# Improving Patient-Centered Medical Home Coordination in a Safety Net Healthcare System Among Adults Living with HIV

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# I HAVE NO DISCLOSURES

This study has been approved by the Hennepin County Medical Center IRB: 11-3306

#### Positive Care Center

- Part of Hennepin County Medical Center
- Serves >1600 Patients in >8000 encounters
- Funded by Ryan White
  - Outpatient Medical Services
  - Case Management
  - Health Education/Risk Reduction
  - Benefits Counseling
  - Transportation Services
  - Chemical Dependency
- Certified Minnesota Health Care Home



#### Patient-Centered Medical Home

- AKA Health Care Homes
- Passed in 2008
- Certifies clinics that meet criteria:
  - Patient- and Family- Friendly
  - Quality Improvement Teams
  - Learning Collaborations
  - Aligned Financial Incentives
  - Outcomes-Based Recertification

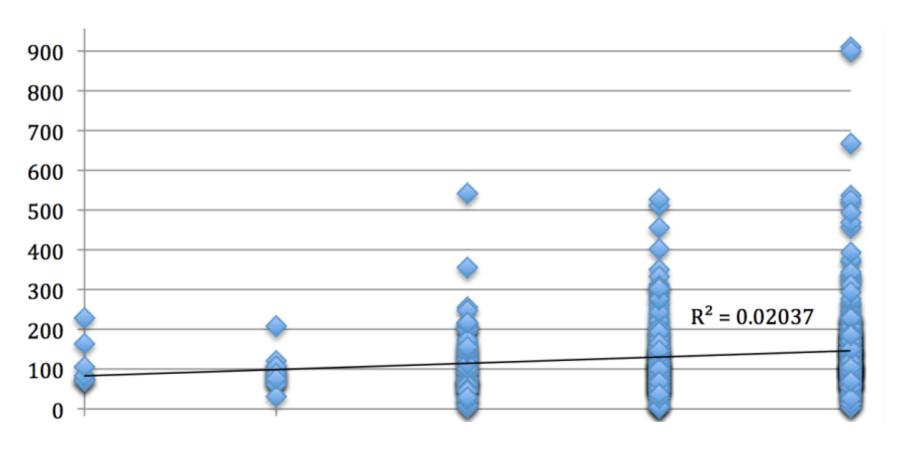
# PCMH Payment Methodology

#### **Care Coordination Tier Assignment Tool Health Care Home Initiative** Patient ID:\_ Date: / / / year Condition Is Severe Condition Requires A Care Team<sup>3</sup> Does this patient present with these conditions..... SCORE\* Allergy, Asthma Cardiovascular Respiratory ☐ Gastrointestinal/Hepatic Musculoskeletal Renal Endocrine 8 ■ Neurologic Mental Health/Psychosocial Hematologic 000000 Rheumatologic 100001 Malignancies Genito-urinary Female Reproductive Genetic Toxic Effects Ear, nose, and throat ☐ Eye Dental Infections Skin Nutrition

# PCMH Payment Methodology

Systems	Tier	Minutes	Payment
0	0	0	\$0
1-3	1	15	\$10.14
4-6	2	30	\$20.27
7-9	3	45	\$40.54
10+	4	60	\$60.81

#### Medical Tier Versus Actual Coordination Time



# HOW CAN WE BETTER UNDERSTAND CARE COORDINATION REQUIREMENTS OF PEOPLE LIVING WITH HIV?

#### Methods

- Collected data from 2008 2011:
  - Medical data (HIV VL, Weight Loss, Complexity Tier)
  - Social data (Housing, Employment, Income, Literacy, Interpreter Needs)
  - Case Management utilization (Activity, Minutes)
- Statistical Analysis:
  - Linear regression
  - Students t-test

### Results

610 patients

Average: 141 min/mo

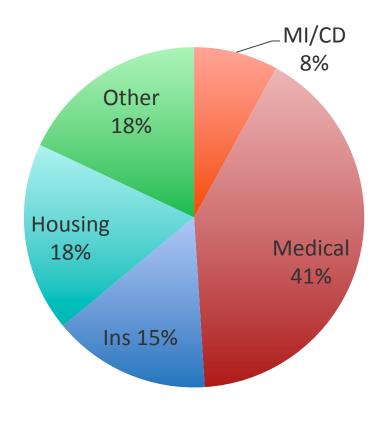
• Range: 2 – 910 min/mo

Gender	
Male	69.0%
Female	31.0%

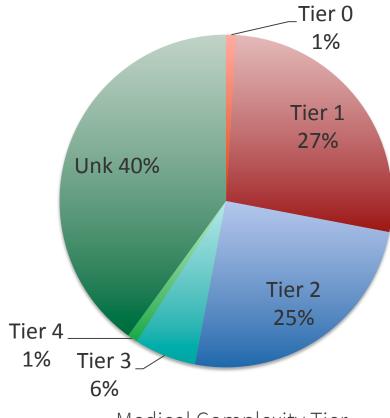
Age	
18-34	19.7%
35-44	28.2%
45-54	36.5%
55+	15.5%

Race/Ethnicity	
White	20.7%
Black	61.0%
Hispanic	5.3%
Al	2.6%
Asian	1.1%
Multi	1.6%
Other	5.1%
Unk	2.5%

#### Results



Care Coordination Activity



Medical Complexity Tier

### Results – Linear Model

	Patients	Estimate
Unemployed or Disabled	83.5%	35.78**
In Poverty	84.3%	20.81
Uncontrolled Weight Loss	4.6%	23.04
Requires Interpreter	9.9%	59.50***
>= 100 Miles From Clinic	2.4%	-40.14

<sup>\*</sup>p < 0.05; \*\*p < 0.01; \*\*\*p < 0.0001

### Results – Linear Model

	Patients	Estimate
Literacy – Learning Disabled	6.5%	5.32
Literacy – Not	6.6%	43.27*
Housing Status – With Friend	23.4%	19.21
Housing Status – Homeless	19.0%	6.29
Housing Status – Institutional	10.2%	75.51***

<sup>\*</sup>p < 0.05; \*\*p < 0.01; \*\*\*p < 0.0001

### Results – Linear Model

	Parameter Estimate
Medical Complexity Tier	12.59*

<sup>\*</sup>p < 0.05; \*\*p < 0.01; \*\*\*p < 0.0001

# Summary of Findings

- Current payment methodology has limited correlation with actual care coordination utilization.
- Social Conditions have larger impact than Medical Conditions:
  - Institutionally Housed
  - Requiring Interpreter
  - Unemployed
  - Literacy

# Limitations and Further Study

- Limited to HIV population
  - Already receiving services through Ryan White
- Use of billing data
- Variable quality of social data

#### Thank You!

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