ACA and the HIV Provider:
An Introduction to the
Patient-Centered Medical Home (PCMH)

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Co-Principal Investigator, HIV-Medical Homes Resource Center (HIV-MHRC)

Objectives

• Summarize the history and driving forces behind the PCMH model in the US
• Discuss why the US healthcare system needs the PCMH
• Recognize key components of the PCMH initiative, how HIV clinics relate to the model of care delivery and how to get started
• Identify resources available through the HIV-Medical Homes Resource Center (HIV-MHRC)

François Xavier Bagnoud Center, School of Nursing, Rutgers, The State University of New Jersey
In collaboration with:
The Center for Excellence in Primary Care in HIV (CEPC), Department of Family and Community Medicine, University of California at San Francisco

Overall Goals of the HIV-Medical Home Resource Center (MHRC)
Provide support to Ryan White grantees and service providers to:
• Understand concepts behind PCMH and their relationship to the HIV model of care
• Learn the requirements for recognition/certification as a PCMH and successfully become recognized/certified medical homes
• Increase capacity to implement PCMH principles in practice settings

The Patient Centered Medical Home:

• A model for delivering primary care that facilitates partnerships between patients, their providers and care teams
• Core components: patient-centered, evidence-based, comprehensive, accessible, and committed to quality and safety

The Triple AIM:

• Improving the patient experience
• Increasing quality
• Reducing costs
HISTORY OF THE PCMH MOVEMENT

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1. Enhanced reimbursement for primary care
2. Growing evidence that the PCMH improves quality,
   increases patient satisfaction and decreases costs
3. States adopt policies and programs to advance the medical home
4. Essential Health Benefits include prevention, wellness, and chronic disease management

Forty-Seven States Advancing Medical Homes in Medicaid and/or CHIP Programs

- CMS Medicare MH
- CMS Advanced Primary Care Pilot w/ State Medicaid
- Medicare FQHC MH pilot program

Identified to have a medical home initiative

What are some implications of the ACA and PCMH for nurses?

- Increased demand
- Opportunity to challenge status quo and build on existing strengths of HIV clinical programs
- New leadership opportunities—in transforming clinical care delivery
- Patient-centered care
- Healthcare team roles
- Chronic illness care and prevention: growing needs for patients living with HIV
The US Needs to Invest in New Models of Primary Care like the PCMH…

1. Our current system of care is too expensive and is not accountable for its results
2. Healthcare in the US is not patient-centered
3. Our performance on quality measures and control of chronic medical problems is not good enough
4. Workforce issues require we develop improved models of Team-based care where the work is shared more effectively
5. All of the above
6. I am not convinced we have to make changes

Affordable Care Act: Measures to Revitalize Primary Care

- Payment reform
  - Medicare and Medicaid fees
- Infrastructure investment and facilitating practice redesign
  - CMS Innovations Center
  - Medical Home pilot programs
  - Primary Care Extension Program
  - ARRA HIT incentives and TA
- Educational pipeline
  - NHSC
- Primary Care Training Grants

Select the most compelling reasons why the US needs to INVEST IN NEW MODELS OF PRIMARY CARE LIKE PCMH

Mortality Amenable to Health Care

- Deaths per 100,000 population*

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<td>Italy</td>
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<td>Canada</td>
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<td>Norway</td>
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<tr>
<td>United States</td>
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<td>131</td>
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</table>

* Countries are standardised death rates for age 75+, including acute heart disease, diabetes, stroke, and bacterial infections.

Data: E. Nolte and C. M. McKee, London School of Hygiene and Tropical Medicine analysis of World Health Organization mortality files (Nolte and McKee 2008).

The PCMH in More Detail: What is included in this care delivery model?

- Terminology differences based upon accreditation entities
- Multiple sources of the core concepts
- Multiple sources of recognition/accreditation/certification possibilities

Change Concepts for PCMH Transformation

- Engaged Leadership
- Quality Improvement Strategy
- Empanelment
- Continuous and Team-based Healing Relationship
- Organized, Evidence-Based Care
- Patient-Centered Interactions
- Enhanced Access
- Care Coordination

Wagner, EH et al, February, 2012

The Building Blocks of High-Performing Primary Care: Lessons from the field

- 23 high-performing practices
- Intensive visits to 7 West Coast practices
- Discussions with and observations of clinicians, RNs, MAs, front desk, leaders
- High-performing practices look about the same, with variation in the details
- 10 building blocks – the foundation of these practices

Engaged Leadership

- Catalyzes commitment to a strong mission and vision aligned with patient-centered care
- Assures that the leadership team is aligned with a common vision for change
- Communicates a clear vision for change to the rest of the organization

Engaged Leadership

- Visible leadership for culture change and QI
- Actively manages change processes to keep transformation on track
- Ensures time and resources for transformation
- Ensures PCMH values in staff hiring and training
Empanelment is a Method of Enhancing Continuity

- Same provider/team for every routine visit
- Standardize the number and acuity of patients cared for by each team
- Encourage proactive care and accountability for coordination of care and outcomes

Continuous and Team-based Healing Relationships

- Establish care delivery in teams
- Link patients to providers and care teams
- Role and task distribution in teams

(Are we sharing the care?)

Share the Care: How does your team work?

Directions: Who does it now?

1. Place tick mark in the column that matches who is currently charged with doing the task in Column 1.
   - If more than one person, you can place a tick mark in more than one column.
2. Add up tick marks vertically and place the total number of tick marks in the Totals row.

Note: PCP = MD, NP or PA

Who Does it Now?

<table>
<thead>
<tr>
<th>Tasks</th>
<th>PCP</th>
<th>RN</th>
<th>LVN/LPN</th>
<th>Medical assistant</th>
<th>Pharmacist</th>
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<tr>
<td>Notifies patients of normal lab results</td>
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<td></td>
<td></td>
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<tr>
<td>Reviews HIV registry and contacts patients over lab work</td>
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<tr>
<td>Does medication reconciliation</td>
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<td>Screens patients for depression using PHQ 2 and PHQ 9</td>
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<tr>
<td>Follow up by phone with patients treated for depression</td>
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</tbody>
</table>

Did Your Tally Show This?

<table>
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<tr>
<th>Tasks</th>
<th>PCP</th>
<th>RN</th>
<th>LVN/LPN</th>
<th>Medical assistant</th>
<th>Pharmacist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orders routine CD4 counts and viral loads per guidelines</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refills anti-viral meds for patients with stable labs</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offers preventive counseling</td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Counsels patients on colorectal cancer screening</td>
<td>✔️</td>
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<tr>
<td>Reviews lab tests to separate normals from abnormals</td>
<td>✔️</td>
<td></td>
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</tbody>
</table>

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Are You Maximizing Your Team?

<table>
<thead>
<tr>
<th>Task</th>
<th>FCP</th>
<th>RN</th>
<th>LVN/LPN</th>
<th>Medical Assistant</th>
<th>Pharmacist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Order routine CD4 counts and viral loads per guidelines</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Refill anti-retroviral meds for patients with stable labs</td>
<td>✓</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Offer preventive counseling</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>Counsel patients on colorectal cancer screening</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Test to separate normals from abnormalities</td>
<td></td>
<td>✓</td>
<td></td>
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</tr>
</tbody>
</table>

Patient-Centered Interactions

- Respect patient and family values
- Encourage patient involvement in healthcare
- Every interaction supports self-management
- Patient and family feedback in QI

Organized, Evidence-Based Care

- Use planned care according to patient need
- Manage care for high-risk patients
- Use point-of-care reminders
- Use patient data to enable planned interactions

Enhanced Access

- Ensure 24/7 access to care team
- Provide scheduling options
- E-mail visits, patient portals, group visits for chronic illness care
- Help patients access insurance

Care Coordination

- Link patient with community resources
- Integrate specialty care with co-location
- Referral tracking
- ED/hospital care transitions
- Communicate test results/care plans with patients

Elements of Team-based Care

- Patient identifies with care team
- Stability of the team
- Co-location
- Realistic staffing ratios
- Standing orders/protocols
- Defined workflows and roles – workflow mapping
- Training and cross training
- Ground rules
- Communication – healthy huddles, terrific team meetings and constant conversation
PCMH Development, Recognition and Certification

- Private, state and federally funded demonstration projects support PCMH development
- Recognition/accreditation/certification
  - NCQA
  - The Joint Commission
  - URAC (formerly the Utilization Review Accreditation Commission)
  - Accreditation Association for Ambulatory Health Care
  - State programs
- Health information technology (meaningful use demonstration programs)

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Evidence Supporting the PCMH Model of Care

Quality
- Quality measures
- Access to providers and services
- Patient experiences/provider satisfaction
- Outcomes data
- Chronic disease management
- Prevention and wellness

Costs
- Admission/readmission rates
- Hospital length of stay
- Avoidable ED visits
- Specialist visits
- Per-person health care costs

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Growing Evidence on the Benefits of the PCMH

- Health Care Savings with the PCMH: Community Care of North Carolina’s Experience – Filmore, H et al, 2013
- PCMH improves low-income access, reduces inequities – Berenson R., May 2012
- PCMH improves quality and patient satisfaction, lowers costs – PCPCC, September 2012

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Growing Evidence (cont.)

- Colorado PCMH multi-payer pilot reduced inpatient admission, and ER visits – Harbrect, September 2012
- Decrease in acute inpatient admissions, ER visits and overall PMPM cost, improved compliance with evidence-based guidelines and performance on quality measures – Raskas, R., 2012
- Fewer emergency room visits, hospitalizations and lower overall costs, improved access and performance on key quality indicators – Takach, M., 2011

The Role of Nurses in the PCMH

- Practices that had nurses leading PCMH transformation efforts showed the greatest success – Donahue et.al, 2013
- The care management role (a key role in a PCMH) is consistently performed by a nurse – Patel et. al, 2013
- Successful PCMHs required the addition of NPs, nurses, care managers, pharmacists and behavioral health specialists – Patel et. al, 2013
- The patient-centered medical home: this primary care model offers RNs new practice—and reimbursement—opportunities – Henderson S, Princell CO, Martin SD., 2012

Ryan White: An Unintentional Home Builder

- “An unintended consequence...of the Ryan White Care Act has been the establishment of the comprehensive delivery of multiple services for patients with a complex disease....medical homes for the HIV-infected person...”
- “The act created in his (Ryan White’s) memory, unintentionally created medical homes that are the best examples of how all of us should receive primary care.”

Saag, M. AIDS Reader. 2009

Even Ryan White programs need to improve quality, have workforce issues and need to think about costs

Quality:

- Cervical Cancer Screening: 60%
- Oral Health Exam: 36%
- ARV regimens with no contraindications: 85.6%

Engagement in HIV Care

**Leadership & HIV care Engagement in HIV care**

**Leadership & HIV care Engagement in HIV care**

- Leadership & HIV care: 5.11%
- HIV diagnosis: 84.92%
- HIV care linkage: 726.23%
- HIV care retention: 416.35%
- HIV care suppression: 436.19%
- HIV care suppression: 336.47%

Engagement in HIV care

Vital Signs: HIV Prevention Through Care and – United States. MMWR December 2, 2011/60(47);1618-1623

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**Workforce the Looming Crisis in HIV Care: Who Will Provide the Care?**

- “In a survey conducted by HIVMA…a majority of Ryan White Part C-funded programs reported increasing caseloads and serious challenges recruiting and retaining HIV clinicians. Reimbursement and a lack of qualified providers were the top two barriers cited.”

  HIV Medicine Association, 2010

**Workforce: How long have you worked in the HIV field?**

- This is my first year
- 1-5 years
- 5-10 years
- 10-15 years
- 15-20 years
- More than 20 years

**Funding:**

- Ryan White care model relies on grant funding
- Demand for services will continue to increase: grants not likely to increase
- ACA creates opportunities to be paid for the value we produce
- Participation in Accountable Care Organizations
- PCMH payment reform

**Benefits of Becoming a PCMH in HIV**

- Skills gained as a Ryan White grantee can support PCMH recognition, e.g. developing and implementing a quality management plan, using evidence-based practice, and care teams
- Positions HIV clinics to take advantage of financial incentives and/or bonuses offered by health plans
- Superior value to purchasers & consumers (meets nationally recognized standards for high quality care)
- Foundation to Accountable Care Organizations (medical neighborhood)

**Evidence-based Practice**

...
What You Can Do To Get Started

The HIV-MHRC provides ongoing TA and consultation that address beginning, intermediate and advanced learning needs

- Learn about PCMHs and what is available through the HIV-MHRC and other sources
- Explore the HIV-MHRC web page and resource repository on the HRSA TARGET Center website
- Enroll in the HIV-MHRC listserv
- Attend the HIV-MHRC Webinar series
- For clinics that participated in regional Strategic Planning workshops: the HIV-MHRC has a virtual learning community and web based discussion forum

What You Can Do To Get Started (cont.)

To assess the extent to which your practice functions as a PCMH, and track your progress toward practice transformation you may wish to use:

The Patient-Centered Medical Home Assessment (PCMH-A)

- Jointly developed by the MacColl Center for Health Care Innovation at the Group Health Research Institute and Qualis Health for the Safety Net Medical Home Initiative
- http://www.safetynetmedicalhome.org/resources-tools/assessment

References


Thoughts?

Questions?

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