HIV Prevention and Health Care Reform: Becoming a Patient Centered Medical/Health Home

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JSI Research & Training Institute, Inc.

Public health consulting company

- Involved in HIV prevention and care since the beginning of the epidemic

Capacity building assistance (CBA) provider

- Organizational Infrastructure
- Effective Behavioral Interventions
- Monitoring and evaluation

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Learning Objectives

- Identify at **least three key components** of a patient-centered medical/health home (PCHH).
- Identify **key steps** an organization can take to assess their “health homeness”.
- Describe at le**ast three attributes** of organizations that have successfully transitioned to PCHHs.

Medical Home Terminology

- The Center for Medicaid and Medicare Services - Health Homes
- National Committee for Quality Assurance (NCQA) and the Accreditation Association of Ambulatory Health Care (AAAHC) - Patient Centered Medical Home
- Joint Commission - Primary Care Medical Home

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General Health Home Definition

- "A Health Home provides an **easy-to-use** point of entry into the health care system, **coordinates** ongoing, **comprehensive** medical care that is appropriate and consistent with the patient's **needs and values**, and places the **patient at the center** of all choices concerning their care. The Medical Home's structure supports the patient establishing and maintaining **long-term relationships** within the medical team and other community-based resources while utilizing **health information technology** and other innovations to provide **seamless and timely** access to **all essential care**."

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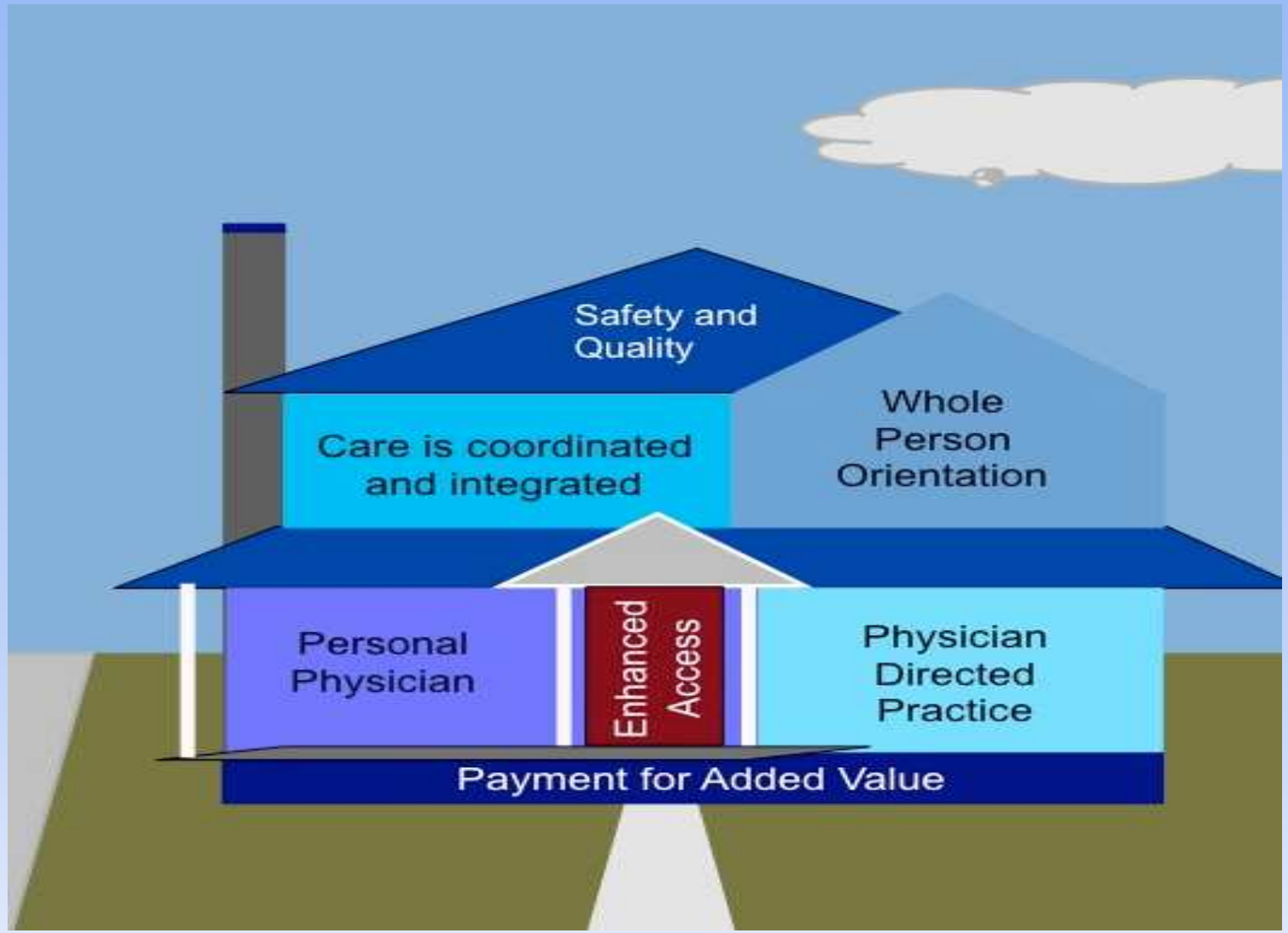
Joint Principles of the Medical Home

(Adopted by AAFP, ACP, AAP, AOA)



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Motivation to become a PCHH

- In response to national trends and enhanced reimbursement
- Enhanced integration and coordination of care
- Improved clinical outcomes
- Higher quality of care
- A health home supports practices of an HIV care site

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Scenarios for PCHH Involvement

- Directly apply for recognition/accreditation if broad range of services is provided, including medical care
- Form strategic alliances with clinical practices
- Partner with an existing or new health home

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Steps to Consider to Become a PCHH

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Is Becoming a PCHH Right for You?

1. Is PCHH Consistent with Mission?
2. Are Strategic Alliances Needed?
3. Create a PCHH Leadership Team
4. Envision your Ideal HH

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Is Becoming a PCHH Right for You?

1. Ensure that becoming or being a part of a health home aligns with your organization's mission.
2. Determine if you can become a health home independently or if you need to form strategic alliances to do so.
3. Create a Project Leadership team with representation from across the organization and partner organizations (if applicable).

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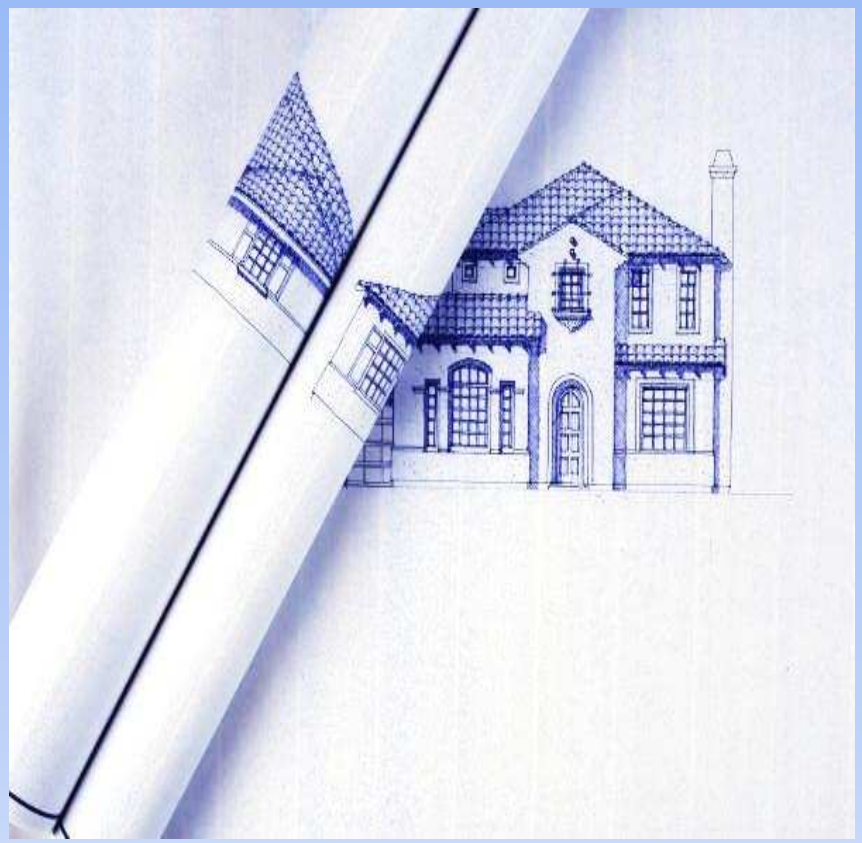
Is Becoming a PCHH Right for You? (continued)

4. Create a vision for what you think a transformed health home would look like for your organization and partners (if applicable).



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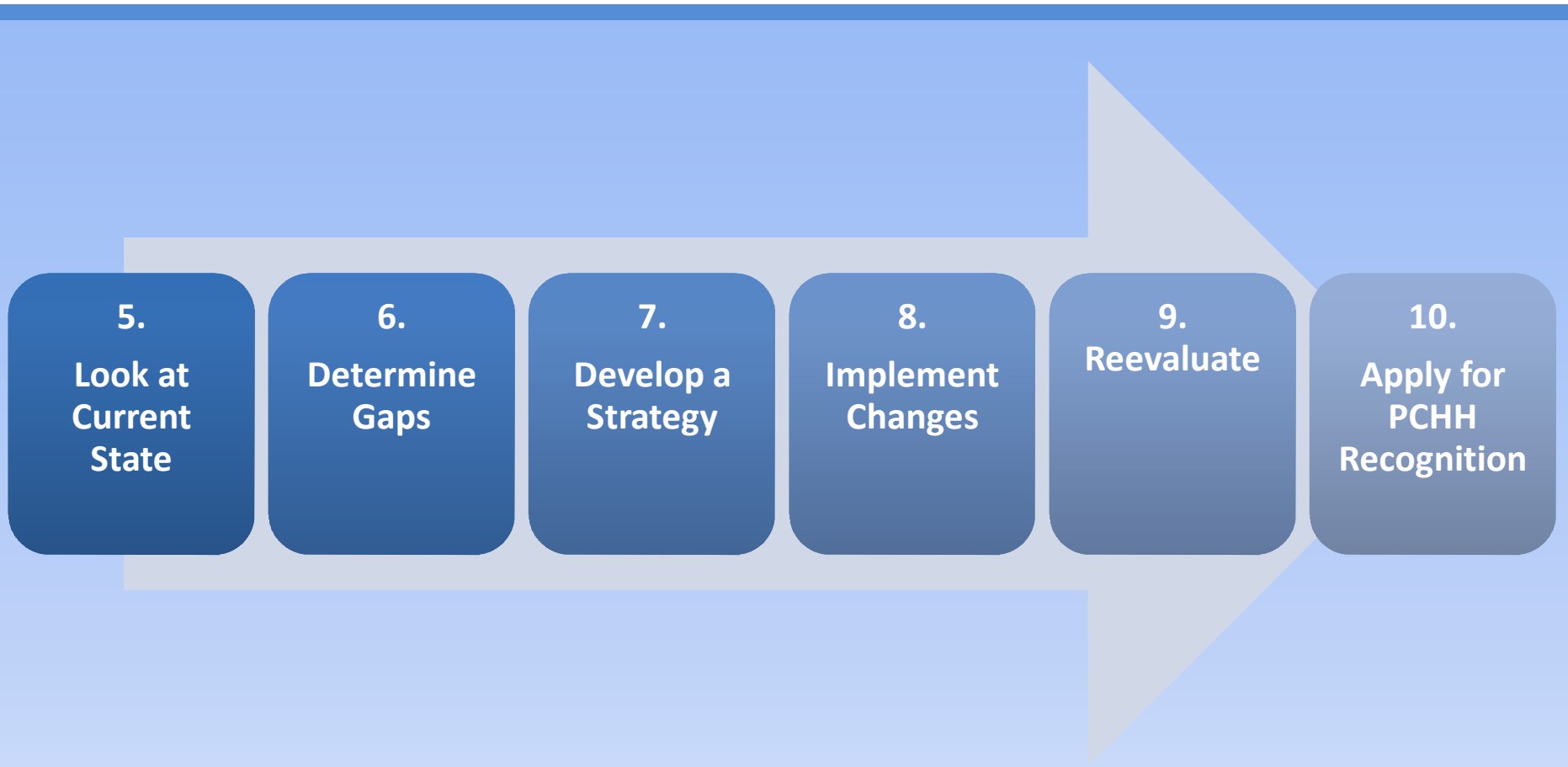
Steps to Become a PCHH



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Steps to Become a PCHH

5. Look at your current organizational practices, e.g. processes, policies, and resources (internal and external).
6. Determine your gaps between your current state and your vision and reevaluate.
7. Develop a strategy (a roadmap), including a timeline, of how you will close the gaps.

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Steps to Become a PCHH (continued)

8. Implement changes.

9. Reevaluate your new state, making necessary tweaks as you go.

10. Apply for state and/or national recognition.

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Main Recognition/ Accreditation Programs

- NCQA - National Committee for Quality Assurance
- AAAHC - Accreditation Association of Ambulatory Health Care
- JCAHO - Joint Commission
- State Specific Recognition Programs

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Sample State Recognition Programs

- Oregon's **Patient Centered Primary Care Home**, certifies, funds and manages practices that operate a health homes.
- **The Colorado Medical Home Initiative,** based on the CO Medical Home Standards, focuses on children.
- Connecticut's Medicaid department provides **payment incentives** to practices and clinics that demonstrate a higher standard of person centered medical care.

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NCQA Standards

PCMH 1: Enhance Access/Continuity

PCMH 2: Identify/Manage Patient Populations

PCMH 3: Plan/Manage Care

PCMH 4: Provide Self-Care Support/ Community Resources

PCMH 5: Track/Coordinate Care

PCMH 6: Measure/Improve Performance

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NCQA MUST-PASS ELEMENTS

PCMH 1 – Element A: Access During Office Hours

PCMH 2 – Element D: Use Data for Population Mgmt

PCMH 3 – Element C: Care Management

PCMH 4 – Element A: Support Self-Care Process

PCMH 5 – Element B: Referral Tracking and Follow-Up

PCMH 6 – Element C: Implement CQI

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NCQA PCMH Recognition Scoring

- Three levels of recognition
- The point allocation is as follows:
    I. Level 1: 35–59 points and all 6 must-pass elements
    II. Level 2: 60–84 points and all 6 must-pass elements
    III. Level 3: 85–100 points and all 6 must-pass elements

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Financing for PCHH

Federal:

- Federal funds are available to States for some health home initiatives
  - Grants: CMS dually diagnosed demonstrations – health home waivers (includes HIV)
  - Federal matching for state investments

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Financing for PCHHs (continued)

State:

- Many states have programs that pay providers for PCHHs:
  - Payments made to networks/MCOs or directly to providers depending on how care is organized in the states
- Many states also provide training/technical assistance to support transformation to a health home model.

Financing for PCHHs (continued)

Private:

- Private payers, including MCOs, may have similar reimbursement mechanisms for their network providers, and/or private Medicare or Medicaid providers.
- May also be participating in Medicare Health Home reimbursement strategies.

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Financing for PCHHs (continued)

Grant funds:

- National foundations and/or Federal bureaus establishing pilots (Safety Net Medical Home Initiative)
- State and local foundations
- Private donors (including hospitals needing to demonstrate community benefit)

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Yumiko Fukuda, LMSW

Chief Operating Officer

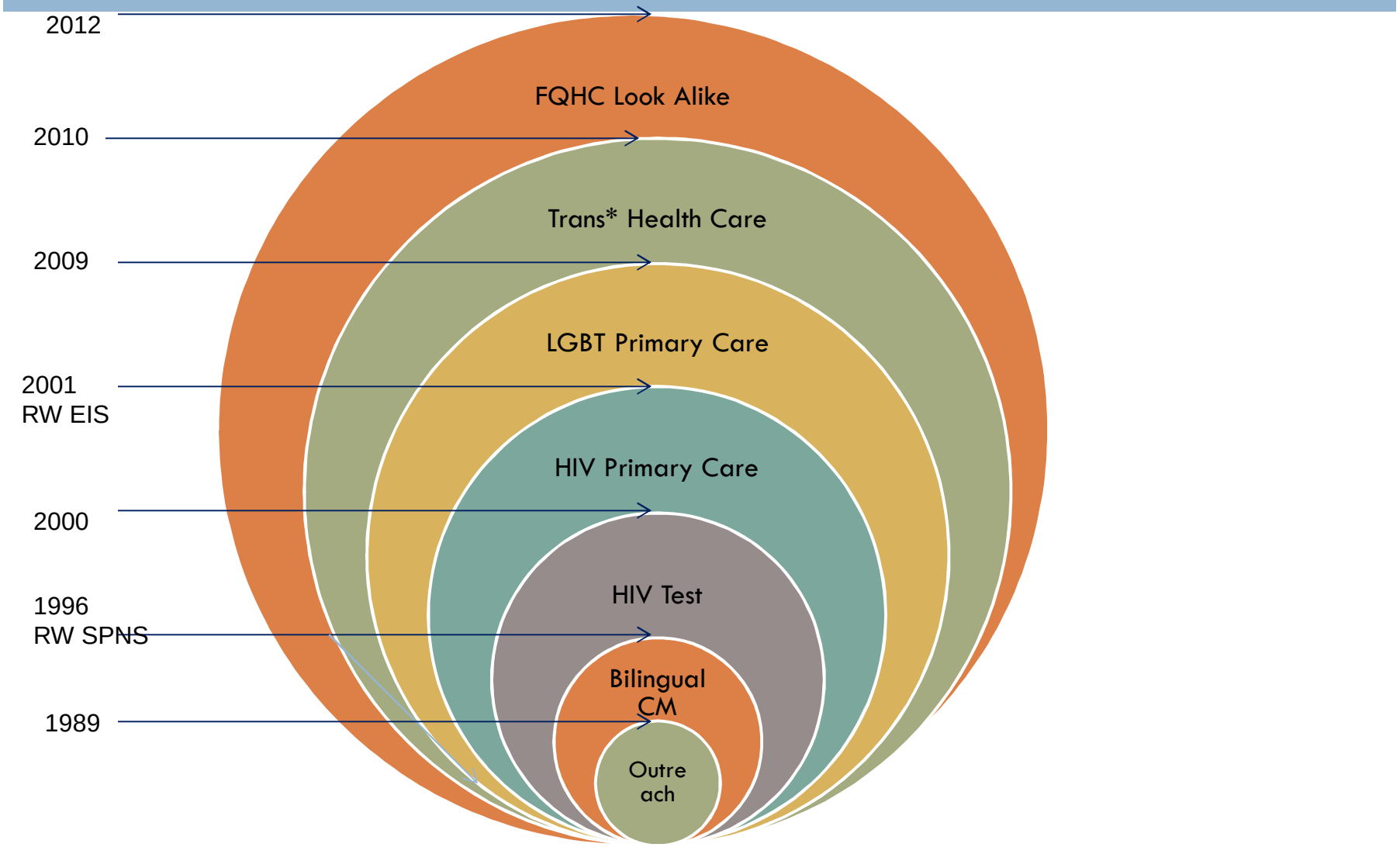
APICHA's Mission Statement

To improve the health of our community and to increase access to comprehensive primary care, preventive health services, mental health and supportive services. We are committed to excellence and to providing culturally competent services that enhance the quality of life.

APICHA advocates for and provides a welcoming environment for underserved and vulnerable people, especially Asians & Pacific Islanders, the LGBT community and individuals living with and affected by HIV/AIDS.

(revised 2010)

Evolution of APICHA



APICHA Community Health Center Medical Home Model

Success

- Expanding HIV model of care to other population and sustaining services to HIV infected and high risk patients
- Volume increase
  - 99 HIV patients in 2007 to 401 HIV patients in 2012
- Quality indicators (2012)
  - 94.3% of patients are retained in care
  - 87.8% of patients are on ARV
  - Viral load suppression: 93% of those on ARV

Key to Success

- Morning Huddle with PCP, clinic support staff, CMs, MH
- Weekly multidisciplinary meeting
- Monthly case conference: MH, CMs, PCP
- MH and PCP meeting twice a month
- Use of EMR (APICHA CHC is Patient Centered Medical Home Level 3)
- Participation of HIV prevention staff at multidisciplinary meeting to ensure access to care for HIV positive and very high risk.

Recommendations

- Leadership buy-in especially from CEO and CMO
- Needs Champion in certification process
- Technical Assistance from CHC Network et al
- Explore possibility to collaborate with existing health centers if not interested in providing medical care

Resources

- NCQA Patient-Centered Medical Home Recognition - http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx
- AAAHC Medical Home Certification - http://www.aaahc.org/accreditation/primary-care-medical-home/
- The Joint Commission Primary Care Medical Home Certification – http://www.jointcommission.org/accreditation/pchi.aspx
- Advanced Primary Care Practice link: http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Medicare-Demonstrations-Items/CMS1230557.html
- CMS Health Homes for Medicaid Enrollees with Chronic Conditions - http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

Thank you

for your time and participation!

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