THE PATIENT CENTERED MEDICAL HOME:
A Model for Improving Access & Engagement in Care for HIV and HCV Patients

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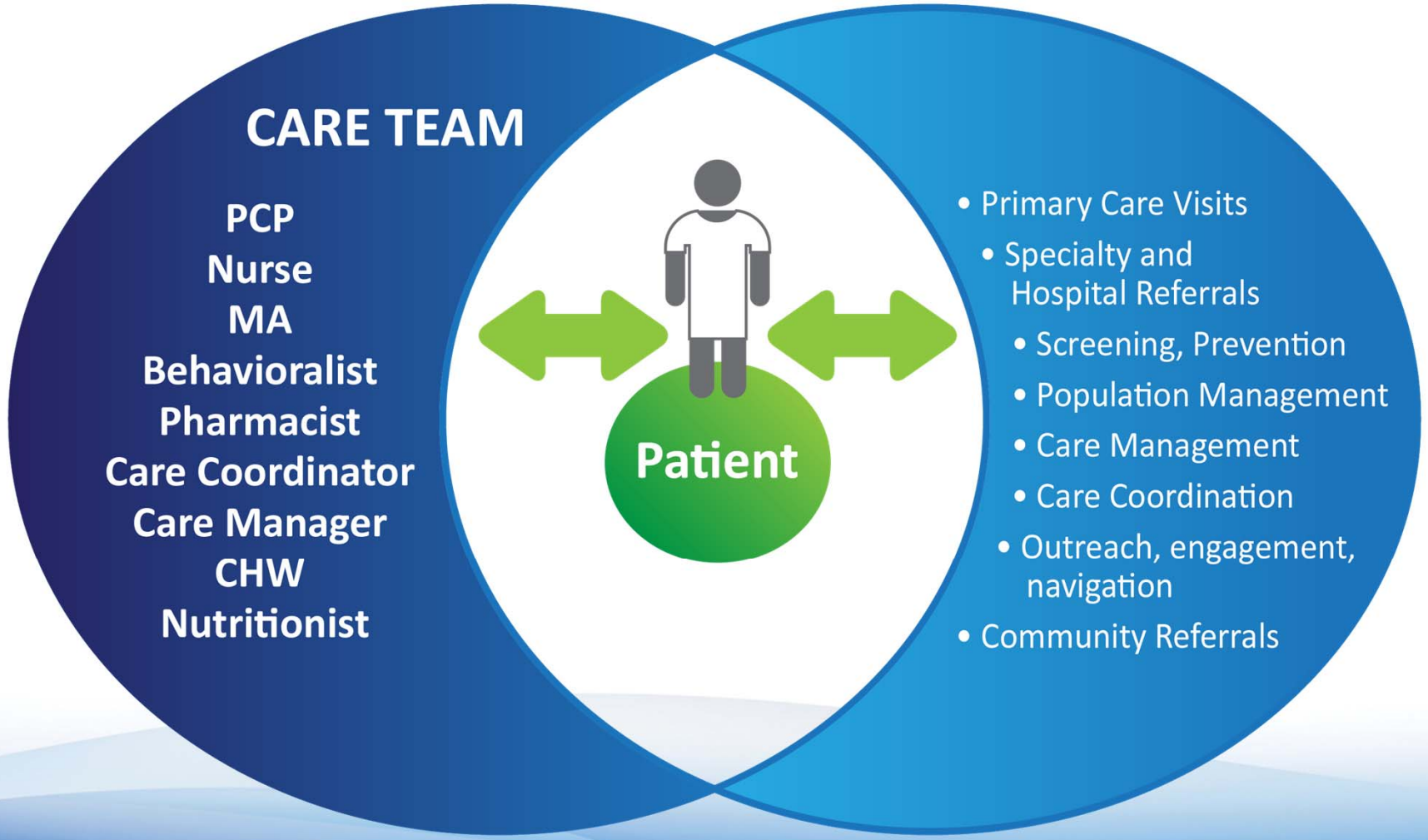
Pro-Active Multidisciplinary Team-based Care



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NCQA PCMH 2014 Content and Scoring

1: Enhance Access and Continuity	Pts
A. *Patient-Centered Appointment Access	**4.5**
B. 24/7 Access to Clinical Advice	3.5
C. Electronic Access	2
	10

2: Team-Based Care	Pts
A. Continuity	3
B. Medical Home Responsibilities	2.5
C. Culturally and Linguistically Appropriate Services (CLAS)	2.5
D. *The Practice Team	**4**
	12

3: Population Health Management	Pts
A. Patient Information	3
B. Clinical Data	4
C. Comprehensive Health Assessment	4
D. *Use Data for Population Management	**5**
E. Implement Evidence-Based Decision-Support	4
	20

4: Plan and Manage Care	Pts
A. Identify Patients for Care Management	4
B. *Care Planning and Self-Care Support	**4**
C. Medication Management	4
D. Use Electronic Prescribing	3
E. Support Self-Care and Shared Decision-Making	5
	20

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

6: Measure and Improve Performance	Pts
A. Measure Clinical Quality Performance	3
B. Measure Resource Use and Care Coordination	3
C. Measure Patient/Family Experience	4
D. *Implement Continuous Quality Improvement	**4**
E. Demonstrate Continuous Quality Improvement	3
F. Report Performance	3
G. Use Certified EHR Technology	0
	20

Scoring Levels

Level 1: 35-59 points.
Level 2: 60-84 points.
Level 3: 85-100 points.

*Must Pass Elements

PCMH Payment Mechanisms

Initiative	Payment
Vermont Blueprint for Health Integrated Medical Home	$1.20-$2.39 pmpm based on NCQA tier Payers share cost of Community Care teams HIE provided
CSI-Rhode Island (Multi-payer)	$3 pmpm to practices Additional allocation for practice-based care manager
Minnesota Health Care Homes	Risk adjusted care coordination pmpm: average $31.39 pmpm
Massachusetts	**MA PCMHI:** $3 pmpm and shared savings **PCPR:** risk adjusted primary care and behavioral health global payment: $34.78 – $58.58 pmpm

PCMH Evidence Base

- Moderately strong evidence suggests:
  - Small positive effect on patient experiences
  - Small to moderate effect on preventive care services
  - Small to moderate effect on staff experiences (low strength of evidence)
- Most studies evaluated effects in older adults with multiple chronic illnesses
- Conclusion: Current evidence is insufficient to determine effects on clinical and most economic outcomes.

Jackson GL, Powers BJ, Chatterjee R, et al. The patient-centered medical home: a systematic review. *Ann Intern Med. 2013;158(3):169-178.*

HIV/HCV PCMHS

TYPE OF PCMH	NUMBER or PERCENT	Comment
PMCH Recognized FQHC	61%	At least one site PCMH recognized
PCMH recognized RWCA funded clinics	36 (26 pending)	2012 data
Medicaid Health Homes	19 states	5 include HIV and/or HCV
Medicaid/CHIP PCMH Initiatives	46 states	Since 2006
National PCMH Demonstrations	3 active	Comprehensive Primary Care Initiative Multipayer Advanced Primary Care Practice VA Patient Aligned Care Team
Dual eligible demonstrations	12 states	
Hepatitis C demonstration project	6 practice teams	FQHCs in New York State

Innovative Approaches to Accessing Specialty Care

- Telemedicine
  - Project ECHO-
    - Support HCV treatment throughout New Mexico through a TeleECHO Clinic.
    - Now in 9 states, 3 countries, VA, Department of Defense
  - Medicaid reimbursement for telemedicine – 45 states
- eConsults/eReferral

MA PCMHI Qualitative Evaluation: 5 Factors Contributing to Transformation

- Sequence of core competency adoption
- Strong leadership and staff buy-in
- Focus on staff capacity and resources
- Electronic Medical Record (EMR) proficiency
- Active use of available technical assistance and peer learning
- Inclusion of behavioral health integration in each component of the PCMH model

PCMH Resources

- HRSA Accreditation and Patient-Centered Medical Recognition Initiative
- HRSA/CDC collaboration - $9 million awarded to 22 CHCs to advance HIV/AIDS care- 3 year initiative, announced Sept, 2014
- AHRQ PCMH Resource Center
- RWCA Target Center
  - National Center for Innovation in HIV Care
  - Medical Homes
  - Hepatitis C Care