USCA Summit to End AIDS

The Role of Medical Homes in HIV Care

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Patient Centered Medical Home (PCMH): Key Features

1. Patient-centered
2. Comprehensive
3. Coordinated
4. Accessible
5. Committed to quality and safety

### PCMH 2011 Content and Scoring

<table>
<thead>
<tr>
<th>PCMH 1: Enhance Access and Continuity</th>
<th>Pts</th>
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<tbody>
<tr>
<td>A. Access During Office Hours**</td>
<td>4</td>
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<tr>
<td>B. After-Hours Access</td>
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<tr>
<td>C. Electronic Access</td>
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<tr>
<td>D. Continuity</td>
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<tr>
<td>E. Medical Home Responsibilities</td>
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<tr>
<td>F. Culturally and Linguistically Appropriate Services</td>
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<tr>
<td>G. Practice Team</td>
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<tr>
<th>PCMH 2: Identify and Manage Patient Populations</th>
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<tr>
<td>A. Patient Information</td>
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<tr>
<td>B. Clinical Data</td>
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<tr>
<td>C. Comprehensive Health Assessment</td>
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<tr>
<td>D. Use Data for Population Management**</td>
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<th>PCMH 3: Plan and Manage Care</th>
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<tr>
<td>A. Implement Evidence-Based Guidelines</td>
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<tr>
<td>B. Identify High-Risk Patients</td>
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<tr>
<td>C. Care Management**</td>
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<td>D. Manage Medications</td>
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<tr>
<td>E. Use Electronic Prescribing</td>
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<th>PCMH 4: Provide Self-Care Support and Community Resources</th>
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<tr>
<td>A. Support Self-Care Process**</td>
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<td>B. Provide Referrals to Community Resources</td>
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<th>PCMH 5: Track and Coordinate Care</th>
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<tr>
<td>A. Test Tracking and Follow-Up</td>
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<tr>
<td>B. Referral Tracking and Follow-Up**</td>
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<td>C. Coordinate with Facilities/Care Transitions</td>
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<th>PCMH 6: Measure and Improve Performance</th>
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<tr>
<td>A. Measure Performance</td>
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<tr>
<td>B. Measure Patient/Family Experience</td>
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<tr>
<td>C. Implement Continuously Quality Improvement**</td>
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<td>D. Demonstrate Continuous Quality Improvement</td>
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<td>E. Report Performance</td>
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<td>F. Report Data Externally</td>
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**Must Pass Elements: A, C, D, E, F**
Essential Components of Effective HIV Care: A Policy Paper of the HIV Medicine Association of the Infectious Diseases Society of America and the Ryan White Medical Providers Coalition

Program Sustainability
- Access to Care
- Ryan White
- Public & Private Coverage
- Provider Reimbursement

Patients
- Adherence to Rx
- Adherence to Care
- Enhanced Quality of Life
- Improved Immune Status
- Risk/Harm Reduction
- Virologic Control

Service Delivery & Integration
- HIV Testing
- Linkage to Care
- Engagement & Retention in Care
- Access to Rx
- Medication Adherence Support
- Medical Case Management
- Co-located Social Services
- Public Health & Community Agencies

Quality Improvement
Performance Standards
Practice Guidelines

Electronic Health Records

Healthcare Team
- HIV/Primary Care Provider
- Specialty Medical Care
- Clinical Pharmacist
- Care Coordinator
- Oral Health
- Nursing

Support Services
- Alcohol and Drug Tx
- Drug Assistance
- Housing
- Legal Services
- Secondary Prevention Counseling
- Nutrition Counseling
- Pharmacy
- Psychosocial
- Mental Health

Electronic Health Records
Quality Improvement Performance Standards Practice Guidelines
Growing Evidence on PCMH

• PCMH improves low-income access, reduces inequities
  Berenson, Commonwealth Fund, May 2012

• PCMH improves quality and patient satisfaction, lowers costs
  PCPCC, September 2012

• Medicaid Pilots: Improved access to care, reduced PMPM/PMPY costs, decreased ER and inpatient utilization, great use of evidence-based primary care
  Takach 2011

NCQA. Facilitating PCMH Recognition. July 16-17, 2013
ACA & PCMH Care: Medicaid Health Homes

- 2011 New State Plan Option
- Target individuals with 2 or more chronic conditions
- 90% enhanced federal match for 2 years
- Guidance references HIV -- Nov 2010
- Sec. Sebelius announces rule will include HIV -- Dec 2012

Read the 2010 Guidance:
Medicaid Health Homes: Status Update

- 17 Approved in 12 States
- 4 Are HIV-specific
  - New York (10,000 enrollees)
  - Oregon dual eligibles with HIV
  - Washington State (approved July 2013)
  - Wisconsin (limited geographically, expected to enroll 600)

Source: Email Communication. 9/6/13. CMCS. Division of Integrated Health Systems.
43 States Promoting PCMH

http://www.nashp.org/med-home-map
Where Are Ryan White Clinics?

Estimated PCMH Status of RW Clinics - 2012

- 20% Pursuing or Recognized
- 80% Not Yet

Many More Well Positioned to Become PCHM

- 7% refer for primary care
- 50% HIV Primary Care Clinic
- 50% HIV Specialty Clinic

85% of Survey Respondents Used EMRs

10% have separate HIV practices

Ryan White Clinics - Early Adopters of the PCMH

• **Who they are**
• Why they decided to become a PCMH
• Strategies that they used to transform to a PCMH
• What they learned

• **Benefits**

Excerpts from *Should We Become a Patient-Centered Medical Home (PCMH)? An Introduction to the PCMH model and its role in Ryan White Clinics*. View full webinar at: [https://careacttarget.org/library/should-we-become-patient-centered-medical-home-pcmh-introduction-pcmh-model-and-its-role-0](https://careacttarget.org/library/should-we-become-patient-centered-medical-home-pcmh-introduction-pcmh-model-and-its-role-0)
Ryan White Clinics-
Early Adopters of the PCMH

- University of Florida Center for HIV/AIDS Research, Education and Service (UF CARES), Jacksonville, Florida
- Harris County Health System, Thomas Street Health Center, Houston, Texas
- Metro Community Provider Network, Denver, Colorado and surrounding area
- Callen Lorde CHC, New York, New York
- Hudson River Health Care, Hudson Valley and Long Island, New York
- Inova Juniper Program, Springfield, Virginia
Early Adopters - Benefits

• Increased patient engagement
• Increased quality of care
• Improved patient flow and shortened wait times for patients
• Opened doors for new funding
The Opportunities

• Create integrated care networks = improved partnerships between RW programs along the continuum
• Lead revolution in chronic care management
• Diversify funding and develop sustainable financing models
• Improve PWA health outcomes – quality of life

Center for Medicare and Medicaid Innovation – Health Care Innovation Awards – Round Two?
A Big Thank You to the HIV Medical Homes Resource Center – HIV-MHRC

More Resources Available at https://careacttarget.org/mhrc
Learn More

http://www.pcpcc.org/

http://www.safetynetmedicalhome.org/