The Patient Centered Medical Home (PCMH) Guidance: A Model of Care Delivery for People Living with HIV

Andrea Norberg, MS, RN
Executive Director François Xavier Bagnoud Center
Co-Principal Investigator HIV-Medical Homes Resource Center (HIV-MHRC)

Learning Objectives

At the conclusion of this activity, the participant will be able to:

- Describe the Patient Centered Medical Home (PCMH) model, application to RW funded clinics and associated change concepts
- Summarize the history and driving forces behind the PCMH model in the US
- Introduce the HIV-Medical Homes Resource Center (HIV-MHRC)

What is a Patient-Centered Medical/Health Home (PCMH)?

A model for delivering primary care

- Personal primary care provider (PCP)
- PCP directed medical practice
- Whole person orientation
- Care coordinated and/or integrated
- Hallmarks: quality and safety
  - Optimal outcomes / care planning process
  - Evidence-based / standards of care
  - Accountability for CQI

Patient Centered Medical Home

"A blending of aspirations And evidence based building blocks"

"Whatever works in improving patient centered primary care"

A JOURNEY TO TRANSFORMING

PRIMARY CARE — NOT A KNOWN DESTINATION

Pawlson, G., (2011)

History of the PCMH

- Originated in the care of children with special health needs—American Academy of Pediatrics (AAP)1967
- March 2007 Joint Principals of the PCMH: AAP, American Academy of Family Physicians (AAFP), American College of Physicians (ACP), American Osteopathic Association (AOA)
- Has become the model of care supported by ACOs under the Patient Protection and Affordable Care Act (PPACA)

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Primary care challenges that PCMH might help solve:

- Plummeting numbers of new practitioners entering primary care
- Declining access to primary care
- Patient experience (Press Ganey scores) and quality metrics are unsatisfactory
- Practitioner burn-out

Other Driving Forces:

- Prompt access to primary care is a major complaint of patients in the US
- Healthcare Reform
- Ryan White specific:
  - The impending HIV workforce crisis
    - Projected shortage of trained HIV providers
    - Many existing / new primary care generalists not comfortable caring for HIV
    - HIV-specialists lack primary care knowledge
  - Flat funding for HIV
  - Ryan White re-authorization in 2013?

HRSA 2010, Blumenthal 2001, Adams 2010, Fultz 2005

Driving Forces (continued)

POOR CLINICIAN / PATIENT RELATIONSHIPS

73% of adults surveyed reported difficulty getting a prompt appointment, phone advice, or night/weekend care without going to the ER.

Public views on of US health system organization, Commonwealth Fund, 2008

23 seconds: Average time before patients were interrupted when making initial statement of their problem to their PCP

Marvel et al. JAMA 1999;281:283

50% of patients leave the office visit without understanding what their physician said.

Schillinger et al. Arch Intern Med 2003;163:83

INCONSISTENT QUALITY

What percent of people in the US have poorly controlled

- **Hypertension?**
- **Diabetes?** 25%, 50%, 75%?
- **Cholesterol?**

50% of people with hypertension, 80% of people with high cholesterol, 43% of people with diabetes are poorly controlled.

Egan et al. JAMA 2010; 303(20):2043-2050, Ford, Internat'l J Cardiol 2010;140:226, Cheung et al. Am J Med 2009;122:443

Slide 7

d3 dstorm, 10/12/2012

A Functional Definition of Primary Care:

Barbara Starfield Framework

First Contact
Comprehensive
Continuity
Coordination

The Value of Primary Care: (Just As True for Patients with HIV Infection)

- **Accessible**
- **Comprehensive**
  - Co-morbidity
  - Preventive, chronic, urgent, psychosocial care
- **Continuity**
  - HIV a chronic condition
- **Coordination**
  - Integrating specialty and other services

Abundant research evidence indicates that health systems and regions with a strong foundation of primary care have:

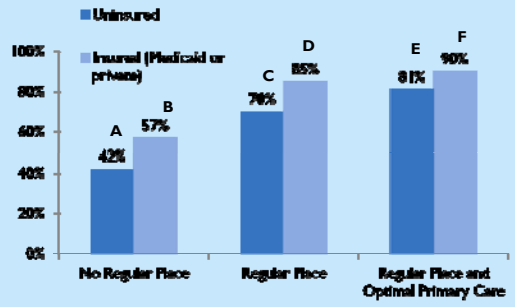
- Better population health outcomes
- Better quality of care
- More preventive care
- Lower costs
- Better patient and provider experience
- More equitable care and mitigation of health disparities

Patient Attitudes Towards Primary Care Physicians

	% Agree	% Disagree	% Don't Know or Uncertain
Value having one PCP	**94**	**2**	**4**
Helpful for PCP to participate in decision to see specialist	**89**	**3**	**8**

Source: Grumbach. JAMA, 1999;282:261

Mean % of Preventive Services Received



Source: Bindman, *J Gen Int Med* 1996;11:269

Affordable Care Act: Measures to Revitalize Primary Care

Physician 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

Training pipeline

- NHSC
- Primary Care Training Grants

PCMH Development, Recognition and Certification

- Private, state and federally funded demonstration projects support PCMH development
- Recognition/certification
  - NCQA
  - The Joint Commission
  - URAC
  - National Ambulatory Care Association
  - 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

- A. **Support Self-Care Process****
- B. Provide Referrals to Community Resources

PCMH5: Track and Coordinate Care

- A. Test Tracking and Follow-Up
- B. **Referral Tracking and Follow-Up****
- C. Coordinate with Facilities/Care Transitions

PCMH6: Measure and Improve Performance

- A. Measure Performance
- B. Measure Patient/Family Experience
- C. **Implement Continuously Quality Improvement****
- D. Demonstrate Continuous Quality Improvement
- E. Report Performance
- F. Report Data Externally

****Must Pass Elements**

What NCQA PCMH Recognition is NOT

- It does NOT define what a PCMH is
- It does NOT substitute for practice transformation activities (only a roadmap)
- It does NOT accredit practices as medical Homes (NCQA, 2011)

– It, only qualifies a practice as having met the basic standards that "predict" being a PCMH

- It is NOT Permanent in content or scoring

– Was designed to evolve over time

Benefits of Certification

- Positions RW funded HIV Clinics to take advantage of financial incentives / 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)

The Medical Home in Ryan White HIV Programs: what positions these programs for success?

Slide 19

d4 dstorm, 10/12/2012

"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. The AIDS Reader, April 24, 2009

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Primary Care Approaches for Patients With HIV

- Integrated into primary care practices serving diverse patient population
- HIV-only practice assuming responsibility for comprehensive primary care
- HIV-only practice delegating non-HIV comprehensive care needs to other providers

Building Blocks of high performing primary care practices:

- Rachel Willard
- Tom Bodenheimer
- Amireh Ghorob

UCSF Center for Excellence in Primary Care

http://www.chcf.org/publications/2012/04/building-blocks-primary-care

Change Concepts for the PCMH

- 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, Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes; February, 2012

Engaged Leadership

- Visible leadership for culture change and QI
- Ensure time and resources for transformation
- PCMH values in staff hiring and training

Empanelment

- Assign all patients to provider panel
- Balance supply and demand
- Use panel data to manage population

Wagner, EH et al, Guiding Transformation: How Medical Practices Can Become Patient-Centered Medical Homes; February, 2012

Continuous and Team-based Healing Relationships

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

Team-based care

- Culture shift: share the care
- Stable teamlets
- Co-location
- Staffing ratios
- Standing orders/protocols
- Defined workflows and roles – workflow mapping
- Training, skills checks, and cross training
- Ground rules
- Communication – healthy huddles, terrific team meetings and constant conversation

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

Patient-Centered Interactions

- Respect patient and family values. Cultural competency
- Encourage patient involvement in health care
- Every interaction supports Self-management
- Patient and family feedback in QI

Enhanced Access

- Ensure 24/7 access to care team
- Provide scheduling options
- 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

Evidence on Value of New Primary Care Models:

Case Study of Group Health Cooperative of Puget Sound

Patient Centered Medical Home model piloted at one site in 2007

- Avg PCP panel size reduced from 2327 to 1800
- Longer face-to-face visits and scheduled time for phone and email encounters
- Increased team staffing and teamwork
- HIT
- Panel management

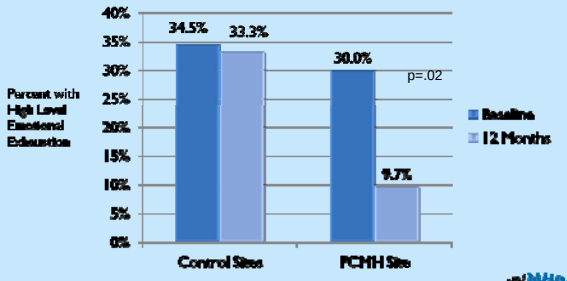
Group Health PCMH Pilot:

Controlled Evaluation 12 Month Outcomes

- Improved continuity of care
- Better patient experiences (6 of 7 measures)
- Better composite quality of care score
- Reductions in ED visits and Ambulatory Care Sensitive Hospitalizations
- No difference in total costs at year 1 (lower total costs by year 2)

Source: R Reid et al. Am J Managed Care 2009;15:e71

Group Health PCMH Pilot: Effect on Clinic Staff



The HIV-Medical Homes Resource Center (HIV-MHRC)

- Provide support to Ryan White grantees and service providers to understand the requirements of and successfully apply for and become certified medical homes.
- Build on the principles of primary care that are at the heart of the patient-centered medical home.
- Funded by the HRSA HIV/AIDS Bureau
- Cooperative Agreement # 11-068 for 3 years (September 2011-2014)
- Targeting Ryan White Funded HIV Clinics throughout the US

HIV Medical Homes Resource Center

François-Xavier Bagnoud Center

School of Nursing, University of Medicine & Dentistry of New Jersey

The Center for Excellence in Primary Care in HIV (CEPC), Department of Family and Community Medicine, University of California at San Francisco

HIV-MHRC Personnel

HRSA/HAB

- Dora Ober, HRSA Project Officer

FXB Center

- Andrea Norberg, MS, RN Co-PI
- Carolyn Burr, EdD, RN Co-PI
- Deborah Storm, MSN, PhD
- Denise Anderson-Carr, MPH, RD
- Macsu Hill, MPH
- Termerra Flournoy

CEPC/UCSF

- Thomas (Tom) Bodenheimer, MD
- Steven (Steve) Bromer, MD
- Ronald (Ron) Goldschmidt, MD
- Kevin Grumbach, MD

HIV-MHRC Needs Assessment

Objectives:

- Inform development of the HIV-MHRC activities and resources
- Characterize RWCA-funded clinics
- Assess PCMH readiness based on practice elements consistent with the PCMH model of care
- Assess interest, actions and progress in PCMH development
- Determine interests and needs for training and technical assistance

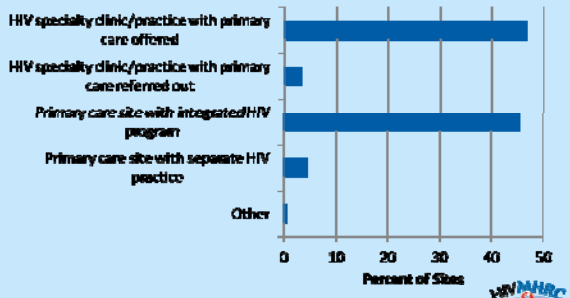
HIV-MHRC Needs Assessment

- 48 item online questionnaire, 2/1-4/2/2012
- Disseminated by email to 554 Ryan White HIV/AIDS program grantees across Parts A, B, C and D
- Challenges in defining total number of potential respondents, dependent on grantees forwarding to funded clinical sites
- Webinar presentation to HRSA project officers, AETC NRC listserv, reminder emails
- Data analysis using SAS version 9.2

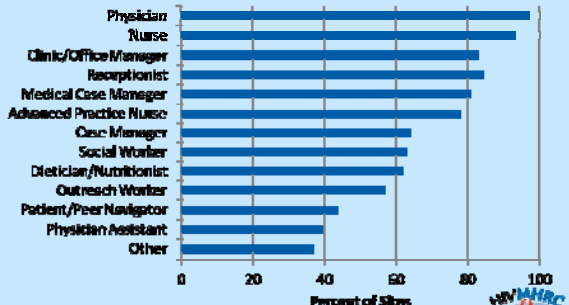
Respondents

- 223 respondents
- 40 states, DC, 3 U.S. territories (PR, Guam, U.S.VI) – all 10 HRSA regions
- Most responses: NY (n=21) and CA (n=14)
- 9 states with at least 10 responses: NY, CA, PA, GA, FL, IL, MA, NJ, NC
- Responses from organizations with more then one funded clinic
- Responses from separate programs in same agency (e.g., pediatric/youth and adult)

Types of Clinics



Multidisciplinary Healthcare Team



Provision of Health Services

Description	In our clinic	In our organization	Referral to outside agency
HIV specialty care	95%	10%	9%
Primary health care	93%	20%	15%
Pap screening	93%	24%	17%
Chronic conditions, e.g., DM, HTN	91%	26%	23%
Medical case management	88%	8%	14%
24 hour on call	79%	19%	10%
Mental health services	73%	27%	39%
Care of hepatitis C virus (HCV)	65%	21%	39%
Dental care	38%	30%	48%
Substance abuse treatment	33%	22%	67%

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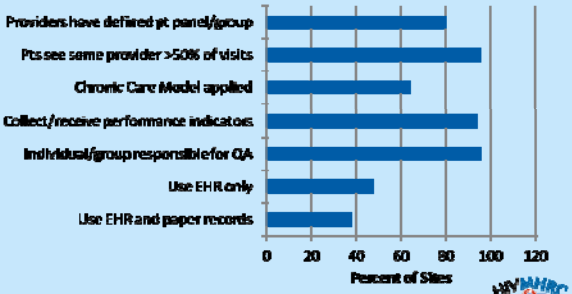
Practice Characteristics that Support the PCMH Model of Care



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Capacity for Practice Change: Systems and Procedures

- *Implementation of electronic health records, e-prescribing*
- *Added an order tree for clinicians to order Ryan White specific labs in the EHR*
- *Applying small red stickers to patients' superbills to remind front desk to make sure patient had received an HIV test prior to checkout*
- *Templates for providers now have more flexibility to allow for same-day slots…for walk ins*
- *Established provider panels*

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Capacity for Practice Change: Focus on Quality and Comprehensive Care

- *[APN] trained to perform routine pap smears*
- *Modified …internal processes related to completing annual well woman exams in our clinic…achieve[d] improvement from 44% in 2009 to 67% in 2011.*
- *HIV testing of pregnant women. A PDSA tested process helped improve and sustain compliance rates from 65% to 100% over the past three years*
- *Rating new patients using an acuity scale and tailoring follow-up contact and frequency of visits based on the scale*
- *Improving retention through a "Missed Visit Protocol" and giving staff specific responsibilities with respect to reminder calls and rescheduling missed appointments*

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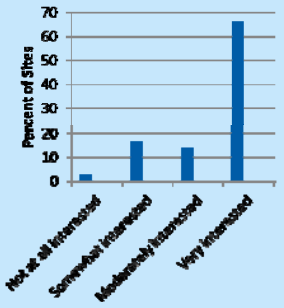
Interest in Obtaining or Maintaining PCMH Recognition/Certification



Reasons for Interest

- Improve quality of care (86%)
- Improve patient outcomes (82%)
- Stay viable/competitive (69%)
- Way of the future (68%)
- Provide motivation and support for advancing change in practice (67%)
- Incentive payments/enhanced reimbursement (63%)

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Current Status of PCMH Recognition/ Certification among Ryan White Grantees

Organization	# Recognized or Certified Sites	# Pending Applications	Locations
NCQA level 1 **NCQA level 2** **NCQA level 3**	3 1 14	13	AR, AZ, CA, CO, CT, IL, MA, MI, NY, TX, VA, WI
The Joint Commission	11	9	AR, CT, FL, IA, IL, LA, MA, NJ, NY, TX, PR
State Program	5	4	ID, LA, MA, NJ, NY, PR
AAAHC	2		CO

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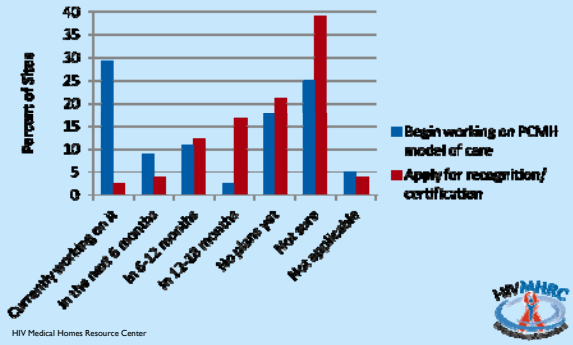
Plans Among Sites Without Current or Pending Recognition/Certification (n=156)



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Actions Taken with Respect to PCMH Recognition/Certification (n=156)

- Seeking information about PCMHs (64%) or PCMH recognition/ certification (42%)
- Discussing with administration and staff (41%)
- Reviewing requirements (39%)
- Assessing clinic/practice readiness (38%)
- Working to align practice/clinic with requirements (25%)
- Implementing necessary practice change (23%)
- Have begun planning process to apply for PCMH recognition/certification (6%)

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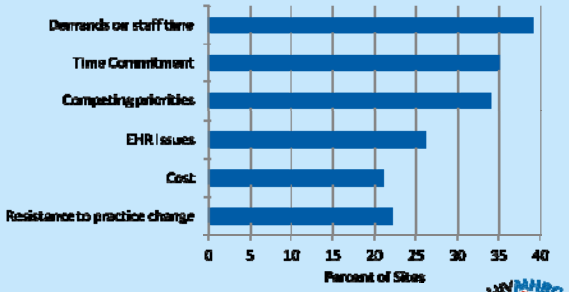
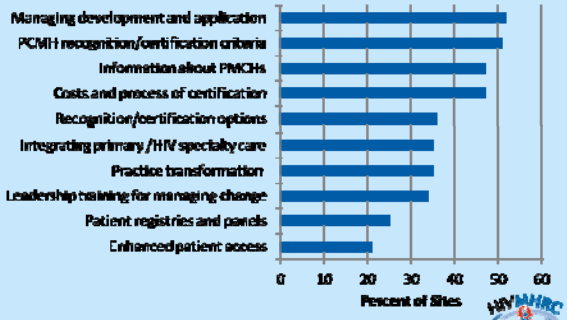
Barriers to PCMH Recognition/Certification



TA and Training Needs



Needs Assessment Summary/Conclusions

- Many characteristics of Ryan White clinics align with key elements of PCMH
- Responses demonstrate widespread interest and readiness for PCMH development and certification among Ryan White clinics, including capacity for practice change
- Sites with current or pending PCMH recognition/certification illustrate progress and provide an important source of expertise within the RWCA program
- Findings provide insights about issues to be considered / addressed in HIV-MHRC training and technical assistance, including
  - Primary care vs. HIV specialty sites
  - Types of recognition/certification
  - Clinics' interests and priorities for training and TA

Strategic Planning Workshops for Ryan White Agencies

Goals:

- Increase participants' knowledge about PCMH
- Develop an agency team that will provide a "critical mass" to promote change within the agency
- Support each agency's development of an initial action plan for achieving PCMH certification
- Provide tools and resources to assist in meeting PCMH requirements

Regional Strategic Planning Workshops Selection of Participants

- Needs assessment responses to assess readiness
- Regional balance vs. high impact
- Community health centers and HIV specialty clinics
- "Very interested/ "Moderately-very familiar" with MH
- 3 - 4 person teams of key leadership – clinical and management
- Year 1: Baltimore, Dallas, Atlanta

Principles Underlying the Workshop Format

- Key leadership needs to be at the table
- Opinion leaders can change agency practice
- Teams are more likely to bring about change than individuals alone
- Experience of peers is influential
- Hands-on practice and clinician support tools ease implementation

Regional Strategic Planning Workshop: Approaches

- Provide presentations by experts to make the clinical and economic arguments for certification as a medical home.
- Enlist local opinion leaders with PCMH experience to discuss feasibility and implementation
- Provide an opportunity for each agency to assess its strengths and weaknesses in making change particularly as related to PCMH
- Facilitate development of an action plan for moving forward with PCMH certification

Agenda for the Strategic Planning Workshops: Day 1

- Keynote: Clinical and economic rationale for PCMH
  - Expert presentation
- Lessons from the field panel
  - Implementation stories from experienced peers
  - Panelists
  - Level 3 NCQA certified
- SWOT analysis – Agency teams

Agenda for the Strategic Planning Workshops: Day 2

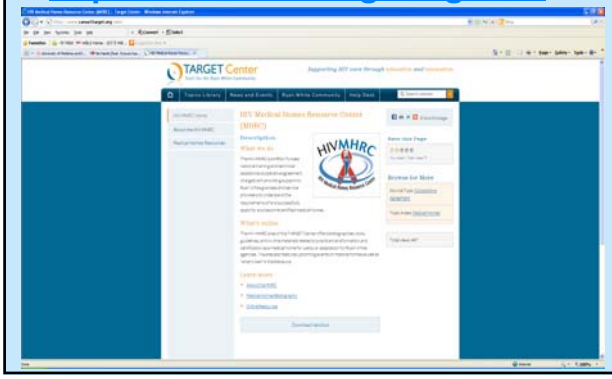
- "Change Concepts" – interactive exercise
  - Mixed agency teams
  - Focus on the 8 concepts of PCMH
  - Identify key changes
  - Develop a wild success story of what a successful transformation to a PCMH would look like from a specified perspective (i.e. from MD, RN, MA, front desk, social worker, consumer)
  - Report to large group

Agenda for the Strategic Planning Workshops: Day 2

- Team Huddle – Agency Teams
  - What do we need to focus on when we get home?
  - Who will go to which workshops?
- Breakout workshops
  - Leadership for Practice Change
  - Team-based Care
  - Patient-Centered Care/Self-management
- Action Planning – Agency Teams
- Sharing of Action Plans

Resource Repository

http://www.careacttarget.org/mhrc



On-Going Technical Assistance (TA)

- Baseline TA
  - Strategic Planning Workshops:
  - Two in year 2: west coast and northeast coast
- Beginner TA: referrals, guidance to resources
- Intermediate TA: Beginner + webinars
  - 1st webinar in December 2012 "Using Documentation to Capture Your Gains in Practice Transformation"
- Advanced TA: Intermediate + regular conference calls and/or site visits (based on nature of request)

Discussion topics

As a nurse what do you see as the strengths, weaknesses, opportunities and threats of this practice delivery model?

Who should lead the medical home?

What do you think about AAFP's statement that physicians should only be permitted to lead the medical home?

Change Concepts Exercise:

Envisioning a successful implementation of the change concepts in clinical practice

Thank You