RUTGERS
François-Xavier Bagnoud Center

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

Andrea Norberg, MS, RN
Executive Director, François Xavier Bagnoud Center
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

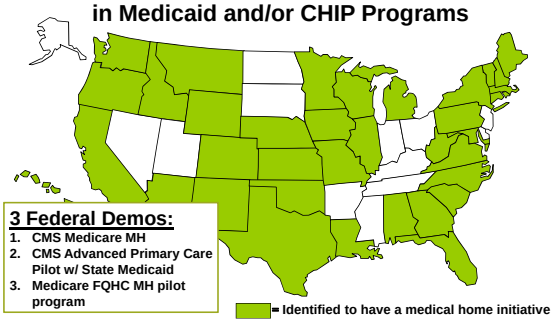
History of the PCMH Movement

History (Cont.)

ACA, Primary Care and the PCMH: 2011-13

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

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



Source: National Academy for State Health Policy State Scan, May 2010. http://www.nashp.org/med-home-map

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

RUTGERS François-Xavier Bagnoud Center

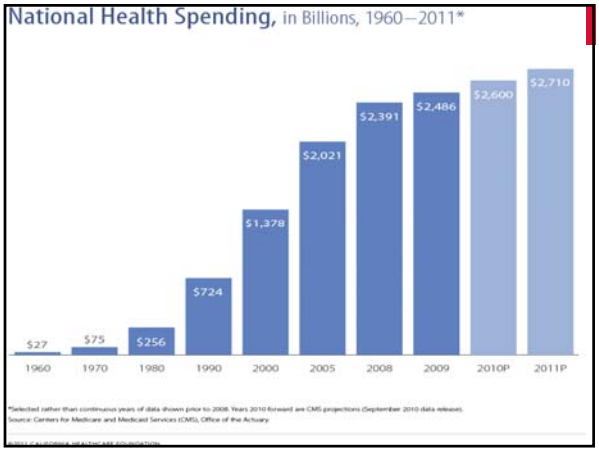
Select the most compelling reasons why the US needs to

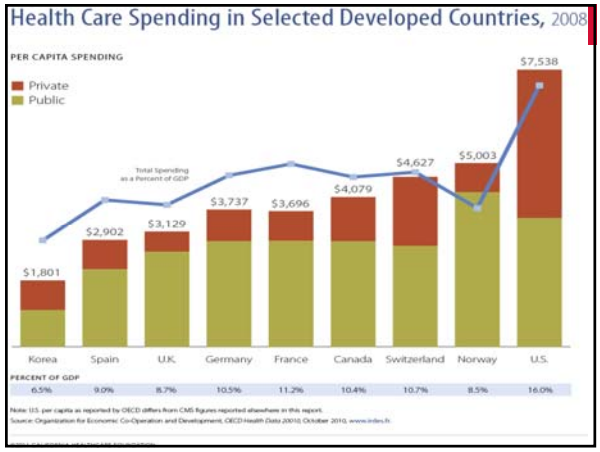
INVEST IN NEW MODELS OF PRIMARY CARE LIKE PCMH

RUTGERS François-Xavier Bagnoud Center

The US Needs to Invest in New Models of Primary Care like the PCMH…

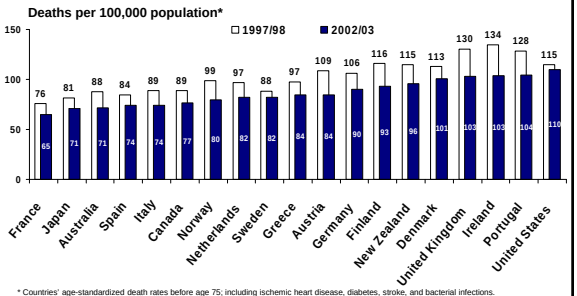
1. Our current system of care is too expensive and is not accountable for its results
2. Healthcare in the US is not patient-centered
3. Our performance on quality measures and control of chronic medical problems is not good enough
4. Workforce issues require we develop improved models of Team-based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





RUTGERS François-Xavier Bagnoud Center

Mortality Amenable to Health Care



* Countries' age-standardized death rates before age 75; including ischemic 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).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008.

RUTGERS François-Xavier Bagnoud Center

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

RUTGERS François-Xavier Bagnoud Center

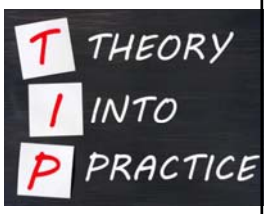
The PCMH in More Detail: What is included in this care delivery model?

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

RUTGERS François-Xavier Bagnoud Center

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

RUTGERS François-Xavier Bagnoud Center

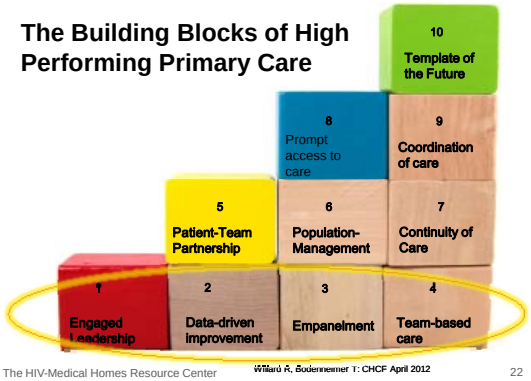
The Building Blocks of High-Performing Primary Care: Lessons from the field

- 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

Willard R, Bodenheimer T: CHCF April 2012

RUTGERS François-Xavier Bagnoud Center

The Building Blocks of High Performing Primary Care



Willard R, Bodenheimer T: CHCF April 2012

RUTGERS François-Xavier Bagnoud Center

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

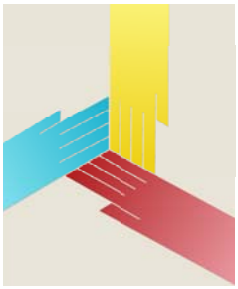
RUTGERS François-Xavier Bagnoud Center

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?

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

Who Does it Now?

Tasks	PCP	RN	LVN/LPN	Medical assistant	Pharmacist
Notifies patients of normal lab results					
Reviews HIV registry and contacts patients overdue for lab work					
Does medication reconciliation					
Screens patients for depression using PHQ 2 and PHQ 9					
Follows up by phone with patients treated for depression					

Did Your Tally Show This?

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

RUTGERS François-Xavier Bagnoud Center

Are You Maximizing Your Team?

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

RUTGERS François-Xavier Bagnoud Center

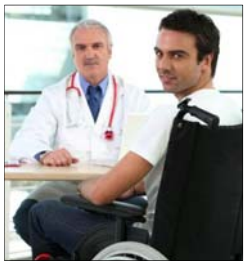
Elements of Team-based Care

- 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

RUTGERS François-Xavier Bagnoud Center

Patient-Centered Interactions

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



RUTGERS François-Xavier Bagnoud Center

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

RUTGERS François-Xavier Bagnoud Center

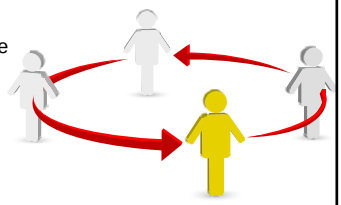
Enhanced Access

- 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

RUTGERS François-Xavier Bagnoud Center

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



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)

PCMH 2011 Content and Scoring

PCMH1: Enhance Access and Continuity	Pts
A. Access During Office Hours**	4
B. After-Hours Access	4
C. Electronic Access	2
D. Continuity	2
E. Medical Home Responsibilities	2
F. Culturally and Linguistically Appropriate Services	2
G. Practice Team	4
	20

PCMH2: Identify and Manage Patient Populations	Pts
A. Patient Information	3
B. Clinical Data	4
C. Comprehensive Health Assessment	4
D. Use Data for Population Management**	5
	16

PCMH3: Plan and Manage Care	Pts
A. Implement Evidence-Based Guidelines	4
B. Identify High-Risk Patients	3
C. Care Management**	4
D. Manage Medications	3
E. Use Electronic Prescribing	3
	17

PCMH4: Provide Self-Care Support and Community Resources	Pts
A. Support Self-Care Process**	6
B. Provide Referrals to Community Resources	3
	9

PCMH5: Track and Coordinate Care	Pts
A. Test Tracking and Follow-Up	6
B. Referral Tracking and Follow-Up**	6
C. Coordinate with Facilities/Care Transitions	6
	18

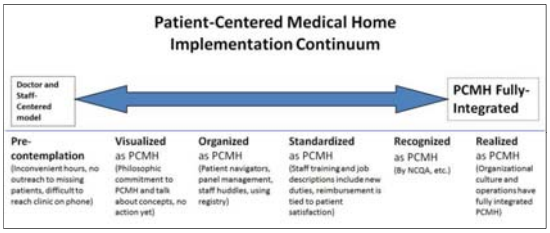
PCMH6: Measure and Improve Performance	Pts
A. Measure Performance	4
B. Measure Patient/Family Experience	4
C. Implement Continuously Quality Improvement**	4
D. Demonstrate Continuous Quality Improvement	3
E. Report Performance	3
F. Report Data Externally	2
	20

**Must Pass Elements

NCQA Patient-Centered Medical Home Standards Workshop 2011

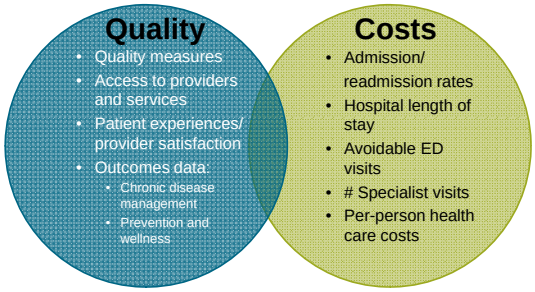
Change Concepts	Building Blocks	NCQA Recognition
Engaged Leadership	Data for Improvement	Enhance Access/Continuity
Quality Improvement Strategy	Empanelment, Panel size management	Identify/Manage Patient Populations
Empanelment	Team-based Care	Plan/Manage Care
Continuous and Team-based Healing Relationships	Population Management	Provide Self-Care Support/Community Resources
Organized Evidence-based Care	Continuity of Care	Track/Coordinate Care
Patient-Centered Interaction	Prompt Access to Care	Measure/Improve Performance
Enhanced Access	Expanded Access	
Care Coordination	Mission with objectives and goals	
	Care coordination with Medical Neighborhood	
	Trained Leaders	

39



Slide developed by Kathleen Clanon, MD
Associate Chief Medical Officer, Alameda County Medical Center
Principal Investigator, HIV Access PCMH Demonstration Project

Evidence Supporting the PCMH Model of Care



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*

RUTGERS François-Xavier Bagnoud Center

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*

RUTGERS François-Xavier Bagnoud Center

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 mangers, 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*

SB1 RUTGERS François-Xavier Bagnoud Center

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."

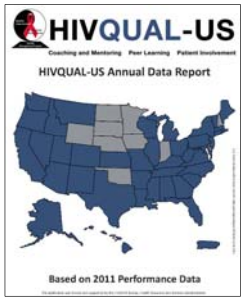
Saag, M. AIDS Reader. 2009

RUTGERS François-Xavier Bagnoud Center

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

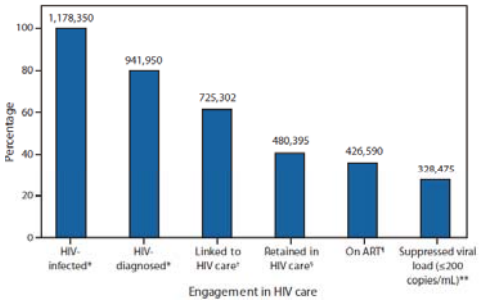
RUTGERS François-Xavier Bagnoud Center

Quality:



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

RUTGERS François-Xavier Bagnoud Center



Engagement in HIV Care

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

Slide 45

SB1 Steve Bromer, 3/21/2012

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?

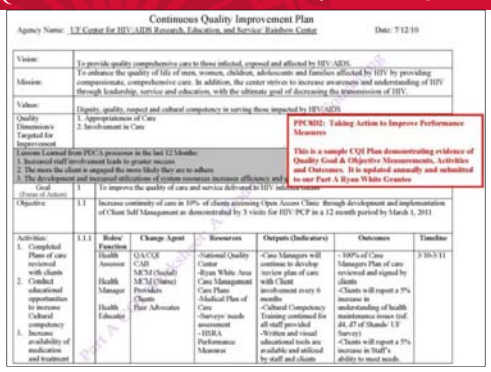
- This is my first year
- 1-5 years
- 5-10 years
- 10-15 years
- 15-20 years
- More than 20 years

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)



Continuous Quality Improvement Plan

Agency Name: UF Center for HIV/AIDS Research, Education, and Service/ Rainbow Center Date: 7/12/10

Vision:	To provide quality comprehensive care to those infected, exposed and affected by HIV/AIDS.
Mission:	To enhance the quality of life of men, women, children, adolescents and families affected by HIV by providing compassionate, comprehensive care. In addition, the center strives to increase awareness and understanding of HIV through leadership, service and education, with the ultimate goal of decreasing the transmission of HIV.
Values:	Dignity, quality, respect and cultural competency in serving those impacted by HIV/AIDS.
Quality Dimension's Targeted for Improvement	1. Appropriateness of Care 2. Involvement in Care

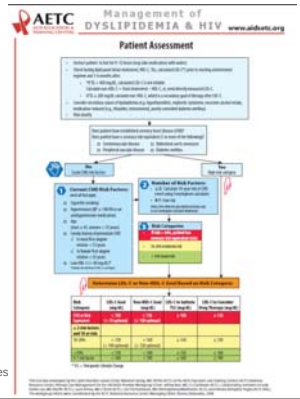
PPCH02: Taking Action to Improve Performance Measures

This is a sample CQI Plan demonstrating evidence of Quality Goal & Objective Measurements, Activities and Outcomes. It is updated annually and submitted to our Part A Ryan White Grantee

Lessons Learned from PDCA processes in the last 12 Months:
1. Increased staff involvement leads to greater success
2. The more the client is engaged the more likely they are to adhere
3. The development and increased utilizations of system resources increases efficiency and

Goal (Focus of Action)	1	To improve the quality of care and service delivered to HIV				
Objective	1.1	Increase continuity of care in 10% of clients accessing Open Access Clinic through development and implementation of Client Self Management as demonstrated by 3 visits for HIV-PCP in a 12 month period by March 1, 2011				
Activities:	1.1.1	Roles/ Function	Change Agent	Resources	Outputs (Indicators)	Outcomes	Timeline
1. Completed Plans of care reviewed with clients 2. Conduct educational opportunities to increase Cultural competency 3. Increase availability of medication and treatment		Health Assessor Health Manager Health Educator	QA/CQI CAB MCM (Social) MCM (Nurse) Providers Clients Peer Advocates	-National Quality Center -Ryan White Area Care Management Care Plans -Medical Plan of Care -Surveys/ needs assessment -HSRA Performance Measures	-Case Managers will continue to develop review plan of care with Client involvement every 6 months -Cultural Competency Training continued for all staff provided -Written and visual educational tools are available and utilized by staff and clients	- 100% of Case Managers Plan of care reviewed and signed by clients -Clients will report a 5% increase in understanding of health maintenance issues (ref. #4, #7 of Shands' UF Survey) -Clients will report a 5% increase in Staff's ability to meet needs.	3/10-3/11

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

What you can do to get started:

- Review each recognition and/or accreditation entity to see which is the best fit for your organization
  - NCQA
    - http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH/PCMH2.aspx
  - Joint Commission
    - http://www.jointcommission.org/accreditation/pchi.aspx
    - http://www.jointcommission.org/assets/1/18/PCMH_AHC_May31_2012.pdf
  - AAAHC
    - http://www.aaahc.org/accreditation/primary-care-medical-home/
  - URAC
    - https://www.urac.org/healthcare/pchch/index.aspx

Resource Repository
http://www.careacttarget.org/mhrc

References

Berenson RA, P. R. (2012). Medicare's Readmissions-Reduction Program-A Positive Alternative. *New England Journal Of Medicine*, 1364-66.

Donahue K.E., Halladay J.R., Reiter K. (2013). Facilitators of Transforming Primary Care: A Look Under the Hood at Practice Leadership. *Annals of Family Medicine*,11, 527-533.

Fillmore H, Dubard, C. A., Ritter G. A. (2013). Health Care Savings with the Patient-Centered Medical Home: Community Care of North Carolina's Experience. *Population Health Management.* DOI: 10.1089/pop.2013.0055

Ghorob A., Bodenheimer T. (2012). Sharing the Care to Improve Access to Primary Care. *New England Journal Of Medicine*, 366, 1955-7.

Harbrecht MG, Lattis L. M. (2012). Colarado's Patient-Centered Medical Home Pilot Met Numerous Obstacles, Yet Saw Results Such as Reduced Hospital Admissions. *Health Affairs*, 2010-17.

References

Henderson S., Pricell C.O. (2012). The Patient-Centered Medical Home: this Primary Care Model Offers RNs New Practice-and reimbursement opportunities. *American Journal of Nursing*, 54-9.

Patel MS, Arron, M.J., Sinsky T.A. (2013). Estimating the staffing infrastructure for a patient-centered medical home. *American Journal of Managed Care,* 509-16.

Raskas RS, Latts L.M., Hummel J.R. (2012). Early Results Show WellPoint's Patient-Centered Medical Home Pilots Have Met Some Goals for Costs, Utilization, and Quality. *Health Affairs*, 2002-9.

Takach, M. (2011). Reinventing Medicaid: State Innovations to Qualify and Pay for Patient-Centered medical Homes Showing Promising Results. *Health Affairs, 1325-1334.*

Thoughts?

Questions?

To receive copies of the presentation please e-mail me:

norberan@sn.rutgers.edu