plan and clinician quality scores and drive up costs system-wide. That is because PCMHs do much more than provide care. PCMH practice teams also help patients access and navigate both the health care system and community-based supports that are critical for addressing disparities.

Healthy People 2020 defines health disparity as "a particular type of health difference that is closely linked with social, economic and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion." Affected populations have poorer health and care outcomes overall because they lack support for diagnosed conditions, receive less preventive care and the care they do receive often deviates from evidence-based treatment guidelines. They also may have higher priorities than health, such as a place to sleep if homeless or enough food if without adequate income. Affected people suffer from avoidable conditions that raise costs and limit their abilities. Disparities also lower quality scores that influence payment to health plans and clinicians.

To become NCQA PCMHs, primary care practices meet standards that help them to address the underlying "social determinants of health" that drive disparities. PCMH clinicians and staff work as teams to focus on each individual patient's needs, preferences, language and culture, and overcome barriers to care by developing long-term partnerships rather than hurried, sporadic visits. All NCQA PCMHs provide enhanced access to care through expanded and after-hours care, and many offer electronic communication (e.g., online portals, secure email). PCMHs coordinate the care patients get in other settings, connect patients/families/caregivers to community resources and help teach patients how to care for themselves. PCMHs help patients understand their treatment options and use shared decision-making to design each patient's care plan with and for that individual patient.

This paper describes how NCQA PCMH standards can help practices build capacity to address disparities by:

- Assessing patient populations for disparities and the factors that drive them,
- Linking affected patients to community and other resources to address those factors, and
- Tracking progress on goals to reduce disparities and ultimately eliminate them.

This paper also describes in Appendix A how Chicago's Medical Home Network uses NCQA PCMH standards to address disparities for its Medicaid patients. We hope this paper helps clinicians and other stakeholders to understand and take steps to maximize PCMH potential to tackle disparities and build on growing evidence that PCMHs are reducing disparities.

Background:

NCQA's PCMH program is the largest of its kind, with about one in five U.S. primary care physicians practicing in an NCQA-Recognized PCMH. Medicare, most states and many insurers provide incentives for NCQA PCMH Recognition because of the results NCQA PCMHs achieve.[1]

NCQA PCMH program includes 100 distinct criteria in six categories:

- Knowing & Managing Your Patients
- Patient-Centered Access & Continuity
- Care Management & Support
- Performance Measurement & Quality Improvement
- Care Coordination & Care Transitions
- Team-Based Care & Practice Organization

Forty standards are "core" requirements that practices must meet because they are essential attributes of PCMHs. The 60 "elective" standards provide additional points, and practices need at least 25 of these elective points to earn recognition. The elective standards enhance the core and let practices focus on patient-centered attributes that best fit their patients' needs, what the practice can do with its resources, skills and staff, and what matters most to their patients. A list of all NCQA PCMH standards is in Appendix B.

Knowing & Managing Your Patients

Knowing and managing patients – both as individuals and as populations - is at the heart of patient-centered care and is critical for addressing disparities. NCQA PCMHs collect critical information about each patient to inform how the practice addresses that patient's needs.

[1] Benefits of NCQA Patient-Centered Medical Home Recognition.

Core Knowing & Managing Your Patients Standards:

All PCMHs maintain comprehensive assessments and problem lists for each patient. These include assessment of social determinants, information about the patient's social and cultural characteristics, medical history, communication needs, social functioning and behaviors affecting health, such as mental health and substance use. All those factors impact disparities.

PCMHs assess the diversity of their patient population, including race, ethnicity, language and other factors influencing disparities. This helps to identify segments of populations that may have special needs or systemic barriers that lead to disparities. NCQA requires screening for depression which can be a key driver of disparities. Also, communicating with patients in their preferred language and tailoring education materials based on their demographics helps clinical teams understand their unique, personal health care needs and how to address them.

PCMHs conduct proactive outreach to meet people where they are by reminding patients, families and caregivers about needed services like immunizations, recommended screening and chronic and acute care services. Helping patients get these needed services is essential for reducing disparities.

PCMHs use evidence-based clinical decision supports for mental health, unhealthy behaviors like substance use disorder, chronic and acute medical conditions, and inappropriate care – all of which are important factors in disparities.

PCMHs help patients access community resources like food banks, cooking classes, safe and accessible exercise venues, support groups and education that can help patients take better care of themselves. Connecting patients to helpful community resources is a powerful tool for reducing disparities.

Elective Knowing & Managing Your Patients Standards:

PCMHs educate their staff on health literacy and cultural competence so they know how to meet diverse patient needs. PCMHs tailor education materials for each patient based on their demographics, language and communication preferences, health literacy – or ability to understand health and health care, values and preferences. PCMHs also provide other educational opportunities such as peer-support sessions, group classes and online self-management programs. PCMHs especially target education about new prescriptions to make sure patients understand the purpose for a medication and how to properly take it.

PCMHs assess patient responses to medications and any barriers to taking them as prescribed which may be more common for patients with disparities. This focus on medication education, barrier reduction and treatment adherence helps avoid preventable complications that increase disparities and health care costs. PCMHs further address them through community partnerships, self-management resources and other tools. These interventions focus on either the individual patient, populations or both. PCMHs maintain and regularly update lists of these community resources and assess their usefulness by seeking feedback from patients, their families and caregivers.

PCMHs assess patients' oral health and provide oral hygiene education, because unmet oral health needs can contribute to disparities by exacerbating chronic conditions like diabetes and heart disease.

PCMHs also conduct "case conferences" with the practice team, community supports and other outside partners like hospital discharge planners and health plan chronic disease case managers on care plans for high-risk patients who often face social determinants.

Patient-Centered Access & Continuity

Limited access to care is a key contributor to disparities, and enhanced access is an NCQA PCMH cornerstone that helps to address disparities.

Core Access & Continuity Standards:

PCMHs assess patients' access to care, including poor access indicators such as high emergency department use and limited transportation. PCMHs ensure that patients can get appointments outside business hours, timely clinical advice by phone that aligns with what is in their medical records and same-day appointments when needed. Assessing patients' access to care and barriers to it helps PCMHs identify which patients need greater support in getting needed care. Enhanced access after business hours, by phone, and same-day when needed can help reduce disparities impacted by limited access.

PCMHs also help patients, families and caregivers find the right personal clinician for them and conduct patient visits with the clinical team to make sure they are getting the personalized attention at the heart of patient-centered care.

Elective Access & Continuity Standards:

PCMHs look for access disparities across different types of patients so they can take steps to address the problem. By identifying patients with, for example, high emergency department use or no-show rates, PCMHs can have discussions with their patients about why that might be and work together to find solutions.

PCMHs provide additional enhanced access via video chat, secure instant messaging and other electronic technologies instead of just by traditional in-person office visits. Practices can further engage patients with secure, interactive electronic systems that let patients, families and caregivers communicate back and forth with them to request appointments, refill prescriptions and request referrals and test results. This helps patients who may be experiencing disparities due to limited transportation options.

Care Management & Support

Managing care and supporting patients to be more actively involved in their own health and self-care is a powerful tool for addressing disparities.

Core Care Management & Support Standards:

PCMHs use their patient assessments to identify those who need extra care management. Specifically, this includes people impacted by a lack of basic needs, such as food and/or transportation. They also include those with behavioral conditions, high cost or high utilization, poorly controlled or complex conditions and others. PCMHs set person-centered care plans for these patients and share them with the patient, their family and their caregivers.

Elective Care Management & Support Standards:

PCMHs use risk stratification to prioritize which patients in their population need care management, which can further help to target those most impacted by disparities. PCMHs work with patients, families and caregivers, to incorporate patient preferences and functional lifestyle goals into care plans, which helps promote a collaborative partnership to overcome any disparities. They identify, discuss and address barriers to treatment, functional and lifestyle goals for their patients. They develop self-management plans with patients, their families and caregivers to address the day-to-day challenges their patients face.

Quality Improvement

PCMHs continue to drive improvement in the quality of care they deliver, focusing specifically on addressing social determinants and disparities.

Core Quality Improvement Standards

PCMHs monitor clinical quality measures on immunizations, other preventive services like cancer screenings, chronic or acute care and behavioral health — all of which can be lower for people impacted by disparities. PCMHs then set goals and take actions to improve results for these clinical quality measures. They also set goals and take actions to improve on access and meet patient needs and preferences.

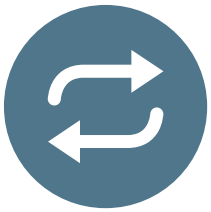
PCMHs also solicit feedback from patients on their experience with access to care and how well the practice communicates and coordinates their care. Practices do this, with surveys, focus groups or patient advisory councils that provide firsthand information on issues patients face.

Elective Quality Improvement Standards

PCMHs assess disparities among their patients stratified by at-risk populations, such as specific race or ethnic groups, people living with disabilities, languages, education and income levels or disadvantaged neighborhoods. Knowing which at-risk populations face which types of disparities helps practices target efforts to eliminate disparities in each subpopulation.

PCMHs use standardized, validated, benchmarked patient experience survey tools, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS). They specifically identify a vulnerable group of patients where there is evidence of disparities to get feedback on their unique experiences in getting care and use that information to further target efforts to eliminate disparities.

PCMHs also set goals for reducing disparities on specific quality measures, evaluate the results of their efforts, and show that they have improved results on at least one measure related to disparities. PCMHs involve patients, families and caregivers in these quality improvement efforts, which helps include voices of those impacted by disparities in the work.



Care Coordination & Care Transitions

Poor care coordination, especially as patients transition from one care setting to another, is among the most common causes of poor care quality. It also is a significant factor that can exacerbate disparities for people who lack the skills or resources to coordinate care for themselves.

Core Care Coordination & Care Transitions Standards:

PCMHs improve care coordination and transitions by systematically managing patient referrals. They share clinical and demographic data when referring patients to other clinicians and settings, and track the referral until they get follow-up reports. Also, after discharge from hospitals or emergency departments, PCMHs contact patients, families and/or caregivers to assess needed follow-up care. This management, tracking and follow-up closes gaps in care that can exacerbate disparities.

Elective Care Coordination & Care Transition Standards:

PCMHs further set clear expectations for referrals made to behavioral health care clinicians and to document how they collaborate with behavioral clinicians. For example, when a specialist regularly treats a PCMH patient, the PCMH and specialist can enter into agreements for safe and efficient co-management.

This is particularly important for patients with mental health and behavioral issues.

PCMHs also follow up with inpatient facilities after patients give birth to make sure infants get recommended hearing and blood-spot screening. This is especially important for mothers who are African American or other ethnic and racial groups who have well-documented poorer birth outcomes.

PCMHs help patients understand the cost of treatment options and help identify resources like copay and prescription assistance programs. Such support can be lifelines for people with income-based disparities.

PCMHs track unplanned hospital and emergency department visits which are more common among patients facing disparities. PCMHs also follow up with patients who have been to hospitals or emergency departments, and set care plans to manage transitions from one care setting to another.

Team-Based Care

To succeed as a PCMH, practices must operate as a team. Clinicians and other staff in the practice work together to ensure that they meet every patient's needs – especially those affected by social risks.

Core Team-Based Care Standards:

PCMHs have defined roles for key members of the team, and have regular team meetings to focus on individual patient needs. These team meetings help the practice target the unique needs of each individual patient affected by disparities.

Elective Team-Based Care Standards:

PCMHs include patients, families and caregivers in governance or stakeholder committees that provide feedback and advice on how to better meet patient needs. Practices also have care managers who are qualified to identify and coordinate behavioral health needs that are greater among patients affected by disparities.

The Evidence

A growing number of studies document that PCMHs in fact are reducing disparities:

- Rhodes et al found that NCQA PCMHs cut inpatient use and psychiatric outpatient use for high-risk Medicaid patients with both medical and psychiatric conditions, saving $4,145 per patient per year. **(Journal of General Internal Medicine, 2016)**

- The Vermont Blueprint for Health found that PCMHs provided Medicaid patients on average $56.50 more in non-medical support services targeted at meeting social, economic, and rehabilitative needs (e.g., transportation, home and community-based services, case management, dental, residential treatment, day treatment, mental health facilities, and school-based services). **(Vermont Blueprint for Health 2015 Annual Report)**

- Markovitz et al found PCMHs cut breast cancer screening disparities from a 6% to 3%. **(JAMA Internal Medicine, 2015)**

- Garcia-Huidobro et al found that PCMHs increase preventative care especially to Hispanic and foreign-born adolescents at risk for disparities. **(Pediatrics, 2016)**

- Berenson et al found that low-income adults with insurance and a medical home are less likely to report cost-related access problems, more likely to be up-to-date with preventive screenings, report greater satisfaction with the quality of their care and have significantly lower gaps in care vs. higher-income populations. **(Commonwealth Fund, 2012)**

- Roby et al found that PCMHs eliminated disparities in multiple emergency room visits, while reducing likelihood of multiple admissions among ethnic groups with mental illness. **(Medical Care Research and Review, 2010)**

- Beal et al found that PCMHs eliminated or reduced disparities for Latinos. **(Journal of General internal Medicine, 2009)**

Conclusion

Patient-Centered Medical Homes thoroughly address disparities to improve quality, equity and patient experiences. As a result, people get better care, PCMH primary care practices and their partners in the health care system perform better and health care costs decline. We hope this white paper helps all stakeholders understand how PCMHs can help practices develop greater capacity to reduce and ultimately eliminate disparities in our health care system.

Appendix A: NCQA PCMH Disparities Standards in the Real World

Chicago's Medical Home Network (MHN) is a healthcare innovations organization employing a unique, patient-centered model of care that aligns with NCQA PCMH standards to systematically address disparities in its service population. MHN operates the MHN ACO, a Medicaid accountable care organization owned by 9 FQHCs and 3 health systems and their primary care practices. Under MHN's model, the MHN ACO engages its patients by reaching out to each patient individually to perform a health risk assessment designed to get information about their health status and social determinants impacting health. Care team members use this patient-reported data to connect patients to community-based organizations offering services they may need. MHN is partnering with NCQA to systematically research the impact of PCMHs linking patients to community-based services.

MHN's model is predicated on the use of innovative technology that organizes disparate data sources (such as real-time ADT, claims, and pharmacy data), acts as the hub for care management and care coordination work, and links care management teams with patients and one another. MHN has recently begun incorporating machine learning into this technology to analyze these data feeds and update patient risk factors dynamically, bringing that information to care managers and coordinators. That means practices are always learning about and reassessing their patients, which is especially important in Medicaid where patient issues can compound quickly.

Medium and high-risk patients are given care plans, on which care managers follow up every 90 days for medium and at least monthly for high risk patients (although sometimes much more often). Every time new needs or data inputs arise, care managers work with each patient's integrated care team – physicians, allied professionals, family, friends, natural supports and patient themselves – to review and update the care plan.

MHN's Transitions of Care (TOC) program analyzes real-time data to help patients with discharge planning and to connect the hospital with the medical home. TOC managers line up follow-up appointments and services as needed. ACO medical homes text message patients with appointment reminders and to help with the redetermination of benefits so patients keep Medicaid coverage, which is a challenge for patients with low literacy or other social determinants like unstable housing. Care managers also assist patients with obtaining transportation for care needs – a significant contributor to disparities.

MHN ACO operates under a risk-bearing, value-based agreement for 120,000 Medicaid lives, aligning incentives and rewarding medical homes for work that leads to better care, better engagement and lower cost (e.g. Transitions of Care and care management work). To bolster ongoing quality improvement efforts, the contract also includes pay-for-performance incentives based on HEDIS® clinical quality measure results.

Appendix B – Patient-Centered Medical Home Core/Elective Concepts

Criteria	Criteria Title	Core vs. Elective	Explanation
TC 02	Structure & Staff Responsibilities	Core	Ensures implementation/support of entire practice
TC 03	External PCMH Collaborations	1 Credit	Population-based or learning collaboratives only
TC 04	Patient/Family/Caregiver Involvement in Governance	2 Credits	Ensuring patient input/engagement, opportunity to include vulnerable population
TC 08	Behavioral Health Care Manager	2 Credits	Managing behavioral health needs/services
Knowing & Managing Patients			
KM 01	Problem Lists	Core	Should document disparities in up-to-date list
KM 02	Comprehensive Health Assessment	Core	Assessment of social, behavioral, physical influences
KM 03	Depression Screening	Core	Proactive identification using standardized tool
KM 04	Behavioral Health Screenings	1 Credit	Proactive identification using standardized tool
KM 05	Oral Health Assessment & Services	1 Credit	Proactive identification & treatment/coordination
KM 06	Predominant Conditions & Concerns	1 Credit	Assessment to identify most common issues
KM 07	Social Determinants of Health	2 Credits	Assessment based on problem lists (KM01)
KM 08	Patient Materials	1 Credit	Access to easy/understandable health literacy
KM 09	Diversity	Core	Assessment to identify potential disparities/needs
KM 10	Language	Core	Assessment to identify potential disparities/needs
KM 11	Population Needs	1 Credit	Assessment to identify specific needs of practice
KM 17	Medication Responses & Barriers	1 Credit	Addressing health disparities as a barrier
KM 20	Clinical Decision Support	Core	Use of evidence-based guidelines for mental health
KM 21	Community Resource Needs	Core	Ensuring support based on population needs
KM 23	Oral Health Education	1 Credit	Management of common disparity
KM 26	Community Resource List	1 Credit	Community support of disparity
KM 27	Community Resource Assessment	1 Credit	Assessment of community support
KM 28	Case Conferences	2 Credits	Ensuring adequate care for complex patients
Patient-Centered Access & Continuity			
AC 01	Access Needs & Preferences	Core	Assessment specific to population to identify needs
AC 03	Appointments Outside Business Hours	Core	Availability to meet needs of population
AC 06	Alternative Appointments	1 Credit	Additional access to all patients
AC 09	Equity of Access	1 Credit	Specific assessment of health disparate population
Care Management & Support			
CM 01	Identifying Patients for Care Management	Core	Identification using disparity as a component
CM 03	Comprehensive Risk-Stratification Process	2 Credits	Identification of patients from entire population
CM 04	Person-Centered Care Plans	Core	Established for care managed patients
CM 05	Written Care Plans	Core	Care plan developed specific to needs/preferences
CM 06	Patient Preferences & Goals	1 Credit	Care plan incorporates functional/lifestyle goals

Appendix B – Patient-Centered Specialty Practice Core/Elective Concepts

Criteria	Criteria Title	Core vs. Elective	Explanation
Care Coordination & Care Transitions			
CC 09	Behavioral Health Referral Expectations	2 Credits	Continuity of care and information sharing
CC 10	Behavioral Health Integration	2 Credits	Patient support in physical location of practice
CC 13	Treatment Options & Costs	2 Credits	Patient education & support to enable care
CC 14	Identifying Unplanned Hospital & ED Visits	Core	Common among patients facing health disparities
Quality Improvement			
QI 05	Health Disparities Assessment	1 Credit	Specific health disparities assessment

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