GAINING NCQA RECOGNITION AS A PATIENT-CENTERED MEDICAL HOME

THE ROLE OF COMMUNITY RESOURCE CONNECTIONS

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Nationwide, over 90 commercial health plans, 42 state Medicaid programs, federal agencies, and the military have adopted the Patient Centered Medical Home (PCMH) model on varying scales. In their wide-ranging review of the results of implementing the PCMH, the Patient-Centered Primary Care Collaborative’s authors conclude¹, “The majority of state Medicaid programs are initiating or expanding their PCMH programs” (Nielsen et al, 2012). Indeed, more than three dozen payers now pay providers more if their medical group has received formal Recognition by the National Council for Quality Assurance (NCQA) as a Level 3 Patient Centered Medical Home. Aetna, CIGNA, and United Health Care, for example, use PCMH Recognition as a requirement for entry into their high-performance networks (Torda, 2013). As a recent example of the incentives, CareFirst Blue Cross Blue Shield in the Washington D.C. area gives doctors a 12% pay increase, plus $200 for each detailed care plan they set up for a patient. Doctors who meet efficiency and quality goals have gotten additional bonuses of about 20%, i.e., $12,000 on average per doctor since July 1, 2012 (Sun, 2012). About 150 multi-physician panels had received these incentives from CareFirst as of June 2012 (Overland, 2012).

This paper describes the ways Health Leads helps clinical partner organizations achieve NCQA Recognition as Patient Center Medical Homes by fulfilling certain requirements such as: keeping a resource database, tracking the patient referral process, and incorporating health education. Health Leads’ leading edge client tracking system and platform provides reports on demand with information to explicitly show how Health Leads addresses these PCMH requirements. Health Leads coordinates care for patients’ basic resource needs, inclusive of actually connecting the patients out to community-based

¹ The Patient Centered Primary Care Collaborative is a coalition of more than 1,000 employers, consumer and patient/family advocacy groups, patient quality organizations, health plans, labor unions, hospitals, physicians and other health professionals representing 50 million consumers that promotes the widespread use of PCMH.
resources and ensuring that they have successfully received such resources. For example, if the patient is eligible for SNAP [Supplemental Assistance Nutrition Program, or Food Stamps] benefits, Health Leads will help the patient complete and submit all enrollment documents, remain in touch with the patient until they receive their EBT [Electronic Benefits Transfer] card and have successfully been able to use it for securing food. This focus on the key social determinants of health is at the heart of the patient centered medical home.

Connecting patients with resources to meet their basic needs can help medical groups to win PCMH Recognition. Within the PCMH accreditation criteria is a call for the explicit documentation and tracking of referrals to community-based resources to insure that the basic resource needs for patients are met. Health Leads’ clinical partners are benefiting financially, or are expecting to benefit, from PCMH Recognition, though not necessarily as they had expected.

Children’s National Medical Center in Washington DC, whose seven health centers all have achieved the [highest] Level 3 Recognition in 2011, now receives $1.50 - $2.00 Per Member Per Month (PMPM) for its Aetna subscribers, as well as the CareFirst (Blue Cross Blue Shield) enhanced payments mentioned above, according to Dr. Mark Weissman, the Division Chief of the Goldberg Center for Community Pediatric Health, and Nasima Hossain, the Executive Director for their Goldberg Center for Community Pediatric Health. When Children’s National began pursuing PCMH Recognition, healthcare reform was being hotly contested. They believed there would be some enhanced Medicaid revenue, but there was no guarantee, so they were proceeding without the benefit of an incentive program “through a bit of a leap of faith,” according to Dr. Weissman. They did so for four reasons:

- They perceived a significant trend in healthcare toward the medical home as a better way of organizing and delivering care.
- Their mission is to train the next generation of providers to deliver care.
- They anticipated the new payment models on the horizon.
- To plan and design facilities for the future, they should build that around high-functioning medical teams.
Having proceeded, Children’s National was able to leverage their PCMH Recognition to get traction on their medical pilot project to transition patient care from the Emergency Department to the Medical Home, and with the new medical home framework, to improve their access and capacity, after which they extended clinics’ hours into weekday evenings and Saturdays.

Boston’s Dimock Community Health Center hopes to see a financial up-side from PCMH Recognition as they move to a global payment model, according to the Chief Medical Officer, Dr. Nandini Sengupta. As she explains, “In general, anything that keeps patients out of the hospital and healthier offers a financial upside in the global payment world. For instance, if we can provide housing and utility support, so that a child has a stable place to live, and the lights are on, she could use the medications she needed for asthma (there is a nebulizer machine that we often prescribe that uses electricity), and would not have an asthma crisis requiring hospitalization. The medication and the machine together cost less than $250, which should be covered by health insurance. A hospital admission for lack of medication/machine/electricity would cost upwards of $5,000 - a conservative estimate.”

For some, PCMH certification is not optional. As Warren Brodine, CEO of Chicago Family Health Center, a network of six health centers serving low-income Chicagoans, observes, “As an FQHC [Federally Qualified Health Center], we’ve been given no choice by HRSA; we have to reach PCMH Recognition for our continued operation. It’s a good thing that the industry is being pushed in this direction, since as an industry we don’t have a handle on the revenue and operational impacts of these changes. But anything that focuses health centers on quality, outcomes and customer care - as well as on lowering cost - is a positive development.” (HRSA, the Health Resources and Services Administration, is the primary Federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable.)

There is great variation in the immediate return on investment to get PMCH Recognition, as Dr. Weissman notes. PCMHs are not evenly distributed across the country; rather, there are clusters in New York and Pennsylvania, for example, because both had incentives driven at the state level, or collaboration among the state’s Medicaid and commercial payers. They and Massachusetts and
Maryland all have had pilot programs that have provided some practice coaching and support; some involve payments to hire coordinators, or enhanced payments.

**NCQA’S REQUIREMENTS**

Three Factors in the NCQA’s requirements in the most recent 2011 standards concern providers’ community resource linkages: Factors 1, 2 and 4 within Standard PCMH 4, Element B: “Provide Referrals to Community Resources.” Factor 1 requires that the medical practice maintain a current resource list on five topics or key community service areas of importance to the patient population.* Factor 2 asks that the practice track referrals provided to patients/families with a log or report over at least one month. Factor 4 specifies that the medical practice offers opportunities for health education programs such as group classes and peer support. As documentation for each of these, NCQA requests that:

- **Factor 1**: The practice has a list of community services or agencies with specified categories (e.g., smoking cessation programs).

- **Factor 2**: The practice has a log or report showing referral tracking to the community service resources used in PCMH 4, Element B, Factor 1 over a minimum period of one month.

- **Factor 4**: The practice has a documented process, evidenced by at least three examples.

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*Any five factors which may include: smoking cessation, weight management, exercise/physical activity, nutrition, parenting, dental, transportation, noncommercial health insurance, obtaining prescription medication, falls prevention, meal support, hospice, respite care, child development, immunization information, child care, and breastfeeding.
### TABLE 1: WHAT HEALTH LEADS PROVIDES FOR PCMH SUBMISSIONS

<table>
<thead>
<tr>
<th>Standard in PCMH 4, Element B</th>
<th>Documentation NCQA Requests</th>
<th>What HL Can Provide</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Factor #1:</strong> Resource list</td>
<td>Categorized List</td>
<td>List of resources in the provider’s city by need category (&amp; optionally by zip code) [See Appendices]</td>
</tr>
<tr>
<td><strong>Factor #2:</strong> Tracking and referral process</td>
<td>Log/report showing referral tracking over at least one month</td>
<td>Table of one row per sub-need and a column for each closing code for that desk over 1 year [See Appendices for an example]</td>
</tr>
<tr>
<td><strong>Factor #3:</strong> Mental health and substance abuse</td>
<td>Documented process and 3 examples</td>
<td>Health Leads does not address mental and behavioral health but can refer patients to appropriate services and/or works with social services within provider organizations to address these needs</td>
</tr>
<tr>
<td><strong>Factor #4:</strong> Health Education classes</td>
<td>Documented process and 3 examples</td>
<td>Flow chart of the Health Leads process; definitions of need closure codes; two three one-paragraph client stories with met needs</td>
</tr>
</tbody>
</table>

For **Factor 1**, Health Leads makes available a list with a row for each resource, and columns for the organization’s name and type of service, their phone number and zip code, and the type of needs they fill (clothing, food assistance, etc., among 50+ categories of sub-needs).

For **Factor 2**, Health Leads provides both aggregate and individual-level reports. The report on individual referrals has a row for each patient, with columns for the primary presenting sub-need for that patient, the date the case was opened (and closed) by Health Leads, the type of program to which the patient was referred, and the resolution of that need. The aggregate report shows a row for each of the 50 sub-needs, with columns breaking out the number of patients for whom the need had been met, the number who now feel equipped to meet the need on their own, the number who prefer not to work further on that need, the number who did not respond to three attempts to reach them, the number for whom

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2 These are the codes that characterize the reason for closure:
1. Health Leads and Client have met the need as defined in the Scope of Services (e.g., a referral to the Women Infants and Children program resulted in the client’s enrollment in WIC)
2. Client placed on wait list for two months or longer, no further follow-up necessary
3. Client’s need not yet met but feels equipped to proceed without further follow-up
4. Client no longer wants to work on this need because need met elsewhere OR not a priority for client
5. No resources exist to meet client’s need
6. Client did not respond after three consecutive attempts within 30 days
7. Health Leads did not attempt to contact client for at least 30 days
8. Rapid Resource Referrals
there are no resources in the vicinity, and the number of patients who were not contacted within 30 days.

For Factor 4, Health Leads provides one-paragraph descriptions of three individual clients who were connected to health education resources. The text describes the patient, their living situation, their key need(s), milestones of the opening and closing dates of their cases, and their confirmed participation in the nutritional education they received from the WIC or an adult education program.

ASSISTANCE PROVIDED BY HEALTH LEADS

Dimock Community Health Center received Level 3 PCMH Recognition in April 2013. The Chief Medical Officer commended Health Leads for contributing to a section of the application pertaining to access to community resources in five specific areas—food security, housing, respite care, child care and job search/G.E.D. opportunities. The Executive Director for Health Leads’ Boston region provided a description in February about how Health Leads integrates services with providers, communicates to the provider about the connections to resources, etc. As requested by Dimock’s CMO, Health Leads also provided a one-page narrative about Health Leads’ community resources, both operationally and data-wise. At the request of the CMO, Health Leads also provided information and patient flow documentation about connections to respite services. Health Leads was able to articulate how referrals are received and how screens and intakes are performed, how action plans with patients are developed, and how weekly follow-up calls with patients/families are performed and documented in the medical record for clinicians.

The internal medicine/adult clinic at Bellevue Hospital Center has received PCMH designation; their pediatric clinic is also applying for PCMH Recognition, as of August 2013. Increased revenue projections related to PCMH will allow Bellevue to hire several additional full-time nursing staff.

The Health Leads Executive Director for the New York Region provided the resource directory and the report for Factor 2 for inclusion in the submission for PCMH. Bellevue submitted these to their parent

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3 To get NCQA Level 3 Recognition as a PCMH, the medical practice’s submission must receive at least 85 of a possible 100 points. Up to three points are awarded for the medical practice’s community resource linkages. That can lift a provider over the threshold for Level 1 (35 points), or gain Level 2 certification (60 points), or lift a provider above Level 2 to achieve Level 3 Recognition (85 points).
organization, Health and Hospitals Corporation, in June 2013 for their inclusion in the submission to NCQA. Dr. Cynthia Osman, the Associate Medical Director of the Bellevue Pediatric Clinic, commented, “We were able to respond to questions about referrals to community resources with information that Health Leads provided for us. This is quite helpful for our application.” Also, Bellevue’s management has been able to use ongoing monthly reports since July 2013 to track the effectiveness of their community resource linkages. To renew the three-year Recognition, Bellevue needs to document their continued compliance with NCQA’s requirements, which the monthly report corroborates.

For the tracking of referrals for Factor 2, Codman Square Health Center submitted to NCQA the monthly figures on Health Leads referrals in the first ten months of CY 2012 on their referrals to Health Leads. Health Leads’ leading edge client tracking system and platform can now readily provide and disaggregate the complete totals, e.g., by sub-need and disposition, as in the Appendices.

NCQA raised its requirements in 2011 for the third time since 2003. These changes enhance the requirements’ applicability to pediatric practices, enhance patient-centeredness, emphasize language and culturally sensitive practices, integrate behaviors affecting health, substance abuse, mental health and risk factor assessment and management, and align with CMS Meaningful Use requirements (Torda, 2013). Much as the electronic medical record and back-office systems can provide data to speed continuous improvement, Health Leads’ leading edge client tracking system and platform can conveniently inform the improvements in clinical practice that these standards will require. Medical practices will need to continue aggressively integrating their clinical activities to meet the needs of patients, payers, and the next round of NCQA standards. Given these time-intensive requirements, the attention by Health Leads to the needs of patients for basic resources is especially valuable in freeing clinicians to focus on the medical needs of their patients.
REFERENCES

NCQA, Standards and Guidelines for NCQA’s Patient-Centered Medical Home (PCMH) 2011.


P. Torda, “Patient-Centered Medical Homes: Key Components and Results,” April 2013, NCQA.

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