Patient Centered Medical Home: The VA Experience

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<table>
<thead>
<tr>
<th>Alberta</th>
<th>VA</th>
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<tr>
<td>• 4.2 Million People</td>
<td>• 5.5 Million Veterans</td>
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<td>• +/- Universal coverage</td>
<td>• Selective coverage (~50% eligible)</td>
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<td>• 36.1 years (median)</td>
<td>• 63.5 years (mean)</td>
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<tr>
<td>• ~50% male</td>
<td>• 94% male</td>
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<td>• 17% rural</td>
<td>• 40% rural</td>
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<td>• $20 billion</td>
<td>• $47 billion</td>
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<td>• 83% of physicians FFS</td>
<td>• 0% of physicians FFS</td>
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<td>• ~75% have private insurance</td>
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<td></td>
<td>• <strong>Extensive infrastructure</strong></td>
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<td>• 150 hospitals</td>
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<td>• 971 outpatient clinics</td>
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<td>• 133 nursing homes</td>
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Conclusions

• Healthcare Systems (i.e., payors, providers, patients) need to consider all dimensions of **Access** as we strive for higher quality and better health

• The **Patient Centered Medical Home** is one innovation that has promise to improve Access, quality, and health
  – Challenging to implement
  – Gains will be slow and modest
  – Adoption will need to match incentives if moving from Fee-for-service
Access: Definition


• New 21st Century Definition (Fortney, et al. JGIM)

• **Access to Care** represents the potential ease of having virtual or face-to-face interactions with a broad array of healthcare providers including clinicians, caregivers, peers, and computer applications.
  
  – **Actual**: represents those directly-observable and objectively measurable dimensions of access.
  
  – **Perceived**: represents those self-reported and subjective dimensions of access.
New Framework/Model for Access

• Set of specific dimensions that characterize the fit between the patient and the healthcare system
• Less focus on patient-to-provider face-to-face encounters
• Perceived and Actual Access
• Dimensions of access:
  – Geographical
  – Temporal
  – Digital
  – Financial
  – Cultural
Actual Access to Care

- **Geographical**
  - Travel distance/time
- **Temporal**
  - Time to next appointment
  - Waiting time in reception
- **Financial**
  - Eligibility
  - Out of pocket costs
- **Cultural**
  - Language match
  - Provider stigma
  - Public stigma
- **Digital**
  - Connectivity

Perceived Access to Care

- **Geographical**
  - Ease of travel
- **Temporal**
  - Time convenience
- **Financial**
  - Eligibility complexity
  - Affordability
- **Cultural**
  - Understandability
  - Trust
  - Self Stigma
- **Digital**
  - Connectivity opportunities
  - Usability and privacy

Perceived Need for Care

- Symptom burden
- Susceptibility
- Stoicism
- Treatment efficacy
- Self efficacy
Measuring Access: Actual v. Perceived

**Actual**
- Directly observable
- Objectively measurable
- Predictive validity
- Reliable
  - Distance
  - Wait times
    - All waiting is not equal or bad
  - Co-payments
    - $9 Rx, $50 clinic, $900 inpatient

**Perceived**
- Capture patient perceptions about the opportunity and ease associated with seeking treatment
  - Travel ease
    - Mileage or VA Transport System
  - Appointments when requested
  - Co-payment burden
  - Usability of computer apps
1. Synchronous patient-to-provider encounters
   • Phone, video (26 states require comparable payment)
2. Asynchronous patient-to-provider communications
   • IVR, text, email, personal monitoring devices
3. Peer-to-peer communications
   • Patients: chat rooms, on-line forums, social networking
   • Providers: e-consults, store-and-forward imaging
4. Synchronous interactions between patients and health apps
   • Kiosks, personal health records, health behavior apps (e.g., cognitive behavioral therapy)
Patient Portals: MyHealthyVET

In the Spotlight

HIV: Did You Know...?
December 2011

The first cases of Acquired Immunodeficiency Syndrome or AIDS were reported by the Center for Disease Control and Prevention on June 5, 1981. Some of the first cases were diagnosed by VA doctors. Since then, VA has been a leader in HIV/AIDS care. HIV/AIDS is no longer a death sentence but a treatable, chronic disorder that can be managed in the same way as diabetes and hypertension (high blood pressure). There is no cure for HIV/AIDS. But with treatment, patients live much longer and healthier lives, in some cases, well into retirement. Read More »

Talking to your Health Care Provider about Human Immunodeficiency Virus (HIV)

Talking with your health care provider about HIV and HIV testing is important. Many people who have HIV infection do not have any signs or symptoms of the disease for many years. Read More »

A Veteran's Story: Living 25 Years with HIV

In 1986, I was diagnosed with HIV. Participating in my own health care and being aware of the importance of my own attitude and actions has enabled me to live with this disease successfully. Read More »

Dealing with Job Loss over the Holidays

The holidays can be an especially hard time to deal with the loss of a job or an income. Sadly, many Americans this holiday season are faced with inadequate employment and are struggling to make ends meet. This includes Veterans. In fact, post-9/11 Veterans who are known to suffer a particularly high rate of unemployment. One reason may be that recent Veterans are often best equipped to work in jobs that the recession has hit the hardest. No matter the reason, loss of a job or an income can have a far-reaching impact. Learn More »
Distance was #1 access barrier by patients and staff.

Patient health status, resources, preferences, transportation.

Complexity and urgency of services needed:
- Low complexity (e.g., podiatry, labs, prosthetics)
- High complexity (e.g., cancer care, neurosurgery)
- Emergency/after hours care

“You don’t know rural ‘til you know 40 miles from a gallon of milk. Now that’s rural.” Veteran in South Dakota
Access

“Can we buy our way out of this problem? If so, then it isn’t a problem.”
Aggregate State Quality Rankings for 24 Indicators and Medicare Spending

Baicker & Chandra, Health Affairs, 2004

Overall quality ranking

Annual Medicare spending per beneficiary (dollars)


NOTE: For quality ranking, smaller values equal higher quality.
Conclusions: Re-conceptualization of Access to Care

• Measurement is important, for both Actual and Perceived Access:
  – Patient perception may be as important as actual access

• More is not always better:
  – We can’t buy our way out of this problem

• Tele-health and digital apps can help Access

• Access and outcomes are hard to measure:
  – Even harder to link

• At the extremes:
  – NO Access is bad; Excessive Access is wasteful
Does the Patient-Centered Medical Home Improve Access?
VHA - Largest integrated health care system in the US

5.5 million primary care patients

- 21 Networks (VISNs)
- 152 Medical Centers
- 971 Outpatient Clinics
- 802 Community-Based
- 152 Hospital-Based
- 11 Mobile
- 6 Independent
- 293 Vet Centers
- 98 Domiciliary Residential Rehabilitation Programs
- 133 Community Living Centers
Other Team Members
Clinical Pharmacy Specialist: ± 3 panels
Clinical Pharmacy Anticoag: ± 5 panels
Social Work: ± 2 panels
Nutrition: ± 5 panels
Specialty Case Managers
Trainees
Integrated Behavioral Health
Psychologist ± 3 panels
Social Worker ± 5 panels
Care Manager ± 5 panels
Psychiatrist ± 10 panels

For each parent facility
Health Promotion Disease Prevention Program Manager: 1 FTE
Health Behavior Coordinator: 1 FTE
Patient Portal Coordinator: 1 FTE

Teamlet: assigned to 1 panel (±1200 patients)
- Provider: 1 FTE
- RN Case Mgr: 1 FTE
- Clinical Associate: 1 FTE (LPN, MA)
- Clerk: 1 FTE

The Patient’s Primary Care Team
Patient Caregiver

PACT
PATIENT ALIGNED CARE TEAM
What does a VA Medical Home look like?

- Patient
- Provider (MD, DO, APRN, NP, PA)
- RN Care Manager
- Clinical Associate (LPN)
- Clerical Associate

Team
- Teamlet
- Neighbors
- Teamlet
- Teamlet
- Teamlet
- Teamlet
- Teamlet

VETERANS HEALTH ADMINISTRATION
Patient Aligned Care Team

Access
- Offer same day appointments
- Increase shared medical appointments
- Increase non-appointment care

Care Coordination and Management
- Focus on high-risk patients
  * Identify
  * Manage
  * Coordinate
- Improve care for:
  * Prevention
  * Chronic disease
- Improve transitions between PACT and:
  * Inpatient
  * Specialty
  * Broader team

Practice Redesign
- Redesign Team:
  * Roles
  * Tasks
- Enhance:
  * Communication
  * Teamwork
- Improve Processes:
  * Visit work
  * Non-visit work

Patient Centeredness: Mindset and Tools
Improvement System Redesign, TAMMCS
Resources: Technology, Staff Space, Community
Important Challenges to Consider if Adopting the Medical Home
Implementation is difficult:

Involves major role transitions for team members, creates stress, and requires clear delineation of responsibilities.

Role transitions particularly difficult for nursing staff.

Increasing expectations and pressure on team members.

Training needed:

Role-specific technical skills (e.g., teaching self-management), computer skills, and leadership and team facilitation skills.

Empowerment Paradox:

Barrier to having everyone work to top of license.
10 Keys to a Successful Medical Home

1. Stable Team Membership
   - Provider + RN Case Manager + Medical Assistant + Clerk

2. Team Boundaries
   - Work within the Teamlet; avoiding “extra duties as assigned”

3. Role Clarity
   - Work to top of license; avoid the “empowerment paradox”

4. Team Development
   - Takes time for teams to become cohesive

5. Ongoing Training
   - Wide variety of training opportunities; computer-based to hands-on
10 Keys to a Successful Medical Home

6. Harmonized Leadership
   • Support across all levels of leadership to support Medical Home

7. Interactive Communication
   • Two-way communication with effective information flow

8. Accessible Data
   • Data available to Teams

9. Aligned Metrics
   • Can’t improve what can’t measure; align expectations with metrics

10. True Commitment
    • Long-term admin commitment to Medical Home vs. flavor-of-the-day
Potential Advantages/Improvements with the Medical Home
ER/Urgent Care Visits after Medical Home Implementation

Urgent Care Visit rate by Panel (Fee Excluded)

- 6% decrease (8% FY11)

ER Visit rate by Panel (Fee Excluded)

- 5% increase
Hospital Admissions after Medical Home Implementation

VHA Admission Rate by Panel
(Fee Excluded)

4.2% reduction in Ambulatory Care Sensitive Conditions (Obs vs. Predicted)

6% decrease (4% FY11)
Patient-Centered Medical Home Initiative Produced Modest Economic Results for VHA, 2010-12
Hebert, et al. Health Affairs. 6(2014) 980-987

• Cost data from 2003-2012
• 2010 Implementation: $774M investment
• Modest decreases in:
  – Primary Care visits
  – Hospitalizations (ACSC)
  – Outpatient Mental Health visits
• $596M avoided costs
• Net loss of $178M
• “Adopting patient-centered care does not appear to have been a major financial risk for the VHA.”
Implementation of PCMH in VHA: Satisfaction, Quality, Burnout, and Hospital and ED Use

• VHA admin data; patient and provider surveys

• PACT Implementation Progress Index (Pi²)
  – 53 items, 3 domains (i.e., Access/coordination, team-based care, patient-centered care)

• 913 Primary Care Clinics comparing top decile (77 clinics) to bottom decile (87 clinics):
  – Higher patient satisfaction (p<.001)
  – Higher performance on 41/48 quality metrics
  – Lower staff burnout (p=.02)
  – Lower hospitalization rates for ACSC (p<.001)
  – Lower ED use (p<.001)
Assoc Between Participation in a Multipayer Medical Home Intervention and Changes in Quality, Utilization, and Costs

- Southeastern PA Chronic Care Care Initiative
  - 64,000 patients compared to 56,000 controls
  - National Committee for Quality Assurance (NCQA) designation for PCMH

- Only 1/11 quality indicators improved
- No change in utilization or costs
- $92,000 average in bonuses per physician
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